

INSURANCE CODE

TITLE 2. TEXAS DEPARTMENT OF INSURANCE

SUBTITLE A. ADMINISTRATION OF THE TEXAS DEPARTMENT OF INSURANCE

CHAPTER 30. GENERAL PROVISIONS

Sec. 30.001. PURPOSE OF TITLES 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, AND 20. (a) This title and Titles 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, and 20 are enacted as a part of the state's continuing statutory revision program, begun by the Texas Legislative Council in 1963 as directed by the legislature in the law codified as Section 323.007, Government Code. The program contemplates a topic-by-topic revision of the state's general and permanent statute law without substantive change.

(b) Consistent with the objectives of the statutory revision program, the purpose of this title and Titles 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, and 20 is to make the law encompassed by the titles more accessible and understandable by:

- (1) rearranging the statutes into a more logical order;
- (2) employing a format and numbering system designed to facilitate citation of the law and to accommodate future expansion of the law;
- (3) eliminating repealed, duplicative, unconstitutional, expired, executed, and other ineffective provisions; and
- (4) restating the law in modern American English to the greatest extent possible.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Amended by Acts 2001, 77th Leg., ch. 1419, Sec. 17, eff. June 1, 2003; Acts 2001, 77th Leg., ch. 1420, Sec. 11.001, eff. Sept. 1, 2001; Acts 2003, 78th Leg., ch. 1274, Sec. 9, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 727 (H.B. [2017](#)), Sec. 10, eff. April 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 1A.001, eff. April 1, 2009.

Sec. 30.002. CONSTRUCTION. Except as provided by Section 30.003 and as otherwise expressly provided in this code, Chapter 311, Government Code (Code Construction Act), applies to the construction of each provision in this title and in Titles 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, and 20.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.
Amended by Acts 2001, 77th Leg., ch. 1419, Sec. 17, eff. June 1, 2003; Acts 2001, 77th Leg., ch. 1420, Sec. 11.001, eff. Sept. 1, 2001; Acts 2003, 78th Leg., ch. 1274, Sec. 9, eff. April 1, 2005.
Amended by:

Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 10, eff. April 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1A.001, eff. April 1, 2009.

Sec. 30.003. DEFINITION OF PERSON. The definition of "person" assigned by Section 311.005, Government Code, does not apply to any provision in this title or in Title 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, or 20.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.
Acts 2001, 77th Leg., ch. 1419, Sec. 17, eff. June 1, 2003. Amended by Acts 2001, 77th Leg., ch. 1420, Sec. 11.001, eff. Sept. 1, 2001; Acts 2003, 78th Leg., ch. 1274, Sec. 9, eff. April 1, 2005.
Amended by:

Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 10, eff. April 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1A.001, eff. April 1, 2009.

Sec. 30.004. REFERENCE IN LAW TO STATUTE REVISED BY TITLE 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, OR 20. A reference in a law to a statute or a part of a statute revised by this title or by Title 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, or 20 is considered to be a reference to the part of this code that revises that statute or part of that statute.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.
Acts 2001, 77th Leg., ch. 1419, Sec. 17, eff. June 1, 2003; Acts 2001, 77th Leg., ch. 1420, Sec. 11.001, eff. Sept. 1, 2001. Amended by Acts 2003, 78th Leg., ch. 1274, Sec. 9, eff. April 1, 2005.
Amended by:

Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 10, eff. April 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1A.001, eff. April 1, 2009.

Sec. 30.005. PREEMPTION. Unless expressly authorized by another statute, a municipality or county may not adopt, enforce, or maintain an ordinance, order, or rule regulating conduct in a field of regulation that is occupied by a provision of this code. An ordinance, order, or rule that violates this section is void, unenforceable, and inconsistent with this code.

Added by Acts 2023, 88th Leg., R.S., Ch. 899 (H.B. 2127), Sec. 9, eff. September 1, 2023.

CHAPTER 31. ORGANIZATION OF DEPARTMENT
SUBCHAPTER A. GENERAL PROVISIONS

Sec. 31.001. DEFINITIONS. In this code and other insurance laws:

- (1) "Commissioner" means the commissioner of insurance.
- (2) "Department" means the Texas Department of Insurance.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

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

- (1) regulate the business of insurance in this state;
- (2) administer the workers' compensation system of this state as provided by Title 5, Labor Code;
- (3) ensure that this code and other laws regarding insurance and insurance companies are executed;
- (4) protect and ensure the fair treatment of consumers; and
- (5) ensure fair competition in the insurance industry in order to foster a competitive market.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.
Amended by:

Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 6.051, eff. September 1, 2005.

Acts 2011, 82nd Leg., R.S., Ch. 1147 (H.B. 1951), Sec. 1.001, eff. September 1, 2011.

Sec. 31.003. COMPOSITION OF DEPARTMENT. The department is composed of the commissioner and other officers and employees required to efficiently implement:

- (1) this code;
- (2) other insurance laws of this state; and
- (3) other laws granting jurisdiction or applicable to the department or the commissioner.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 31.004. SUNSET PROVISION. (a) The Texas Department of Insurance is subject to Chapter 325, Government Code (Texas Sunset Act). Unless continued in existence as provided by that chapter, the department is abolished September 1, 2029.

(b) Unless continued as provided by Chapter 325, Government Code, the duties of the division of workers' compensation of the Texas Department of Insurance under Title 5, Labor Code, expire September 1, 2029, or another date designated by the legislature.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.
Amended by Acts 2003, 78th Leg., ch. 1112, Sec. 2.02, eff. Sept. 1, 2003.

Amended by:

Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 6.052, eff. September 1, 2005.

Acts 2005, 79th Leg., Ch. 1227 (H.B. 1116), Sec. 2.05, eff. September 1, 2005.

Acts 2007, 80th Leg., R.S., Ch. 928 (H.B. 3249), Sec. 3.09, eff. June 15, 2007.

Acts 2009, 81st Leg., 1st C.S., Ch. 2 (S.B. 2), Sec. 1.06, eff. July 10, 2009.

Acts 2011, 82nd Leg., R.S., Ch. 1147 (H.B. 1951), Sec. 1.002, eff. September 1, 2011.

Acts 2011, 82nd Leg., R.S., Ch. 1162 (H.B. 2605), Sec. 1, eff. September 1, 2011.

Acts 2013, 83rd Leg., R.S., Ch. 1279 (H.B. 1675), Sec. 4.02, eff.

June 14, 2013.

Acts 2019, 86th Leg., R.S., Ch. 596 (S.B. 619), Sec. 2.05, eff.

June 10, 2019.

Acts 2021, 87th Leg., R.S., Ch. 850 (S.B. 713), Sec. 2.01, eff.

June 16, 2021.

Acts 2023, 88th Leg., R.S., Ch. 941 (S.B. 1659), Sec. 1.13, eff.

June 18, 2023.

Sec. 31.005. DEFENSE BY ATTORNEY GENERAL. The attorney general shall defend an action brought against the commissioner or an employee or officer of the department as a result of that person's official act or omission, whether or not at the time of the institution of the action that person has terminated service with the department.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 31.006. TEXAS WORKERS' COMPENSATION COMMISSION NOT AFFECTED. This code does not affect the duties imposed by law on the Texas Workers' Compensation Commission.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 31.007. REFERENCES TO BOARD. A reference in this code or other law to the State Board of Insurance, the Board of Insurance Commissioners, or an individual commissioner means the commissioner or the department as consistent with the respective duties of the commissioner and the department under this code and other insurance laws.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

SUBCHAPTER B. COMMISSIONER OF INSURANCE

Sec. 31.021. CHIEF EXECUTIVE. (a) The commissioner is the department's chief executive and administrative officer. The commissioner shall administer and enforce this code, other insurance laws of this state, and other laws granting jurisdiction or

applicable to the department or the commissioner.

(b) The commissioner has the powers and duties vested in the department by:

- (1) this code and other insurance laws of this state; and
- (2) Title 5, Labor Code, and other workers' compensation insurance laws of this state.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Amended by:

Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 6.053, eff. September 1, 2005.

Sec. 31.022. APPOINTMENT; TERM. (a) The governor, with the advice and consent of the senate, shall appoint the commissioner. The commissioner serves a two-year term that expires on February 1 of each odd-numbered year.

(b) The governor shall appoint the commissioner without regard to the race, color, disability, sex, religion, age, or national origin of the appointee.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 31.023. QUALIFICATIONS. The commissioner must:

- (1) be a competent and experienced administrator;
- (2) be well informed and qualified in the field of insurance and insurance regulation; and
- (3) have at least five years of experience in the administration of business or government or as a practicing attorney or certified public accountant.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Amended by Acts 2003, 78th Leg., 3rd C.S., ch. 3, Sec. 10.01, eff. Jan. 11, 2004.

Sec. 31.024. INELIGIBILITY FOR PUBLIC OFFICE. The commissioner is ineligible to be a candidate for a public elective office in this state, unless the commissioner has resigned and the governor has accepted the resignation.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 31.026. COMPENSATION. The commissioner is entitled to compensation as provided by the General Appropriations Act.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 31.027. GROUNDS FOR REMOVAL. (a) It is a ground for removal from office if the commissioner:

(1) does not have at the time of appointment the qualifications required by Section 31.023;

(2) does not maintain during service as commissioner the qualifications required by Section 31.023;

(3) violates a prohibition established by Section 33.001, 33.003, 33.004, or 33.005; or

(4) cannot, because of illness or disability, discharge the commissioner's duties for a substantial part of the commissioner's term.

(b) The validity of an action of the commissioner or the department is not affected by the fact that it is taken when a ground for removal of the commissioner exists.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 31.028. TRAINING PROGRAM FOR COMMISSIONER. (a) Not later than the 90th day after the date on which the commissioner takes office, the commissioner shall complete a training program that complies with this section.

(b) The training program must provide the commissioner with information regarding:

(1) the legislation that created the department;

(2) the programs operated by the department;

(3) the role and functions of the department;

(4) the rules of the department, with an emphasis on the rules that relate to disciplinary and investigatory authority;

(5) the current budget for the department;

(6) the results of the most recent formal audit of the department;

(7) the requirements of:

- (A) the open meetings law, Chapter 551, Government Code;
 - (B) the public information law, Chapter 552, Government Code;
 - (C) the administrative procedure law, Chapter 2001, Government Code; and
 - (D) other laws relating to public officials, including conflict of interest laws; and
- (8) any applicable ethics policies adopted by the department or the Texas Ethics Commission.

Added by Acts 2003, 78th Leg., 3rd C.S., ch. 3, Sec. 10.04, eff. Jan. 11, 2004.

SUBCHAPTER C. PERSONNEL

Sec. 31.041. DEPARTMENT PERSONNEL. (a) Subject to the General Appropriations Act or other law, the commissioner shall appoint deputies, assistants, and other personnel as necessary to carry out the powers and duties of the commissioner and the department under this code, other insurance laws of this state, and other laws granting jurisdiction or applicable to the department or the commissioner.

(b) A person appointed under this section must have the professional, administrative, and insurance experience necessary to qualify the person for the position to which the person is appointed.

(c) A person appointed as an associate or deputy commissioner or to hold an equivalent position must have at least five years of the experience required for appointment as commissioner under Section 31.023. At least two years of that experience must be in work related to the position to be held.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 31.042. DIVISION OF RESPONSIBILITIES. The commissioner shall develop and implement policies that clearly define the respective responsibilities of the commissioner and the staff of the department.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 31.043. EQUAL EMPLOYMENT OPPORTUNITY POLICY; REPORT. (a) The commissioner or the commissioner's designee shall prepare and maintain a written policy statement to ensure implementation of a program of equal employment opportunity under which all personnel transactions are made without regard to race, color, disability, sex, religion, age, or national origin. The policy statement must include:

(1) personnel policies, including policies relating to recruitment, evaluation, selection, appointment, training, and promotion of personnel that are in compliance with Chapter 21, Labor Code;

(2) a comprehensive analysis of the department workforce that meets federal and state guidelines;

(3) procedures by which a determination can be made of significant underuse in the department workforce of all persons for whom federal or state guidelines encourage a more equitable balance; and

(4) reasonable methods to appropriately address those areas of significant underuse.

(b) A policy statement prepared under this section must:

(1) cover an annual period;

(2) be updated annually;

(3) be reviewed by the Commission on Human Rights for compliance with Subsection (a); and

(4) be filed with the governor.

(c) The governor shall deliver a biennial report to the legislature based on the information received under Subsection (b). The report may be made separately or as a part of other biennial reports made to the legislature.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 31.044. QUALIFICATIONS AND STANDARDS OF CONDUCT. The commissioner shall provide to department employees, as often as necessary, information regarding their:

(1) qualification for office or employment under this code;

and

(2) responsibilities under applicable laws relating to standards of conduct for state employees.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 31.045. CAREER LADDER PROGRAM; PERFORMANCE EVALUATIONS.

(a) The commissioner or the commissioner's designee shall develop an intra-agency career ladder program. The program must require intra-agency posting of all nonentry level positions concurrently with any public posting.

(b) The commissioner or the commissioner's designee shall develop a system of annual performance evaluations. All merit pay for department employees must be based on the system established under this subsection.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

CHAPTER 32. ADMINISTRATIVE POWERS AND DUTIES

SUBCHAPTER A. RECORDS

Sec. 32.001. GIVING CERTIFIED COPIES AND CERTIFICATES. (a) On request and on payment of the required fee, the department shall:

(1) certify a copy of a paper or a record in a department office and give the certified copy to any person when the commissioner determines that providing the copy is not prejudicial to the public interest; and

(2) give a certificate as provided by other law.

(b) A fee collected by the department under this section shall be deposited in the general revenue fund to the credit of the Texas Department of Insurance operating account.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 32.0015. FILING ARTICLES OF INCORPORATION AND OTHER PAPERS; CERTIFIED COPIES. (a) The department shall file and maintain in a department office:

(1) all insurance companies' acts or articles of incorporation; and

(2) any other paper required by law to be filed with the department.

(b) The department shall provide a certified copy of a document described by Subsection (a)(1) or (2) to a party interested in the document who:

- (1) submits an application; and
- (2) pays the fee prescribed by law.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1A.002, eff. April 1, 2009.

Sec. 32.002. RECORD OF DEPARTMENT PROCEEDINGS. The department shall maintain a complete record of the department's proceedings.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 32.003. STATEMENTS REGARDING CONDITION OF EXAMINED COMPANIES. The department shall maintain a concise statement of the condition of each company or agency visited or examined.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 32.004. PUBLICATION OF RESULTS OF EXAMINATION. The department shall publish the results of an examination of a company's affairs if the commissioner determines that publication is in the public interest.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1A.002, eff. April 1, 2009.

SUBCHAPTER B. REPORTS

Sec. 32.021. ANNUAL REPORTS. (a) The department shall file annually with the governor and the presiding officer of each house of the legislature a complete and detailed written report that includes:

- (1) a description of the commissioner's official acts;
- (2) a description of the condition of companies doing business in this state; and

(3) other information that exhibits the affairs of the department.

(b) The annual report required by Subsection (a) must be in the form and reported in the time provided by the General Appropriations Act.

(c) The department shall:

(1) send a copy of the annual report required by Subsection (a) to the insurance commissioner or other similar officer of every state; and

(2) on request, send a copy to any company doing business in this state.

(d) The department shall print a separate premium and loss report that contains and arranges in tabular form the premium and loss information contained in the annual statements for companies doing business in this state.

(e) The department shall file the report required by Subsection (d) with the Legislative Reference Library and the Texas State Library with the annual report required by Subsection (a).

(f) The department shall notify the legislature of the availability of the reports required by this section.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 1312 (S.B. 59), Sec. 76, eff. September 1, 2013.

Sec. 32.022. BIENNIAL REPORT TO LEGISLATURE. (a) On or before December 31 of each even-numbered year, the department shall submit to the appropriate committees of each house of the legislature a written report that indicates any needed changes in the laws relating to regulation of the insurance industry or any other industry or occupation under the jurisdiction of the department and that states the reasons for the needed changes.

(b) If the commissioner determines that any capital or surplus requirements established by this code for any insurance companies are inadequate, the department shall:

(1) include in the biennial report specific recommendations relating to the amounts at which the capital or surplus requirements should be set and the findings and evidence on which those

recommendations are based; and

- (2) submit the biennial report to the governor.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 32.023. REPORTS TO OTHER STATES. On request, the department shall provide to the insurance commissioner or other similar officer of another state information relating to a company of this state that does business in the other state if:

- (1) the other state has enacted the substantial provisions of the insurance laws of this state; and
- (2) the commissioner or other similar officer has a legal duty to obtain the information.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

SUBCHAPTER C. FORMS

Sec. 32.041. FORMS. The department shall furnish to the companies required to report to the department the necessary forms for the required statements.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

SUBCHAPTER D. INTERNET ACCESS TO CERTAIN INFORMATION

Sec. 32.101. APPLICABILITY OF SUBCHAPTER. This subchapter applies to insurers who comprise the top 25 insurance groups in the national market and who issue residential property insurance or personal automobile insurance policies in this state, including a Lloyd's plan, a reciprocal or interinsurance exchange, a county mutual insurance company, a farm mutual insurance company, the Texas Windstorm Insurance Association, the FAIR Plan Association, and the Texas Automobile Insurance Plan Association.

Added by Acts 2007, 80th Leg., R.S., Ch. 151 (S.B. [611](#)), Sec. 1, eff. May 21, 2007.

Sec. 32.102. INTERNET WEBSITE. (a) The department, in

conjunction with the office of public insurance counsel, shall establish and maintain a single Internet website that provides information to enable consumers to make informed decisions relating to the purchase of residential property insurance and personal automobile insurance. The website must include:

(1) a description of each type of residential property insurance policy and personal automobile insurance policy issued in this state, including a comparison of the coverage, exclusions, and restrictions of each policy that allows a side-by-side comparison of the features of the policy forms;

(2) a listing of each insurer writing residential property insurance or personal automobile insurance in this state, indexed by each county or zip code in which the insurer is actively writing that insurance, and a profile of the insurer that includes:

(A) contact information for the insurer, including the insurer's full name, address, and telephone number and the insurer's fax number and e-mail address, if available;

(B) information on rates charged by the insurer, including:

(i) sample rates for different policyholder profiles in each county or zip code; and

(ii) the percentage by which the sample rate has fallen or risen due to filings in the previous 12, 24, and 36 months;

(C) a list of policy forms, exclusions, endorsements, and discounts offered by the insurer;

(D) an indication of whether the insurer uses credit scoring in underwriting, rating, or tiering, and a link to the insurer's credit model or a link explaining how to request the insurer's credit model;

(E) the insurer's financial rating determined by A. M. Best or similar rating organization and an explanation of the meaning and importance of the rating;

(F) a complaint ratio or similar complaint rating system for the insurer for each of the previous three years and an explanation of the meaning of the rating system; and

(G) information, other than information made confidential by law, on the insurer's regulatory and administrative experience with the department, the office of public insurance counsel, and insurance regulatory authorities in other states; and

(3) if feasible, as determined by the commissioner and the

public insurance counsel:

(A) a side-by-side comparison of credit scoring models, including factors, key variables, and weights, of residential property insurers in this state; and

(B) a side-by-side comparison of credit scoring models, including factors, key variables, and weights, of private passenger automobile insurers in this state.

(b) The Internet website required by this section may link to and be linked from the department's and the office of public insurance counsel's main websites, but must have its own Internet address distinct from the address of those main sites.

(c) The department and the office of public insurance counsel may include on the Internet website or by link to another site any other information the department and the office of public insurance counsel determine is helpful to consumers of residential property insurance or personal automobile insurance or that the department or the office of public insurance counsel is authorized or required to publish under this code that relates to residential property insurance or personal automobile insurance.

Added by Acts 2007, 80th Leg., R.S., Ch. 151 (S.B. [611](#)), Sec. 1, eff. May 21, 2007.

Sec. 32.103. PUBLIC INFORMATION CONCERNING INTERNET WEBSITE. The department shall publicize the existence of the Internet website required by this subchapter.

Added by Acts 2007, 80th Leg., R.S., Ch. 151 (S.B. [611](#)), Sec. 1, eff. May 21, 2007.

Sec. 32.104. DUTIES OF INSURER. (a) On the request of the department, an insurer shall provide to the department any information the department and the office of public insurance counsel determine is reasonable or necessary to fulfill the department's and the office of the public insurance counsel's duties under this subchapter.

(b) An insurer shall provide in a conspicuous manner with each residential property insurance or personal automobile insurance policy issued in this state notice of the Internet website required

by this subchapter. The commissioner shall determine the form and content of the notice.

Added by Acts 2007, 80th Leg., R.S., Ch. 151 (S.B. 611), Sec. 1, eff. May 21, 2007.

SUBCHAPTER E. RULES REGARDING USE OF ADVISORY COMMITTEES

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

- (1) purpose, role, responsibility, and goals;
- (2) size and quorum requirements;
- (3) qualifications for membership, including experience requirements and geographic representation;
- (4) appointment procedures;
- (5) terms of service;
- (6) training requirements; and
- (7) duration.

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

Added by Acts 2011, 82nd Leg., R.S., Ch. 1147 (H.B. 1951), Sec. 2.001, eff. September 1, 2011.

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

Added by Acts 2011, 82nd Leg., R.S., Ch. 1147 (H.B. 1951), Sec. 2.001, eff. September 1, 2011.

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

Added by Acts 2011, 82nd Leg., R.S., Ch. 1147 (H.B. 1951), Sec. 2.001, eff. September 1, 2011.

CHAPTER 33. STANDARDS OF CONDUCT

Sec. 33.001. APPLICATION OF LAW RELATING TO ETHICAL CONDUCT. The commissioner and each employee or agent of the department is subject to the code of ethics and the standard of conduct imposed by Chapter 572, Government Code, and any other law regulating the ethical conduct of state officers and employees.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 33.002. INSURANCE BUSINESS INTEREST; SERVICE AS COMMISSIONER. (a) A person is not eligible for appointment as commissioner if the person, the person's spouse, or any other person who resides in the same household as the person:

- (1) is registered, certified, or licensed by the department;
- (2) is employed by or participates in the management of a business entity or other organization regulated by or receiving funds from the department;
- (3) owns or controls, directly or indirectly, more than a 10 percent interest in a business entity or other organization regulated by or receiving funds from the department; or
- (4) uses or receives a substantial amount of tangible goods, services, or funds from the department, other than compensation or reimbursement authorized by law.

(b) A person is not eligible for appointment as commissioner if the person:

- (1) is a stockholder, director, officer, attorney, agent, or employee of an insurance company, insurance agent, insurance broker, or insurance adjuster; or
- (2) is directly or indirectly interested in a business described by Subdivision (1).

(c) Subsection (b) does not apply to:

- (1) a person solely because the person is insured by an

insurer or is the beneficiary of insurance; or

(2) a person who:

(A) is appointed as a receiver, liquidator, supervisor, or conservator of an insurer; or

(B) is an employee of a receiver, liquidator, supervisor, or conservator of an insurer with respect to duties under that employment.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 33.003. INSURANCE BUSINESS INTEREST; EMPLOYEE. (a) A person who is a director, officer, attorney, agent, or employee of an insurance company, insurance agent, insurance broker, or insurance adjuster may not be employed by the department.

(b) A person who resides in the same household as a person who is an officer, managerial employee, or paid consultant in the insurance industry may not be employed in an exempt salary position as defined by the General Appropriations Act.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 33.004. TRADE ASSOCIATIONS. (a) A person who is an officer, employee, or paid consultant of a trade association in the field of insurance may not be:

(1) the commissioner; or

(2) an employee of the department who is exempt from the state's position classification plan or is compensated at or above the amount prescribed by the General Appropriations Act for step 1, salary group A17, of the position classification salary schedule.

(b) A person who is the spouse of an officer, manager, or paid consultant of a trade association in the field of insurance may not be:

(1) the commissioner; or

(2) an employee of the department who is exempt from the state's position classification plan or is compensated at or above the amount prescribed by the General Appropriations Act for step 1, salary group A17, of the position classification salary schedule.

(c) In this section, "trade association" means a nonprofit, cooperative, and voluntarily joined association of business or

professional competitors designed to assist its members and its industry or profession in dealing with mutual business or professional problems and in promoting their common interest.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 33.005. LOBBYING ACTIVITIES. A person may not serve as the commissioner or act as the general counsel to the commissioner if the person is required to register as a lobbyist under Chapter 305, Government Code, because of the person's activities for compensation on behalf of a profession related to the operation of the department.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 33.006. FORMER SERVICE. A person may not serve as the commissioner if the person served as a member of the State Board of Insurance.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 33.007. PROHIBITED REPRESENTATION. (a) A person who served as the commissioner, the general counsel to the commissioner, or the public insurance counsel, or as an employee of the State Office of Administrative Hearings who was involved in hearing cases under this code, another insurance law of this state, or Title 5, Labor Code, commits an offense if the person represents another person in a matter before the department or receives compensation for services performed on behalf of another person regarding a matter pending before the department during the one-year period after the date the person ceased to be the commissioner, the general counsel to the commissioner, the public insurance counsel, or an employee of the State Office of Administrative Hearings.

(b) A person who served as a member of the State Board of Insurance or as a staff employee of a member of the State Board of Insurance, or who served as the commissioner, the general counsel to the commissioner, or the public insurance counsel or as an employee of the department or the State Office of Administrative Hearings, commits an offense if, after the person ceased to serve, the person

represents another person or receives compensation for services performed on behalf of another person regarding a matter with which the person was directly concerned during the person's service. For purposes of this subsection, a person was directly concerned with a matter if the person had personal involvement with the matter or if the matter was within the scope of the person's official responsibility.

(c) An offense under this section is a Class A misdemeanor.

(d) This section does not apply to a department employee whose position is eliminated as a direct result of a reduction in the department's workforce.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Amended by:

Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 6.054, eff. September 1, 2005.

CHAPTER 34. IMMUNITY FROM LIABILITY

Sec. 34.001. PERSONAL IMMUNITY. A person who is the commissioner or an employee of the department is not personally liable in a civil action for:

(1) an act performed in good faith within the scope of that person's authority; or

(2) damages caused by an official act or omission of that person unless the act or omission is corrupt or malicious.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 34.002. IMMUNITY FOR FURNISHING INFORMATION RELATING TO FRAUD. (a) A person is not liable in a civil action, including an action for libel or slander, and a civil action may not be brought against the person, for furnishing information relating to suspected, anticipated, or completed fraudulent insurance acts if the information is provided to or received from:

(1) the commissioner or an employee of the department;

(2) a law enforcement agency of this state, of another state, or of the United States or an employee of the agency;

(3) the National Association of Insurance Commissioners or an employee of the association; or

(4) a state or federal governmental agency established to detect and prevent fraudulent insurance acts or to regulate the business of insurance or an employee of the agency.

(b) A person may furnish information as described in Subsection (a) orally or in writing, including through publishing, disseminating, or filing bulletins or reports.

(c) Subsection (a) does not apply to a person who acts with malice, fraudulent intent, or bad faith.

(d) A person to whom Subsection (a) applies who prevails in a civil action arising from the furnishing of information as described in Subsection (a) is entitled to attorney's fees and costs if the action was not substantially justified. In this subsection, "substantially justified" means there was a reasonable basis in law or fact to bring the action at the time the action was initiated.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 34.003. IMMUNITY FOR INVESTIGATIONS AND RELATED REPORTS.

(a) A person who is the commissioner or an employee, agent, or designee of the department is not liable in a civil action, including an action for libel or slander, because of:

(1) an investigation of a violation of this code or an alleged fraudulent insurance act; or

(2) the publication or dissemination of an official report related to the investigation.

(b) Subsection (a) does not apply to a person who acts with malice.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 34.004. IMMUNITY FOR USE OF ANNUAL STATEMENT INFORMATION.

(a) A person is not liable in a civil action, including an action for libel or slander, for collecting, reviewing, analyzing, disseminating, or reporting information collected from annual statements filed under Chapter 802 if the person is:

(1) the department, the commissioner, or an employee of the department;

(2) a member or employee of or delegate to the National Association of Insurance Commissioners or an authorized committee,

subcommittee, or task force of that association; or

(3) another person who is responsible for collecting, reviewing, analyzing, and disseminating information from filed annual statement convention blanks.

(b) Subsection (a) does not apply to a person who acts with malice.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2B.001, eff. April 1, 2009.

Sec. 34.005. EFFECT OF CHAPTER ON OTHER IMMUNITY. This chapter does not affect or modify any common law or statutory privilege or immunity.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

CHAPTER 35. ELECTRONIC TRANSACTIONS

Sec. 35.001. DEFINITIONS. In this chapter:

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

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

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

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

(C) a Mexican casualty company;

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

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

(F) a domestic or foreign fraternal benefit society;

(G) a domestic or foreign title insurance company;

(H) a stipulated premium company;

(I) a nonprofit legal service corporation;

(J) a health maintenance organization;

(K) a statewide mutual assessment company;

(L) a local mutual aid association;
 (M) a local mutual burial association;
 (N) an association exempt under Section 887.102;
 (O) a nonprofit hospital, medical, or dental service corporation, including a company subject to Chapter 842;
 (P) a county mutual insurance company;
 (Q) a farm mutual insurance company; and
 (R) an agency or agent of an insurer, organization, person, or program described by this subdivision.

(3) "Deliver by electronic means" means:

(A) deliver to an e-mail address at which a party has consented to receive notices, documents, or information; or

(B) post on an electronic network or Internet website accessible by an electronic device, including a computer, mobile device, or tablet, and deliver notice of the posting to an e-mail address at which the party has consented to receive notices.

(4) "Party" means a recipient, including an applicant, insured, policyholder, enrollee, or annuity contract holder, of a notice or document or of information required as part of an insurance transaction.

(4-a) "Plan sponsor" means a person, other than a regulated entity, who establishes, adopts, or maintains a health benefit plan, including a vision or dental benefit plan, that covers residents of this state, including a plan established, adopted, or maintained by an employer or jointly by an employer and one or more employee organizations, an association, a committee, a joint board of trustees, or any similar group of representatives who establish, adopt, or maintain a plan.

(5) "Written communication" means a notice or document or other information provided in writing.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1147 (H.B. [1951](#)), Sec. 6.001, eff. September 1, 2011.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 602 (S.B. [1074](#)), Sec. 1, eff. September 1, 2013.

Acts 2017, 85th Leg., R.S., Ch. 967 (S.B. [2065](#)), Sec. 5.001, eff. September 1, 2017.

Acts 2021, 87th Leg., R.S., Ch. 976 (S.B. [2124](#)), Sec. 1, eff. September 1, 2021.

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

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

Added by Acts 2011, 82nd Leg., R.S., Ch. 1147 (H.B. 1951), Sec. 6.001, eff. September 1, 2011.

Sec. 35.003. ELECTRONIC TRANSACTIONS AUTHORIZED. (a) Subject to Section 35.004, a regulated entity may conduct business electronically to the same extent that the entity is authorized to conduct business otherwise if before the conduct of business:

(1) each party to the business agrees to conduct the business electronically; or

(2) each other party to the business has been given notice by the entity that the business will be conducted electronically and has not requested that the business be conducted in nonelectronic form.

(b) If a regulated entity provides notice under Subsection (a)(2) and the other party does not opt out of conducting business electronically, the other party is considered to have agreed to conduct business electronically for the purposes of Chapter 322, Business & Commerce Code.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1147 (H.B. 1951), Sec. 6.001, eff. September 1, 2011.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 309 (H.B. 1040), Sec. 1, eff. September 1, 2023.

Sec. 35.004. MINIMUM STANDARDS FOR REGULATED ENTITIES ELECTRONICALLY CONDUCTING BUSINESS WITH CONSUMERS. (a) Subject to Subsection (c), a notice to a party or other written communication with a party required in an insurance transaction or that is to serve

as evidence of insurance coverage may be delivered, stored, and presented by electronic means only if the delivery, storage, or presentment complies with Chapter 322, Business & Commerce Code.

(b) Delivery of a written communication in compliance with this section is equivalent to any delivery method required by law, including delivery by first class mail, first class mail, postage prepaid, or certified mail.

(c) A written communication may be delivered by electronic means to a party by a regulated entity under this section if:

(1) the party:

(A) affirmatively consented to delivery by electronic means and has not withdrawn the consent; or

(B) if affirmative consent is not sought, has not requested that written communication be delivered to the party in paper or another nonelectronic form instead of by electronic means;

(2) the party, before giving consent or receiving written communication by electronic means, is provided with a clear and conspicuous statement informing the party of:

(A) any right or option the party may have for the written communication to be provided or made available in paper or another nonelectronic form;

(B) the right of the party to withdraw consent under this section or to request written communication be delivered to the party in nonelectronic form, if the party's affirmative consent is not sought, and any conditions or consequences imposed if consent is withdrawn or delivery in nonelectronic form is requested;

(C) whether the party's consent to delivery by electronic means or the party's request or the absence of the party's request for delivery in nonelectronic form applies:

(i) only to a specific transaction for which the written communication must be given; or

(ii) to identified categories of written communications that may be delivered during the course of the relationship between the party and the regulated entity;

(D) the means by which a party may obtain a paper copy of a written communication delivered by electronic means; and

(E) the procedure a party must follow to:

(i) withdraw consent under this section or to otherwise request delivery of written communication in nonelectronic form, as applicable; and

(ii) update information needed for the regulated entity to contact the party electronically; and

(3) the party:

(A) before giving consent or receiving written communication by electronic means, is provided with a statement identifying the hardware and software requirements for the party's access to and retention of a written communication delivered by electronic means; and

(B) if affirmative consent is sought, consents electronically or confirms consent electronically in a manner that reasonably demonstrates that the party can access a written communication in the electronic form used to deliver the communication.

(d) After consent of the party is given or the opportunity to request delivery of written communication in nonelectronic form is given, as applicable, in the event a change in the hardware or software requirements to access or retain a written communication delivered by electronic means creates a material risk that the party may not be able to access or retain a subsequent written communication to which the consent applies, the regulated entity shall:

(1) provide the party with a statement:

(A) identifying the revised hardware and software requirements for access to and retention of a written communication delivered by electronic means; and

(B) disclosing the right of the party to withdraw consent or to otherwise request delivery in nonelectronic form, as applicable, without the imposition of any condition or consequence that was not disclosed under Subsection (c)(2)(B); and

(2) comply with Subsection (c)(3).

(e) This section does not affect requirements for content or timing of any required written communication.

(f) If a written communication provided to a party expressly requires verification or acknowledgment of receipt, the written communication may be delivered by electronic means only if the method used provides for verification or acknowledgment of receipt.

(g) The legal effectiveness, validity, or enforceability of any contract or policy of insurance executed by a party may not be denied solely due to the failure to obtain electronic consent or confirmation of consent of the party in accordance with Subsection

(c)(3)(B).

(h) A withdrawal of consent by a party does not affect the legal effectiveness, validity, or enforceability of a written communication delivered by electronic means to the party before the withdrawal of consent is effective. A withdrawal of consent is effective within a reasonable period of time after the date of the receipt by the regulated entity of the withdrawal. Failure by a regulated entity to comply with Subsection (d) may be treated by the party as a withdrawal of consent.

(i) If the consent of a party to receive a written communication by electronic means is on file with a regulated entity before September 1, 2013, and if the entity intends to deliver to the party written communications under this section, then before the entity may deliver by electronic means additional written communications, the entity must notify the party of:

(1) the written communications that may be delivered by electronic means that were not previously delivered by electronic means; and

(2) the party's right to withdraw consent to have written communications delivered by electronic means.

(j) Except as otherwise provided by law, an oral communication or a recording of an oral communication may not qualify as a written communication delivered by electronic means for purposes of this chapter.

(k) If a signature on a written communication is required by law to be notarized, acknowledged, verified, or made under oath, the requirement is satisfied if the electronic signature of the notary public or other authorized person and the other required information are attached to or logically associated with the signature or written communication.

(l) A notice of the cancellation or termination of a policy to which this section applies must be:

(1) a written communication; and

(2) delivered to a party:

(A) by electronic means; and

(B) in paper or another nonelectronic form.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1147 (H.B. 1951), Sec. 6.001, eff. September 1, 2011.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 602 (S.B. 1074), Sec. 2, eff. September 1, 2013.

Acts 2023, 88th Leg., R.S., Ch. 309 (H.B. 1040), Sec. 2, eff. September 1, 2023.

Sec. 35.0041. CONSENT TO ELECTRONIC DELIVERY BY PLAN SPONSOR.

(a) The plan sponsor of a health benefit plan, including a vision or dental benefit plan, may, on behalf of a party enrolled in the plan, give consent under Section 35.004(c)(1)(A).

(b) Before consenting on behalf of a party, a plan sponsor must:

(1) provide the party with the statements required by Sections 35.004(c)(2) and (c)(3)(A);

(2) confirm that the party routinely uses electronic communications during the normal course of employment; and

(3) provide the party an opportunity to opt out of delivery by electronic means.

Added by Acts 2021, 87th Leg., R.S., Ch. 976 (S.B. 2124), Sec. 2, eff. September 1, 2021.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 309 (H.B. 1040), Sec. 3, eff. September 1, 2023.

Sec. 35.0045. RULES. The commissioner shall adopt rules necessary to implement and enforce this chapter.

Added by Acts 2013, 83rd Leg., R.S., Ch. 602 (S.B. 1074), Sec. 2, eff. September 1, 2013.

Sec. 35.005. EXEMPTION FROM CERTAIN FEDERAL LAWS. This chapter modifies, limits, or supersedes the provisions of the federal Electronic Signatures in Global and National Commerce Act (15 U.S.C. Section 7001 et seq.) as authorized by Section 102 of that Act (15 U.S.C. Section 7002).

Added by Acts 2013, 83rd Leg., R.S., Ch. 602 (S.B. 1074), Sec. 3, eff. September 1, 2013.

CHAPTER 36. DEPARTMENT RULES AND PROCEDURES**SUBCHAPTER A. RULES**

Sec. 36.001. GENERAL RULEMAKING AUTHORITY. (a) The commissioner may adopt any rules necessary and appropriate to implement the powers and duties of the department under this code and other laws of this state.

(b) Rules adopted under this section must have general and uniform application.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.
Amended by Acts 2003, 78th Leg., ch. 206, Sec. 15.01, eff. June 11, 2003.

Sec. 36.002. ADDITIONAL RULEMAKING AUTHORITY. The commissioner may adopt reasonable rules that are:

- (1) necessary to effect the purposes of a provision of:
 - (A) Subchapter B, Chapter 5;
 - (B) Subchapter C, Chapter 1806;
 - (C) Subchapter A, Chapter 2301;
 - (D) Chapter 251, as that chapter relates to casualty insurance and fidelity, guaranty, and surety bond insurance;
 - (E) Chapter 253;
 - (F) Chapter 2008, 2251, or 2252; or
 - (G) Subtitle B, Title 10; or
- (2) appropriate to accomplish the purposes of a provision of:
 - (A) Section 37.051(a), 403.002, 501.159, 941.003(b)(1) or (c), or 942.003(b)(1) or (c);
 - (B) Subchapter H, Chapter 544;
 - (C) Chapter 251, as that chapter relates to:
 - (i) automobile insurance;
 - (ii) casualty insurance and fidelity, guaranty, and surety bond insurance;
 - (iii) fire insurance and allied lines;
 - (iv) workers' compensation insurance; or
 - (v) aircraft insurance;
 - (D) Chapter 5, 252, 253, 254, 255, 256, 426, 493, 494,

1804, 1805, 1806, 2171, 6001, 6002, or 6003;

(E) Subtitle B, C, D, E, F, H, or I, Title 10;

(F) Section 417.008, Government Code; or

(G) Chapter 2154, Occupations Code.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 11, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2B.002, eff. April 1, 2009.

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.0591(d), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.0591(d), eff. September 1, 2007.

Acts 2017, 85th Leg., R.S., Ch. 594 (S.B. 1070), Sec. 3.01, eff. September 1, 2017.

Sec. 36.003. RULES RESTRICTING ADVERTISING OR COMPETITIVE BIDDING. The commissioner may not adopt rules restricting advertising or competitive bidding by a person regulated by the department except to prohibit false, misleading, or deceptive practices by the person.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 36.004. COMPLIANCE WITH NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS REQUIREMENTS; RULES. (a) Except as provided by Subsection (c) and Section 36.005, the department may not require an insurer to comply with a rule, regulation, directive, or standard adopted by the National Association of Insurance Commissioners, including a rule, regulation, directive, or standard relating to policy reserves, unless application of the rule, regulation, directive, or standard is expressly authorized by statute.

(b) For purposes of Subsection (a), a version of a rule, regulation, directive, or standard is expressly authorized by statute if:

(1) the statute explicitly authorizes the commissioner to adopt rules consistent with the rule, regulation, directive, or standard; or

(2) that version is the latest version of the rule, regulation, directive, or standard on the date that the statute was enacted.

(c) The commissioner may adopt a rule to require compliance with a rule, regulation, directive, or standard adopted by the National Association of Insurance Commissioners if:

(1) the commissioner finds the rule is technical or nonsubstantive in nature or necessary to preserve the department's accreditation; and

(2) before the adoption of the rule, the commissioner provides the standing committees of the senate and house of representatives with primary jurisdiction over the department with written notice of the commissioner's intent to adopt the rule.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.
Amended by Acts 2003, 78th Leg., ch. 206, Sec. 15.02, eff. June 11, 2003.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 752 (S.B. [1450](#)), Sec. 1, eff. September 1, 2017.

Sec. 36.005. INTERIM RULES TO COMPLY WITH FEDERAL REQUIREMENTS.

(a) The commissioner may adopt rules to implement state responsibility in compliance with a federal law or regulation or action of a federal court relating to a person or activity under the jurisdiction of the department if:

(1) federal law or regulation, or an action of a federal court, requires:

(A) a state to adopt the rules; or

(B) action by a state to ensure protection of the citizens of the state;

(2) the rules will avoid federal preemption of state insurance regulation; or

(3) the rules will prevent the loss of federal funds to this state.

(b) The commissioner may adopt a rule under this section only if the federal action requiring the adoption of a rule occurs or takes effect between sessions of the legislature or at such time during a session of the legislature that sufficient time does not

remain to permit the preparation of a recommendation for legislative action or permit the legislature to act. A rule adopted under this section shall remain in effect only until 30 days following the end of the next session of the legislature unless a law is enacted that authorizes the subject matter of the rule. If a law is enacted that authorizes the subject matter of the rule, the rule will continue in effect.

Added by Acts 2003, 78th Leg., ch. 206, Sec. 15.03, eff. June 11, 2003.

Sec. 36.007. RULES RELATING TO AGREEMENTS LIMITING STATE AUTHORITY TO REGULATE INSURANCE PROHIBITED; EFFECT OF AGREEMENT. (a) The commissioner may not adopt or enforce a rule that implements an interstate, national, or international agreement that:

(1) infringes on the authority of this state to regulate the business of insurance in this state; and

(2) was not approved by the legislature.

(b) An agreement described by Subsection (a) has no effect on the authority of this state to regulate the business of insurance in this state unless the agreement is approved by the legislature.

Added by Acts 2017, 85th Leg., R.S., Ch. 752 (S.B. 1450), Sec. 2, eff. September 1, 2017.

SUBCHAPTER B. DEPARTMENT PROCEDURES

Sec. 36.101. APPLICABILITY OF CERTAIN LAWS. Except as specifically provided by law, the department is subject to Chapters 2001 and 2002, Government Code.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 36.102. SUMMARY PROCEDURES FOR ROUTINE MATTERS. (a) The commissioner by rule may:

(1) create a summary procedure for routine matters; and

(2) designate department activities that otherwise would be subject to Chapter 2001, Government Code, as routine matters to be handled under the summary procedure.

(b) An activity may be designated as a routine matter only if the activity is:

- (1) voluminous;
- (2) repetitive;
- (3) believed to be noncontroversial; and
- (4) of limited interest to anyone other than persons immediately involved in or affected by the proposed department action.

(c) The rules may establish procedures different from those contained in Chapter 2001, Government Code. The procedures must require, for each party directly involved, notice of a proposed negative action not later than the fifth day before the date the action is proposed to be taken.

(d) The rules may provide for the delegation of authority to take action on a routine matter to a salaried employee of the department designated by the commissioner.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 36.103. REVIEW OF ACTION ON ROUTINE MATTER. (a) A person directly or indirectly affected by an action of the commissioner or the department on a routine matter taken under the summary procedure adopted under Section 36.102 is entitled to a review of the action under Chapter 2001, Government Code.

(b) The person must apply to the commissioner not later than the 60th day after the date of the action to be entitled to the review.

(c) The timely filing of the application for review immediately stays the action pending a hearing on the merits.

(d) The commissioner may adopt rules relating to an application for review under this section and consideration of the application.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 36.104. INFORMAL DISPOSITION OF CERTAIN CONTESTED CASES.

(a) The commissioner may, on written agreement or stipulation of each party and any intervenor, informally dispose of a contested case in accordance with Section 2001.056, Government Code, notwithstanding any provision of this code that requires a hearing before the

commissioner.

(b) This section does not apply to a contested case under Title 5, Labor Code.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Amended by:

Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 6.055, eff. September 1, 2005.

Sec. 36.105. NEWSPAPER PUBLICATION. Except as otherwise provided by law, a notice or other matter that this code requires to be published must be published for three successive weeks in two newspapers that:

- (1) are printed in this state; and
- (2) have a general circulation in this state.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 36.106. WAIVER OF CERTAIN NOTICE REQUIREMENTS. The commissioner may, on written agreement or stipulation of each party and any intervenor, waive or modify the notice publication requirement of Section 822.059, 822.157, 841.060, or 884.058.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2B.003, eff. April 1, 2009.

Sec. 36.107. ACCEPTANCE OF ACTUARIAL OPINION. An opinion of an actuary requested by the commissioner under this code, another insurance law of this state, or a rule of the commissioner is presumed to be accurate and valid, and the department shall accept the opinion unless controverted. The department may employ, at the department's expense, another actuary to provide an alternative opinion.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 36.108. FILING DATE OF REPORT, FINANCIAL STATEMENT, OR PAYMENT DELIVERED BY POSTAL SERVICE. Except as otherwise specifically provided, for a report, financial statement, or payment that is required to be filed or made in the offices of the commissioner and that is delivered by the United States Postal Service to the offices of the commissioner after the date on which the report, financial statement, or payment is required to be filed or made, the date of filing or payment is the date of:

- (1) the postal service postmark stamped on the cover in which the report, financial statement, or payment is mailed; or
- (2) any other evidence of mailing authorized by the postal service reflected on the cover in which the report, financial statement, or payment is mailed.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 10, eff. April 1, 2005.

Sec. 36.109. RENEWAL EXTENSION FOR CERTAIN PERSONS PERFORMING MILITARY SERVICE. (a) The department may extend the renewal period for a license, permit, certificate of authority, certificate of registration, or other authorization issued by the department to engage in an activity regulated under this code or other insurance laws of this state for a person who is unable in a timely manner to comply with renewal requirements, including any applicable continuing education requirements, because the person was on active duty in a combat theater of operations in the United States armed forces.

(b) A person must submit a written application for an extension under this section to the department.

(c) The department shall exempt a person who receives an extension under this section from any increased fee or other penalty otherwise imposed for failure to renew in a timely manner.

(d) The commissioner may adopt rules as necessary to implement this section.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 11, eff. April 1, 2005.

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

- (1) negotiated rulemaking procedures under Chapter 2008,

Government Code, for the adoption of department rules; and

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

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

(c) The commissioner shall:

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

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

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

Added by Acts 2011, 82nd Leg., R.S., Ch. 1147 (H.B. 1951), Sec. 1.003, eff. September 1, 2011.

SUBCHAPTER C. GENERAL SUBPOENA POWERS; WITNESSES AND PRODUCTION OF RECORDS

Sec. 36.151. DEFINITION. In this subchapter, "records" includes books, accounts, documents, papers, correspondence, and other material.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 36.152. SUBPOENA AUTHORITY. (a) With respect to a matter that the commissioner has authority to consider or investigate, the commissioner may issue a subpoena applicable throughout the state that requires:

(1) the attendance and testimony of a witness; and

(2) the production of records.

(b) In connection with a subpoena, the commissioner may require attendance and production of records before the commissioner or the commissioner's designee:

(1) at the department's offices in Austin; or

(2) at another place designated by the commissioner.

(c) In connection with a subpoena, the commissioner or the

commissioner's designee may administer an oath, examine a witness, or receive evidence.

(d) The commissioner must personally sign and issue the subpoena.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.
Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.001, eff. Sept. 1, 2003.

Sec. 36.153. SERVICE OF SUBPOENA. (a) A subpoena issued by the commissioner may be served, at the discretion of the commissioner, by the commissioner, an authorized agent of the commissioner, a sheriff, or a constable.

(b) The sheriff's or constable's fee for serving the subpoena is the same as the fee paid to the sheriff or constable for similar services.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 36.154. ENFORCEMENT OF SUBPOENA. (a) On application of the commissioner in the case of disobedience of a subpoena or the contumacy of a person, a district court may issue an order requiring a person subpoenaed to obey the subpoena, to give evidence, or to produce records if the person has refused to do so.

(b) A court may punish as contempt the failure to obey a court order under Subsection (a).

(c) If the court orders compliance with the subpoena or finds the person in contempt for failure to obey the order, the commissioner, or the attorney general when representing the department, may recover reasonable costs and fees, including attorney's fees and investigative costs incurred in the proceedings.

(d) An application under Subsection (a) must be made in a district court in Travis County or in the county in which the subpoena is served.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 36.155. COMPENSATION FOR ATTENDANCE. A person required by

subpoena to attend a proceeding before the commissioner or the commissioner's designee is entitled to:

(1) reimbursement for mileage in the same amount for each mile as the mileage travel allowance for a state employee for traveling to or from the place where the person's attendance is required, if the place is more than 25 miles from the person's place of residence; and

(2) a fee for each day or part of a day the person is required to be present as a witness that is equal to the greater of:

(A) \$10; or

(B) a state employee's per diem travel allowance.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 36.156. OUT-OF-STATE MATERIALS. (a) A person with materials located outside this state that are requested by the commissioner may make the materials available for examination at the place where the materials are located.

(b) The commissioner may designate a representative, including an official of the state in which the materials are located, to examine the materials.

(c) The commissioner may respond to a similar request from an official of another state or of the United States.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 36.157. USE AS EVIDENCE IN CERTAIN CASES. (a) This section applies to testimony or records resulting in a case involving an allegation of engaging in the business of insurance without a license.

(b) On certification by the commissioner under official seal, testimony taken or records produced under this subchapter or acquired in response to a request for information under Section 101.104 and held by the department are admissible in evidence in a case without:

(1) prior proof of correctness; and

(2) proof, other than the certificate of the commissioner, that the testimony or records were received from the person testifying or producing the records.

(c) The certified records, or certified copies of the records,

are prima facie evidence of the facts disclosed by the records.

(d) This section does not limit any other provision of this subchapter or any law that makes provision for the admission or evidentiary value of certain evidence.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Amended by:

Acts 2021, 87th Leg., R.S., Ch. 60 (S.B. 1809), Sec. 1, eff. September 1, 2021.

Sec. 36.158. ACCESS TO INFORMATION. (a) A record or other evidence acquired under a subpoena under this subchapter or in response to a request for information under Section 101.104 is not a public record for the period the commissioner considers reasonably necessary to:

- (1) complete the investigation;
- (2) protect the person being investigated from unwarranted injury; or
- (3) serve the public interest.

(b) The record or other evidence is not subject to a subpoena, other than a grand jury subpoena, until:

- (1) the record or other evidence is released for public inspection by the commissioner; or
- (2) after notice and a hearing, a district court determines that obeying the subpoena would not jeopardize the public interest and any investigation by the commissioner.

(c) Except for good cause, a district court order under Subsection (b) may not apply to:

- (1) a record or communication received from another law enforcement or regulatory agency; or
- (2) the internal notes, memoranda, reports, or communications made in connection with a matter that the commissioner has the authority to consider or investigate.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Amended by:

Acts 2021, 87th Leg., R.S., Ch. 60 (S.B. 1809), Sec. 2, eff. September 1, 2021.

Sec. 36.159. PRIVILEGED AND CONFIDENTIAL RECORDS AND INFORMATION; PROTECTIVE ORDERS. (a) A record subpoenaed and produced under this subchapter that is otherwise privileged or confidential by law remains privileged or confidential until admitted into evidence in an administrative hearing or a court.

(b) The commissioner may issue a protective order relating to the confidentiality or privilege of a record described by Subsection (a) to restrict the use or distribution of the record:

(1) by a person; or

(2) in a proceeding other than a proceeding before the commissioner.

(c) Specific information relating to a particular policy or claim is privileged and confidential while in the possession of an insurance company, organization, association, or other entity holding a certificate of authority from the department and may not be disclosed by the entity to another person, except as specifically provided by law.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 36.160. COOPERATION WITH LAW ENFORCEMENT. On request, the commissioner may furnish records or other evidence obtained by subpoena to:

(1) a law enforcement agency of this state, another state, or the United States; or

(2) a prosecuting attorney of a municipality, county, or judicial district of this state, another state, or the United States.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 36.161. CERTAIN SUBPOENAS ISSUED TO FINANCIAL INSTITUTIONS. A subpoena issued to a bank or other financial institution as part of a criminal investigation is not subject to Section 30.007, Civil Practice and Remedies Code.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 36.162. EFFECT ON CONTESTED CASE. Sections 36.152,

36.156, 36.158, 36.160, and 36.161 do not affect the conduct of a contested case under Chapter 2001, Government Code.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

SUBCHAPTER D. JUDICIAL REVIEW

Sec. 36.201. ACTION SUBJECT TO JUDICIAL REVIEW. An action of the commissioner subject to judicial review under this subchapter includes a decision, order, rate, rule, form, or administrative or other ruling of the commissioner.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 36.2015. ACTIONS UNDER TITLE 5, LABOR CODE.

Notwithstanding Section 36.201, a decision, order, form, or administrative or other rule of the commissioner of workers' compensation under Title 5, Labor Code, or a rule adopted by the commissioner of insurance under Title 5, Labor Code, is subject to judicial review as provided by Title 5, Labor Code.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 6.056, eff. September 1, 2005.

Sec. 36.202. PETITION FOR JUDICIAL REVIEW. (a) After failing to get relief from the commissioner, any insurance company or other party at interest who is dissatisfied with an action of the commissioner may file a petition for judicial review against the commissioner as defendant.

(b) The petition must state the particular objection to the action and may be filed only in a district court in Travis County.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 36.203. JUDICIAL REVIEW. Judicial review of the action is under the substantial evidence rule and shall be conducted under Chapter 2001, Government Code.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 36.204. ACTION NOT VACATED. (a) The filing of a petition for judicial review of an action under this subchapter does not vacate the action.

(b) After notice and hearing, the court may vacate the action if the court finds it would serve the interest of justice to do so.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 36.205. APPEAL. (a) A party to the action under Section 36.202 may appeal to an appellate court that has jurisdiction, and the appeal is at once returnable to that court.

(b) An appeal under this section has precedence in the appellate court over any cause of a different character pending in the court.

(c) The commissioner is not required to give an appeal bond in an appeal arising under this subchapter.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

SUBCHAPTER E. INVESTIGATION FILES

Sec. 36.251. DEFINITION. In this subchapter, "investigation file" means any information collected, assembled, or maintained by or on behalf of the department with respect to an investigation conducted under this code or other law. The term does not include information or material acquired by the department that is:

- (1) relevant to an investigation by the insurance fraud unit; and
- (2) subject to Section 701.151.

Added by Acts 2009, 81st Leg., R.S., Ch. 1039 (H.B. [4461](#)), Sec. 1, eff. June 19, 2009.

Sec. 36.252. INVESTIGATION FILES CONFIDENTIAL. (a) Information or material acquired by the department that is relevant to an investigation is not a public record for the period that the

department determines is relevant to further or complete an investigation.

(b) Investigation files are not open records for purposes of Chapter 552, Government Code, except as specified herein.

Added by Acts 2009, 81st Leg., R.S., Ch. 1039 (H.B. 4461), Sec. 1, eff. June 19, 2009.

Sec. 36.253. DISCLOSURE OF CERTAIN INFORMATION NOT REQUIRED. The department is not required to disclose under this subchapter:

(1) information that is:

(A) an attorney-client communication; or

(B) an attorney work product; or

(2) other information protected by a recognized privilege, a statute, an administrative rule, the Texas Rules of Civil Procedure, or the Texas Rules of Evidence.

Added by Acts 2009, 81st Leg., R.S., Ch. 1039 (H.B. 4461), Sec. 1, eff. June 19, 2009.

CHAPTER 37. RATEMAKING AND POLICY FORM PROCEEDINGS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 37.001. CERTAIN PROCEEDINGS RELATING TO RATEMAKING AND POLICY FORMS; RULES. (a) The commissioner shall adopt rules governing proceedings necessary to approve or promulgate rates, policy forms, or policy form endorsements under this code or another insurance law of this state.

(b) The commissioner shall conduct the proceedings in accordance with the rules adopted under this section.

(c) Rules adopted under this section must comply with this code and any other insurance law of this state and must be adopted in accordance with Chapter 2001, Government Code.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

SUBCHAPTER B. CERTAIN PROCEEDINGS RELATING TO RATES

Sec. 37.051. STREAMLINED PROCEDURES. (a) The department shall study and the commissioner may adopt and implement procedures for

streamlining insurance rate proceedings under this code or another insurance law of this state. The procedures must ensure due process to each affected party.

(b) The commissioner shall consider this section in adopting rules under Section 37.001.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 37.052. ROLE OF DEPARTMENT. (a) The application of this section is subject to Chapter 40.

(b) The commissioner may designate the general counsel or an assistant general counsel to serve as a hearings officer in a proceeding in which insurance rates are set or in a prehearing proceeding. The commissioner must make the final decision relating to the rates to be set.

(c) The department shall provide evidence in proceedings before the commissioner or the designated hearings officer that promotes the adoption of fair and reasonable rates for underserved areas to promote access to full insurance coverage for those areas.

(d) The department may appear as a matter of right as a party, present evidence, or question a witness in a proceeding before the commissioner or the designated hearings officer in which insurance rates are set under this code.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.
Amended by Acts 2001, 77th Leg., ch. 1071, Sec. 6, eff. Sept. 1, 2001.

Sec. 37.053. EFFECTIVENESS OF RATE DURING APPEAL. (a) An order of the commissioner that determines, approves, or sets a rate under this code and that is appealed remains in effect during the pendency of the appeal. An insurer shall use the rate provided in the order while the appeal is pending.

(b) The rate is lawful and valid during the appeal, and an insurer may not be required to make any refund from that rate after a decision on the appeal is rendered.

(c) If the order is vacated on appeal, the rate established by the commissioner before the vacated order was rendered remains in effect from the date of remand until the commissioner makes a further

determination. The commissioner shall consider the court's order in setting a future rate.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 12, eff. April 1, 2005.

CHAPTER 38. DATA COLLECTION AND REPORTS
SUBCHAPTER A. GENERAL PROVISIONS

Sec. 38.001. INQUIRIES. (a) In this section, "authorization" means a permit, certificate of registration, or other authorization issued or existing under this code.

(b) The department may address a reasonable inquiry to any insurance company, including a Lloyd's plan or reciprocal or interinsurance exchange, or an agent or other holder of an authorization relating to:

(1) the person's business condition; or

(2) any matter connected with the person's transactions that the department considers necessary for the public good or for the proper discharge of the department's duties.

(c) A person receiving an inquiry under Subsection (b) shall respond to the inquiry in writing not later than the 15th day after the date the inquiry is received. If the department receives written notice from the person that additional time is required to respond to the inquiry, the department shall grant a 10-day extension of the time to respond to the inquiry.

(d) A response made under this section that is otherwise privileged or confidential by law remains privileged or confidential until introduced into evidence at an administrative hearing or in a court.

(e) The department shall maintain a record of all inquiries made by the department under this section.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.
Amended by:

Acts 2005, 79th Leg., Ch. 1295 (H.B. 2614), Sec. 1, eff. September 1, 2005.

Acts 2013, 83rd Leg., R.S., Ch. 398 (S.B. 183), Sec. 1, eff. September 1, 2013.

Sec. 38.002. UNDERWRITING GUIDELINES FOR PERSONAL AUTOMOBILE

AND RESIDENTIAL PROPERTY INSURANCE; FILING; CONFIDENTIALITY. (a)
In this section:

(1) "Insurer" means an insurance company, reciprocal or interinsurance exchange, mutual insurance company, capital stock company, county mutual insurance company, Lloyd's plan, or other legal entity engaged in the business of personal automobile insurance or residential property insurance in this state. The term includes:

(A) an affiliate as described by Section 823.003(a) if that affiliate is authorized to write and is writing personal automobile insurance or residential property insurance in this state;

(B) the Texas Windstorm Insurance Association created and operated under Chapter 2210;

(C) the FAIR Plan Association under Chapter 2211; and

(D) the Texas Automobile Insurance Plan Association under Chapter 2151.

(2) "Personal automobile insurance" means motor vehicle insurance coverage for the ownership, maintenance, or use of a private passenger, utility, or miscellaneous type motor vehicle, including a motor home, mobile home, trailer, or recreational vehicle, that is:

(A) owned or leased by an individual or individuals;
and

(B) not primarily used for the delivery of goods, materials, or services, other than for use in farm or ranch operations.

(3) "Residential property insurance" means insurance coverage against loss to residential real property at a fixed location or tangible personal property provided in a homeowners policy, which includes a tenant policy, a condominium owners policy, or a residential fire and allied lines policy.

(4) "Underwriting guideline" means a rule, standard, guideline, or practice, whether written, oral, or electronic, that is used by an insurer or its agent to decide whether to accept or reject an application for coverage under a personal automobile insurance policy or residential property insurance policy or to determine how to classify those risks that are accepted for the purpose of determining a rate.

(b) Each insurer shall file with the department a copy of the insurer's underwriting guidelines. The insurer shall update its filing each time the underwriting guidelines are changed. If a group

of insurers files one set of underwriting guidelines for the group, they shall identify which underwriting guidelines apply to each company in the group.

(c) The office of public insurance counsel may obtain a copy of each insurer's underwriting guidelines.

(d) The department or the office of public insurance counsel may disclose to the public a summary of an insurer's underwriting guidelines in a manner that does not directly or indirectly identify the insurer.

(e) Underwriting guidelines must be sound, actuarially justified, or otherwise substantially commensurate with the contemplated risk. Underwriting guidelines may not be unfairly discriminatory.

(f) The underwriting guidelines are subject to Chapter 552, Government Code.

Added by Acts 2003, 78th Leg., ch. 206, Sec. 8.01, eff. June 11, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2B.004, eff. April 1, 2009.

Sec. 38.003. UNDERWRITING GUIDELINES FOR OTHER LINES; CONFIDENTIALITY. (a) This section applies to all underwriting guidelines that are not subject to Section 38.002.

(b) For purposes of this section, "insurer" means a reciprocal or interinsurance exchange, mutual insurance company, capital stock company, county mutual insurance company, Lloyd's plan, life, accident, or health or casualty insurance company, health maintenance organization, mutual life insurance company, mutual insurance company other than life, mutual, or natural premium life insurance company, general casualty company, fraternal benefit society, group hospital service company, or other legal entity engaged in the business of insurance in this state. The term includes an affiliate as described by Section 823.003(a) if that affiliate is authorized to write and is writing insurance in this state.

(c) The department or the office of public insurance counsel may obtain a copy of an insurer's underwriting guidelines.

(d) Underwriting guidelines are confidential, and the

department or the office of public insurance counsel may not make the guidelines available to the public.

(e) The department or the office of public insurance counsel may disclose to the public a summary of an insurer's underwriting guidelines in a manner that does not directly or indirectly identify the insurer.

(f) When underwriting guidelines are furnished to the department or the office of public insurance counsel, only a person within the department or the office of public insurance counsel with a need to know may have access to the guidelines. The department and the office of public insurance counsel shall establish internal control systems to limit access to the guidelines and shall keep records of the access provided.

(g) This section does not preclude the use of underwriting guidelines as evidence in prosecuting a violation of this code. Each copy of an insurer's underwriting guidelines that is used in prosecuting a violation is presumed to be confidential and is subject to a protective order until all appeals of the case have been exhausted. If an insurer is found, after the exhaustion of all appeals, to have violated this code, a copy of the underwriting guidelines used as evidence of the violation is no longer presumed to be confidential.

(h) A violation of this section is a violation of Chapter 552, Government Code.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.
Renumbered from Insurance Code Sec. 38.002 and amended by Acts 2003, 78th Leg., ch. 206, Sec. 8.01, eff. June 11, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 2B.005, eff. April 1, 2009.

Sec. 38.004. BALANCE BILLING PROHIBITION REPORT. (a) The department shall, each biennium, conduct a study on the impacts of S.B. No. 1264, Acts of the 86th Legislature, Regular Session, 2019, on Texas consumers and health coverage in this state, including:

(1) trends in billed amounts for health care or medical services or supplies, especially emergency services, laboratory services, diagnostic imaging services, and facility-based services;

(2) comparison of the total amount spent on out-of-network emergency services, laboratory services, diagnostic imaging services, and facility-based services by calendar year and provider type or physician specialty;

(3) trends and changes in network participation by providers of emergency services, laboratory services, diagnostic imaging services, and facility-based services by provider type or physician specialty, including whether any terminations were initiated by a health benefit plan issuer, administrator, or provider;

(4) trends and changes in the amounts paid to participating providers;

(5) the number of complaints, completed investigations, and disciplinary sanctions for billing by providers of emergency services, laboratory services, diagnostic imaging services, or facility-based services of enrollees for amounts greater than the enrollee's responsibility under an applicable health benefit plan, including applicable copayments, coinsurance, and deductibles;

(6) trends in amounts paid to out-of-network providers;

(7) trends in the usual and customary rate for health care or medical services or supplies, especially emergency services, laboratory services, diagnostic imaging services, and facility-based services; and

(8) the effectiveness of the claim dispute resolution process under Chapter 1467.

(b) In conducting the study described by Subsection (a), the department shall collect settlement data and verdicts or arbitration awards, as applicable, from parties to mediation or arbitration under Chapter 1467.

(c) The department may not publish a particular rate paid to a participating provider in the study described by Subsection (a), identifying information of a physician or health care provider, or non-aggregated study results. Information described by this subsection is confidential and not subject to disclosure under Chapter 552, Government Code.

(d) The department:

(1) shall collect data quarterly from a health benefit plan issuer or administrator subject to Chapter 1467 to conduct the study required by this section; and

(2) may utilize any reliable external resource or entity to

acquire information reasonably necessary to prepare the report required by Subsection (e).

(e) Not later than December 1 of each even-numbered year, the department shall prepare and submit a written report on the results of the study under this section, including the department's findings, to the legislature.

Added by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. [1264](#)), Sec. 4.01, eff. September 1, 2019.

For expiration of this section, see Subsection (c).

Sec. 38.005. COMMERCIAL AUTOMOBILE INSURANCE REPORT. (a) The department shall conduct a study each biennium on the effect, for each year of the biennium, on premiums, deductibles, coverage, and availability of coverage for commercial automobile insurance of H.B. 19, 87th Legislature, Regular Session, 2021.

(b) Not later than December 1 of each even-numbered year, the department shall submit a written report of the results of the study conducted under Subsection (a) for the preceding biennium to the legislature.

(c) This section expires December 31, 2026.

Added by Acts 2021, 87th Leg., R.S., Ch. 785 (H.B. [19](#)), Sec. 5, eff. September 1, 2021.

For expiration of this section, see Subsection (b).

Sec. 38.006. EMERGENCY MEDICAL SERVICES PROVIDER BALANCE BILLING RATE DATABASE. (a) A political subdivision may submit to the department, in the form and manner prescribed by the commissioner, a rate set, controlled, or regulated by the political subdivision for purposes of Section 1271.159, 1275.054, 1301.166, 1551.231, 1575.174, or 1579.112. The department shall establish and maintain on the department's Internet website a publicly accessible database for the rates.

(b) This section expires September 1, 2025.

Added by Acts 2023, 88th Leg., R.S., Ch. 981 (S.B. [2476](#)), Sec. 1, eff. September 1, 2023.

SUBCHAPTER B. HEALTH BENEFIT PLAN PROVIDER REPORTING

Sec. 38.051. DEFINITION. In this subchapter, "health benefit plan provider" means an insurance company, group hospital service corporation, or health maintenance organization that issues:

- (1) an individual, group, blanket, or franchise insurance policy, an insurance agreement, a group hospital service contract, or an evidence of coverage, that provides benefits for medical or surgical expenses incurred as a result of an accident or sickness; or
- (2) a long-term care benefit plan, as defined by Section 1651.003.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 2B.006, eff. April 1, 2009.

Sec. 38.052. REQUIRED INFORMATION; RULES. (a) A health benefit plan provider shall submit information required by the department relating to the health benefit plan provider's:

- (1) loss experience;
- (2) overhead; and
- (3) operating expenses.

(b) The department may also request information about characteristics of persons covered by a health benefit plan provider, including information relating to:

- (1) age;
- (2) gender;
- (3) health status;
- (4) job classification; and
- (5) geographic distribution.

(c) A health benefit plan provider may not be required to submit information under this section more frequently than annually.

(d) The commissioner shall adopt rules governing the submission of information under this subchapter.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

SUBCHAPTER E. STATISTICAL DATA COLLECTION

Sec. 38.201. DEFINITION. In this subchapter, "designated statistical agent" means an organization designated or contracted with by the commissioner under Section 38.202.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 38.202. STATISTICAL AGENT. The commissioner may, for a line or subline of insurance, designate or contract with a qualified organization to serve as the statistical agent for the commissioner to gather data relevant for regulatory purposes or as otherwise provided by this code.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 38.203. QUALIFICATIONS OF STATISTICAL AGENT. To qualify as a statistical agent, an organization must demonstrate at least two years of experience in data collection, data maintenance, data quality control, accounting, and related areas.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 708 (H.B. [2188](#)), Sec. 1, eff. September 1, 2023.

Sec. 38.204. POWERS AND DUTIES OF STATISTICAL AGENT. (a) A designated statistical agent shall collect data from reporting insurers under a statistical plan adopted by the commissioner.

(b) The statistical agent may provide aggregate historical premium and loss data to its subscribers.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 38.205. DUTY OF INSURER. An insurer shall provide all premium and loss cost data to the commissioner or the designated statistical agent as the commissioner or agent requires.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 38.206. FEES. (a) A designated statistical agent may collect from a reporting insurer any fees necessary for the agent to recover the necessary and reasonable costs of collecting data from that reporting insurer.

(b) A reporting insurer shall pay the fee to the statistical agent for the data collection services provided by the statistical agent.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 38.207. RULES. The commissioner may adopt rules necessary to accomplish the purposes of this subchapter.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

SUBCHAPTER F. DATA COLLECTING AND REPORTING RELATING TO MANDATED HEALTH BENEFITS AND MANDATED OFFERS OF COVERAGE

Sec. 38.251. APPLICABILITY. This subchapter applies to any issuer of a health benefit plan that is subject to this code 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.

Added by Acts 2001, 77th Leg., ch. 852, Sec. 1, eff. Sept. 1, 2001.

Sec. 38.252. COLLECTION OF INFORMATION; REPORT. (a) The commissioner shall require a health benefit plan issuer to collect and report cost and utilization data for each mandated health benefit and mandated offer designated by the commissioner.

(b) The commissioner shall designate by rule:

(1) the issuers of health benefit plans that must collect and report data based on the annual dollar amounts of Texas premium

collected by the health benefit plan issuer;

(2) the specific mandated health benefits and mandated offers of coverage for which data must be collected;

(3) a description of the data that must be collected;

(4) the beginning and ending dates of the reporting periods, which shall be no less than every two years;

(5) the date following the end of the reporting period by which the report shall be submitted to the commissioner;

(6) the detail and form in which the report shall be submitted; and

(7) any other reasonable requirements that the commissioner determines are necessary to determine the impact of mandated benefits and mandated offers of coverage for which data collection and reporting is required.

(c) The commissioner shall not require reporting of data:

(1) that could reasonably be used to identify a specific enrollee in a health benefit plan;

(2) in any way that violates confidentiality requirements of state or federal law applicable to an enrollee in a health benefit plan; or

(3) in which the health maintenance organization operating under Section 1367.053, Subchapter A, Chapter 1452, Subchapter B, Chapter 1507, Chapter 222, 251, or 258, as applicable to a health maintenance organization, Chapter 843, Chapter 1271, and Chapter 1272 does not directly process the claim or does not receive complete and accurate encounter data.

Added by Acts 2001, 77th Leg., ch. 852, Sec. 1, eff. Sept. 1, 2001.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 2B.009, eff. April 1, 2009.

Sec. 38.253. MAINTENANCE OF INFORMATION. Each health benefit plan issuer shall maintain at its principal place of business all data collected pursuant to this subchapter, including information and supporting documentation that demonstrates that the report submitted to the commissioner is complete and accurate. Each health benefit plan issuer shall make this information and any supporting documentation available to the commissioner upon request.

Added by Acts 2001, 77th Leg., ch. 852, Sec. 1, eff. Sept. 1, 2001.

Sec. 38.254. UTILIZATION AND COST DATA TO COMMISSIONER.

Text of subsection effective until April 1, 2025

(a) Upon request from the commissioner, the Texas Health and Human Services Commission shall provide to the commissioner data, including utilization and cost data, which is related to the mandate being assessed to the population covered by the Medicaid program, including a program administered under Chapter 32, Human Resources Code, and a program administered under Chapter 533, Government Code, even if the program is not necessarily subject to the mandate.

Text of subsection effective on April 1, 2025

(a) Upon request from the commissioner, the Texas Health and Human Services Commission shall provide to the commissioner data, including utilization and cost data, which is related to the mandate being assessed to the population covered by the Medicaid program, including a program administered under Chapter 32, Human Resources Code, and a program administered under Chapter 540 or 540A, Government Code, as applicable, even if the program is not necessarily subject to the mandate.

(b) The commissioner may utilize data as defined in Subsection (a) to determine the impact of mandated benefits and mandated offers of coverage for which data collection and reporting is requested.

Added by Acts 2001, 77th Leg., ch. 852, Sec. 1, eff. Sept. 1, 2001.

Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.002, eff. Sept. 1, 2003.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. [4611](#)), Sec. 2.115, eff. April 1, 2025.

SUBCHAPTER G. DATA REPORTING BY CERTAIN LIABILITY INSURERS

Sec. 38.301. INSURER DATA REPORTING. (a) Each insurer that writes professional liability insurance policies for nursing institutions licensed under Chapter 242, Health and Safety Code, including an insurer whose rates are not regulated, shall, as a condition of writing those policies in this state, comply with a

request for information from the commissioner under this section.

(b) The commissioner may require information in rate filings, special data calls, or informational hearings or by any other means consistent with this code applicable to the affected insurer that the commissioner believes will allow the commissioner to:

(1) determine whether insurers writing insurance coverage described by Subsection (a) are passing to insured nursing institutions on a prospective basis the savings that accrue as a result of the reduction in risk to insurers writing that coverage that will result from legislation enacted by the 77th Legislature, Regular Session, including legislation that:

(A) amended Article 5.15-1 to limit the exposure of an insurer to exemplary damages for certain claims against a nursing institution; and

(B) amended Sections 32.021(i) and (k), Human Resources Code, added Section 242.050, Health and Safety Code, and repealed Section 32.021(j), Human Resources Code, to clarify the admissibility of certain documents in a civil action against a nursing institution; or

(2) prepare the report required of the commissioner under Section 38.252 or any other report the commissioner is required to submit to the legislature in connection with the legislation described by Subdivision (1).

(c) Information provided under this section is privileged and confidential to the same extent as the information is privileged and confidential under this code or any other law governing an insurer described by Subsection (a). The information remains privileged and confidential unless and until introduced into evidence at an administrative hearing or in a court of competent jurisdiction.

Added by Acts 2001, 77th Leg., ch. 1284, Sec. 4.01, eff. June 15, 2001. Renumbered from Insurance Code Sec. 38.251 by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.501, eff. Sept. 1, 2003.

Sec. 38.302. RECOMMENDATIONS TO LEGISLATURE. The commissioner shall assemble information and take other appropriate measures to assess and evaluate changes in the marketplace resulting from the implementation of the legislation described by Section 38.251 and shall report the commissioner's findings and recommendations to the

legislature.

Added by Acts 2001, 77th Leg., ch. 1284, Sec. 4.01, eff. June 15, 2001. Renumbered from Insurance Code Sec. 38.252 by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.501, eff. Sept. 1, 2003.

SUBCHAPTER H. HEALTH CARE REIMBURSEMENT RATE INFORMATION

Sec. 38.351. PURPOSE OF SUBCHAPTER. The purpose of this subchapter is to authorize the department to:

- (1) collect data concerning health benefit plan reimbursement rates in a uniform format; and
- (2) disseminate, on an aggregate basis for geographical regions in this state, information concerning health care reimbursement rates derived from the data.

Added by Acts 2007, 80th Leg., R.S., Ch. 997 (S.B. 1731), Sec. 8, eff. September 1, 2007.

Sec. 38.352. DEFINITION. In this subchapter, "group health benefit plan" means a preferred provider benefit plan as defined by Section 1301.001 or an evidence of coverage for a health care plan that provides basic health care services as defined by Section 843.002.

Added by Acts 2007, 80th Leg., R.S., Ch. 997 (S.B. 1731), Sec. 8, eff. September 1, 2007.

Sec. 38.353. APPLICABILITY OF SUBCHAPTER. (a) This subchapter applies to the issuer of a group health benefit plan, including:

- (1) an insurance company;
- (2) a group hospital service corporation;
- (3) a fraternal benefit society;
- (4) a stipulated premium company;
- (5) a reciprocal or interinsurance exchange; or
- (6) a health maintenance organization.

(b) Notwithstanding any provision in Chapter 1551, 1575, 1579, or 1601 or any other law, and except as provided by Subsection (e), this subchapter applies to:

- (1) a basic coverage plan under Chapter 1551;
- (2) a basic plan under Chapter 1575;
- (3) a primary care coverage plan under Chapter 1579; and
- (4) basic coverage under Chapter 1601.

(c) Except as provided by Subsection (d), this subchapter applies to a small employer health benefit plan provided under Chapter 1501.

Text of subsection effective until April 1, 2025

(d) This subchapter does not apply to:

- (1) standard health benefit plans provided under Chapter 1507;
- (2) children's health benefit plans provided under Chapter 1502;
- (3) health care benefits provided under a workers' compensation insurance policy;
- (4) Medicaid managed care programs operated under Chapter 533, Government Code;
- (5) Medicaid programs operated under Chapter 32, Human Resources Code; or
- (6) the state child health plan operated under Chapter 62 or 63, Health and Safety Code.

Text of subsection effective on April 1, 2025

(d) This subchapter does not apply to:

- (1) standard health benefit plans provided under Chapter 1507;
- (2) children's health benefit plans provided under Chapter 1502;
- (3) health care benefits provided under a workers' compensation insurance policy;
- (4) Medicaid managed care programs operated under Chapter 540 or 540A, Government Code, as applicable;
- (5) Medicaid programs operated under Chapter 32, Human Resources Code; or
- (6) the state child health plan operated under Chapter 62 or 63, Health and Safety Code.

(e) The commissioner by rule may exclude a type of health benefit plan from the requirements of this subchapter if the commissioner finds that data collected in relation to the health benefit plan would not be relevant to accomplishing the purposes of

this subchapter.

Added by Acts 2007, 80th Leg., R.S., Ch. 997 (S.B. 1731), Sec. 8, eff. September 1, 2007.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 2.116, eff. April 1, 2025.

Sec. 38.354. RULES. The commissioner may adopt rules as provided by Subchapter A, Chapter 36, to implement this subchapter.

Added by Acts 2007, 80th Leg., R.S., Ch. 997 (S.B. 1731), Sec. 8, eff. September 1, 2007.

Sec. 38.355. DATA CALL; STANDARDIZED FORMAT. (a) Each health benefit plan issuer shall submit to the department, at the time and in the form and manner required by the department, aggregate reimbursement rates by region paid by the health benefit plan issuer for health care services identified by the department.

(b) The department shall require that data submitted under this section be submitted in a standardized format, established by rule, to permit comparison of health care reimbursement rates. To the extent feasible, the department shall develop the data submission requirements in a manner that allows collection of reimbursement rates as a dollar amount and not by comparison to other standard reimbursement rates, such as Medicare reimbursement rates.

(c) The department shall specify the period for which reimbursement rates must be filed under this section.

(d) The department may contract with a private third party to obtain the data under this subchapter. If the department contracts with a third party, the department may determine the aggregate data to be collected and published under Section 38.357 if consistent with the purposes of this subchapter described in Section 38.351. The department shall prohibit the third party contractor from selling, leasing, or publishing the data obtained by the contractor under this subchapter.

Added by Acts 2007, 80th Leg., R.S., Ch. 997 (S.B. 1731), Sec. 8, eff. September 1, 2007.

Sec. 38.356. CONFIDENTIALITY OF DATA. Except as provided by Section 38.357, data collected under this subchapter is confidential and not subject to disclosure under Chapter 552, Government Code.

Added by Acts 2007, 80th Leg., R.S., Ch. 997 (S.B. 1731), Sec. 8, eff. September 1, 2007.

Sec. 38.357. PUBLICATION OF AGGREGATE HEALTH CARE REIMBURSEMENT RATE INFORMATION. The department shall provide to the Department of State Health Services for publication, for identified regions of this state, aggregate health care reimbursement rate information derived from the data collected under this subchapter. The published information may not reveal the name of any health care provider or health benefit plan issuer. The department may make the aggregate health care reimbursement rate information available through the department's Internet website.

Added by Acts 2007, 80th Leg., R.S., Ch. 997 (S.B. 1731), Sec. 8, eff. September 1, 2007.

Sec. 38.358. PENALTIES. A health benefit plan issuer that fails to submit data as required in accordance with this subchapter is subject to an administrative penalty under Chapter 84. For purposes of penalty assessment, each day the health benefit plan issuer fails to submit the data as required is a separate violation.

Added by Acts 2007, 80th Leg., R.S., Ch. 997 (S.B. 1731), Sec. 8, eff. September 1, 2007.

SUBCHAPTER I. TEXAS ALL PAYOR CLAIMS DATABASE

Sec. 38.401. PURPOSE OF SUBCHAPTER. The purpose of this subchapter is to authorize the department to establish an all payor claims database in this state to increase public transparency of health care information and improve the quality of health care in this state.

Added by Acts 2021, 87th Leg., R.S., Ch. 333 (H.B. 2090), Sec. 1, eff. September 1, 2021.

Sec. 38.402. DEFINITIONS. In this subchapter:

(1) "Allowed amount" means the amount of a billed charge that a health benefit plan issuer determines to be covered for services provided by a non-network provider. The allowed amount includes both the insurer's payment and any applicable deductible, copayment, or coinsurance amounts for which the insured is responsible.

(2) "Center" means the Center for Healthcare Data at The University of Texas Health Science Center at Houston.

(3) "Contracted rate" means the fee or reimbursement amount for a network provider's services, treatments, or supplies as established by agreement between the provider and health benefit plan issuer.

(4) "Data" means the specific claims and encounters, enrollment, and benefit information submitted to the center under this subchapter.

(5) "Database" means the Texas All Payor Claims Database established under this subchapter.

(6) "Geozip" means an area that includes all zip codes with identical first three digits.

Text of subdivision effective until April 1, 2025

(7) "Payor" means any of the following entities that pay, reimburse, or otherwise contract with a health care provider for the provision of health care services, supplies, or devices to a patient:

(A) an insurance company providing health or dental insurance;

(B) the sponsor or administrator of a health or dental plan;

(C) a health maintenance organization operating under Chapter 843;

(D) the state Medicaid program, including the Medicaid managed care program operating under Chapter 533, Government Code;

(E) a health benefit plan offered or administered by or on behalf of this state or a political subdivision of this state or an agency or instrumentality of the state or a political subdivision of this state, including:

- (i) a basic coverage plan under Chapter 1551;
 - (ii) a basic plan under Chapter 1575;
 - (iii) a primary care coverage plan under Chapter 1579; and
 - (iv) a plan providing basic coverage under Chapter 1601; or
- (F) any other entity providing a health insurance or health benefit plan subject to regulation by the department.

Text of subdivision effective on April 1, 2025

- (7) "Payor" means any of the following entities that pay, reimburse, or otherwise contract with a health care provider for the provision of health care services, supplies, or devices to a patient:
- (A) an insurance company providing health or dental insurance;
 - (B) the sponsor or administrator of a health or dental plan;
 - (C) a health maintenance organization operating under Chapter 843;
 - (D) the state Medicaid program, including the Medicaid managed care program operating under Chapters 540 and 540A, Government Code;
 - (E) a health benefit plan offered or administered by or on behalf of this state or a political subdivision of this state or an agency or instrumentality of the state or a political subdivision of this state, including:
 - (i) a basic coverage plan under Chapter 1551;
 - (ii) a basic plan under Chapter 1575;
 - (iii) a primary care coverage plan under Chapter 1579; and
 - (iv) a plan providing basic coverage under Chapter 1601; or
 - (F) any other entity providing a health insurance or health benefit plan subject to regulation by the department.
- (8) "Protected health information" has the meaning assigned by 45 C.F.R. Section 160.103.
- (9) "Qualified research entity" means:
- (A) an organization engaging in public interest research for the purpose of analyzing the delivery of health care in this state that is exempt from federal income tax under Section 501(a), Internal Revenue Code of 1986, by being listed as an exempt

organization in Section 501(c)(3) of that code;

(B) an institution of higher education engaged in public interest research related to the delivery of health care in this state; or

(C) a health care provider in this state engaging in efforts to improve the quality and cost of health care.

(10) "Stakeholder advisory group" means the stakeholder advisory group established under Section 38.403.

Added by Acts 2021, 87th Leg., R.S., Ch. 333 (H.B. 2090), Sec. 1, eff. September 1, 2021.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 603 (H.B. 3414), Sec. 1, eff. June 11, 2023.

Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 2.117, eff. April 1, 2025.

Sec. 38.403. STAKEHOLDER ADVISORY GROUP. (a) The center shall establish a stakeholder advisory group to assist the center as provided by this subchapter, including assistance in:

(1) establishing and updating the standards, requirements, policies, and procedures relating to the collection and use of data contained in the database required by Sections 38.404(e) and (f);

(2) evaluating and prioritizing the types of reports the center should publish under Section 38.404(e);

(3) evaluating data requests from qualified research entities under Section 38.404(e)(2); and

(4) assisting the center in developing the center's recommendations under Section 38.408(3).

(b) The advisory group created under this section must be composed of:

(1) the state Medicaid director or the director's designee;

(2) a member designated by the Teacher Retirement System of Texas;

(3) a member designated by the Employees Retirement System of Texas; and

(4) 13 members designated by the center, including:

(A) two members representing the business community, with at least one of those members representing small businesses that

purchase health benefits but are not involved in the provision of health care services, supplies, or devices or health benefit plans;

(B) two members who represent consumers and who are not professionally involved in the purchase, provision, administration, or review of health care services, supplies, or devices or health benefit plans, with at least one member representing the behavioral health community;

(C) two members representing hospitals that are licensed in this state;

(D) two members representing health benefit plan issuers that are regulated by the department;

(E) two members who are physicians licensed to practice medicine in this state, one of whom is a primary care physician;

(F) two members who are not professionally involved in the purchase, provision, administration, or review of health care services, supplies, or devices or health benefit plans and who have expertise in:

(i) health planning;

(ii) health economics;

(iii) provider quality assurance;

(iv) statistics or health data management; or

(v) medical privacy laws; and

(G) one member representing an institution of higher education.

(c) A person serving on the stakeholder advisory group must disclose any conflict of interest.

(d) Except as provided by Subsection (e), members of the stakeholder advisory group serve fixed terms as prescribed by commissioner rules adopted under this subchapter.

(e) A member representing an institution of higher education under Subsection (b)(4)(G) serves a term of one year.

Added by Acts 2021, 87th Leg., R.S., Ch. 333 (H.B. 2090), Sec. 1, eff. September 1, 2021.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 603 (H.B. 3414), Sec. 2, eff. June 11, 2023.

Sec. 38.404. ESTABLISHMENT AND ADMINISTRATION OF DATABASE. (a)

The department shall collaborate with the center under this subchapter to aid in the center's establishment of the database. The center shall leverage the existing resources and infrastructure of the center to establish the database to collect, process, analyze, and store data relating to medical, dental, pharmaceutical, and other relevant health care claims and encounters, enrollment, and benefit information for the purposes of increasing transparency of health care costs, utilization, and access and improving the affordability, availability, and quality of health care in this state, including by improving population health in this state.

(b) The center shall serve as the administrator of the database, design, build, and secure the database infrastructure, and determine the accuracy of the data submitted for inclusion in the database.

(c) In determining the information a payor is required to submit to the center under this subchapter, the center must consider requiring inclusion of information useful to health policy makers, employers, and consumers for purposes of improving health care quality and outcomes, improving population health, and controlling health care costs. The required information at a minimum must include the following information as it relates to all health care services, supplies, and devices paid or otherwise adjudicated by the payor:

(1) the name and National Provider Identifier, as described in 45 C.F.R. Section 162.410, of each health care provider paid by the payor;

(2) the claim line detail that documents the health care services, supplies, or devices provided by the health care provider;

(3) the amount of charges billed by the health care provider and the payor's:

(A) allowed amount or contracted rate for the health care services, supplies, or devices; and

(B) adjudicated claim amount for the health care services, supplies, or devices;

(4) the name of the payor, the name of the health benefit plan, and the type of health benefit plan, including whether health care services, supplies, or devices were provided to an individual through:

(A) a Medicaid or Medicare program;

(B) workers' compensation insurance;

(C) a health maintenance organization operating under Chapter 843;

(D) a preferred provider benefit plan offered by an insurer under Chapter 1301;

(E) a basic coverage plan under Chapter 1551;

(F) a basic plan under Chapter 1575;

(G) a primary care coverage plan under Chapter 1579; or

(H) a health benefit plan that is subject to the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.); and

(5) claim level information that allows the center to identify the geozip where the health care services, supplies, or devices were provided.

(c-1) Notwithstanding Subsection (c), the center may not require a payor to collect or otherwise obtain from individuals covered by the payor data that is not included in a standard claim form, though the center may require submission of such data if it is otherwise collected by the payor, including provider and eligibility files.

(d) Each payor shall submit the required data under Subsection (c) at a schedule and frequency determined by the center and adopted by the commissioner by rule.

(e) In the manner and subject to the standards, requirements, policies, and procedures relating to the use of data contained in the database established by the center in consultation with the stakeholder advisory group, the center may use the data contained in the database for a noncommercial purpose:

(1) to produce statewide, regional, and geozip consumer reports available through the public access portal described in Section 38.405 that address:

(A) health care costs, quality, utilization, outcomes, and disparities;

(B) population health; or

(C) the availability of health care services; and

(2) for research and other analysis conducted by the center or a qualified research entity to the extent that such use is consistent with all applicable federal and state law, including the data privacy and security requirements of Section 38.406 and the purposes of this subchapter.

(f) The center shall establish data collection procedures and

evaluate and update data collection procedures established under this section. The center shall test the quality of data collected by and reported to the center under this section to ensure that the data is accurate, reliable, and complete.

Added by Acts 2021, 87th Leg., R.S., Ch. 333 (H.B. 2090), Sec. 1, eff. September 1, 2021.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 603 (H.B. 3414), Sec. 3, eff. June 11, 2023.

Sec. 38.405. PUBLIC ACCESS PORTAL. (a) Except as provided by this section and Sections 38.404 and 38.406 and in a manner consistent with all applicable federal and state law, the center shall collect, compile, and analyze data submitted to or stored in the database and disseminate the information described in Section 38.404(e)(1) in a format that allows the public to easily access and navigate the information. The information must be accessible through an open access Internet portal that may be accessed by the public through an Internet website.

(b) The portal created under this section must allow the public to easily search and retrieve the information disseminated under Subsection (a), subject to data privacy and security restrictions described in this subchapter and consistent with all applicable federal and state law.

(c) Any information or data that is accessible through the portal created under this section:

(1) must be segmented by type of insurance or health benefit plan in a manner that does not combine payment rates relating to different types of insurance or health benefit plans;

(2) must be aggregated by like Current Procedural Terminology codes and health care services in a statewide, regional, metropolitan statistical, zip-code, or geozip area; and

(3) may not identify a specific patient, health care provider, health benefit plan, health benefit plan issuer, or other payor.

(d) Before making information or data accessible through the portal, the center shall remove any data or information that may identify a specific patient in accordance with the de-identification

standards described in 45 C.F.R. Section 164.514.

Added by Acts 2021, 87th Leg., R.S., Ch. 333 (H.B. 2090), Sec. 1, eff. September 1, 2021.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 603 (H.B. 3414), Sec. 4, eff. June 11, 2023.

Sec. 38.4055. APPLICATION FOR ACCESS TO CERTAIN DATA OR INFORMATION IN DATABASE. (a) An entity seeking to access data or information that is contained in the database but not accessible through the portal described by Section 38.405 must submit an application to the center for access to that data or information. The application must include:

(1) the sources and identity of all funding and funders of the research the entity will perform;

(2) the names of all individuals who may have access to the data or information that is contained in the database but not accessible through the portal described by Section 38.405, and any affiliations those individuals have with entities other than the entity submitting the application;

(3) the proposed study, research, or project that the entity plans to undertake and the purpose of the study, research, or project, including any anticipated final product from the study, research, or project;

(4) how the proposed research will further the purposes of this subchapter, improve the quality of care, or reduce the cost of care;

(5) a description of the proposed methodology;

(6) a description of the publication method of the manuscripts, reports, or other forms of output from the research; and

(7) for access to data that would require such an approval, an institutional review board determination letter that is an approval or an approval with modifications.

(b) The center shall review and make a determination on all applications in a timely manner.

(c) If the center denies an application, the center must identify with particularity the deficiencies in the application.

Added by Acts 2023, 88th Leg., R.S., Ch. 603 (H.B. 3414), Sec. 5, eff.

June 11, 2023.

Sec. 38.406. DATA PRIVACY AND SECURITY. (a) Information that may identify a patient is confidential and subject to applicable state and federal law relating to records privacy and protected health information, including Chapter 181, Health and Safety Code, and is not subject to disclosure under Chapter 552, Government Code. Except as provided by Subsection (b), any information that may identify a health care provider, health benefit plan, health benefit plan issuer, or other payor is confidential and subject to applicable state and federal law relating to records privacy and protected health information, including Chapter 181, Health and Safety Code, and is not subject to disclosure under Chapter 552, Government Code.

(b) A qualified research entity with access to data or information that is contained in the database but not accessible through the portal described in Section 38.405:

(1) may use the data or information contained in the database only for purposes consistent with the purposes of this subchapter and must use the data or information in accordance with standards, requirements, policies, and procedures established by the center in consultation with the stakeholder advisory group;

(2) may not sell or share any data or information contained in the database; and

(3) may report or publish data or information that identifies one or more health care providers, health benefit plans, health benefit plan issuers, or other mandatory payors only if the report or publication is made available to the public at no cost.

(c) A qualified research entity with access to information that is contained in the database but not accessible through the portal must execute an agreement with the center relating to the qualified research entity's compliance with the requirements of Subsections (a) and (b), including the confidentiality of information contained in the database but not accessible through the portal.

(d) Notwithstanding any provision of this subchapter, the department and the center may not disclose an individual's protected health information in violation of any state or federal law.

(e) The center shall include in the database only the minimum amount of protected health information identifiers necessary to link public and private data sources and the geographic and services data

to undertake studies.

(f) The center shall maintain protected health information identifiers collected under this subchapter but excluded from the database under Subsection (e) in a separate database. The separate database may not be aggregated with any other information and must use a proxy or encrypted record identifier for analysis.

Added by Acts 2021, 87th Leg., R.S., Ch. 333 (H.B. 2090), Sec. 1, eff. September 1, 2021.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 603 (H.B. 3414), Sec. 6, eff. June 11, 2023.

Sec. 38.407. CERTAIN ENTITIES NOT REQUIRED TO SUBMIT DATA. Any sponsor or administrator of a health benefit plan subject to the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.) may elect or decline to participate in or submit data to the center for inclusion in the database as consistent with federal law.

Added by Acts 2021, 87th Leg., R.S., Ch. 333 (H.B. 2090), Sec. 1, eff. September 1, 2021.

Sec. 38.408. REPORT TO LEGISLATURE. Not later than September 1 of each even-numbered year, the center shall submit to the legislature a written report containing:

(1) an analysis of the data submitted to the center for use in the database;

(2) information regarding the submission of data to the center for use in the database and the maintenance, analysis, and use of the data;

(3) recommendations from the center, in consultation with the stakeholder advisory group, to further improve the transparency, cost-effectiveness, accessibility, and quality of health care in this state;

(4) an analysis of the trends of health care affordability, availability, quality, and utilization;

(5) a list of approved applications;

(6) a list of disapproved applications with the

justification required by Section 38.4055(c); and

(7) a list of all applications that were neither approved nor disapproved by the 91st day after the application was submitted, including the particular reasons why each application was not approved or disapproved within that timeframe.

Added by Acts 2021, 87th Leg., R.S., Ch. 333 (H.B. 2090), Sec. 1, eff. September 1, 2021.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 603 (H.B. 3414), Sec. 7, eff. June 11, 2023.

Sec. 38.409. RULES. (a) The commissioner, in consultation with the center, shall adopt rules:

(1) specifying the types of data a payor is required to provide to the center under Section 38.404 to determine health benefits costs and other reporting metrics, including, if necessary, types of data not expressly identified in that section;

(2) specifying the schedule, frequency, and manner in which a payor must provide data to the center under Section 38.404, which must:

(A) require the payor to provide data to the center not less frequently than quarterly; and

(B) include provisions relating to data layout, data governance, historical data, data submission, use and sharing, information security, and privacy protection in data submissions; and

(3) establishing oversight and enforcement mechanisms to ensure that payors submit data to the database in accordance with this subchapter.

(b) In adopting rules governing methods for data submission, the commissioner shall to the maximum extent practicable use methods that are reasonable and cost-effective for payors.

Added by Acts 2021, 87th Leg., R.S., Ch. 333 (H.B. 2090), Sec. 1, eff. September 1, 2021.

CHAPTER 39. PUBLIC ACCESS

Sec. 39.001. ACCESS TO PROGRAMS AND FACILITIES. (a) The commissioner shall prepare and maintain a written plan that describes

how a person who does not speak English may be provided reasonable access to the department's programs.

(b) The department shall comply with federal and state laws for program and facility accessibility.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 39.002. PUBLIC COMMENT. The commissioner shall develop and implement policies that provide the public with a reasonable opportunity to appear before the commissioner and to speak on any issue under the jurisdiction of the commissioner.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 39.003. PUBLIC REPRESENTATION ON ADVISORY BODY. (a) At least one-half of the membership of each advisory body appointed by the commissioner, other than an advisory body whose membership is determined by this code or by another law relating to the business of insurance in this state, must represent the general public.

(b) A public representative may not be:

(1) an officer, director, or employee of an insurance company, insurance agency, agent, broker, solicitor, adjuster, or any other business entity regulated by the department;

(2) a person required to register with the Texas Ethics Commission under Chapter 305, Government Code; or

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

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

**CHAPTER 40. DUTIES OF STATE OFFICE OF ADMINISTRATIVE HEARINGS AND
COMMISSIONER IN CERTAIN PROCEEDINGS; RATE SETTING PROCEEDINGS
SUBCHAPTER A. GENERAL PROVISIONS**

Sec. 40.001. DEFINITION. In this chapter, "office" means the State Office of Administrative Hearings.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 40.002. DUTIES OF STATE OFFICE OF ADMINISTRATIVE HEARINGS. The office shall conduct an administrative hearing required to be held or that may be held under this code or another insurance law of this state.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 40.003. APPLICATION OF CHAPTER; EXCEPTIONS. (a) This chapter applies only to a hearing required to be held before a decision may be rendered or action taken by the commissioner or the department.

(b) If a provision of this code or another insurance law of this state requires that the commissioner take an action at a hearing subject to this chapter, the commissioner shall take the action after receipt of a proposal for decision from the office regarding the hearing conducted by the office.

(c) This chapter does not apply to a proceeding conducted under Chapter 201 or to a proceeding relating to:

- (1) approving or reviewing rates or rating manuals filed by an individual company, unless the rates or manuals are contested;
- (2) adopting a rule;
- (3) adopting or approving a policy form or policy form endorsement;
- (4) adopting or approving a plan of operation for an organization subject to the jurisdiction of the department;
- (5) adopting a presumptive rate under Chapter 1153; or
- (6) a workers' compensation claim brought under Title 5, Labor Code.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Amended by Acts 2001, 77th Leg., ch. 1318, Sec. 3, eff. Sept. 1, 2001.

Amended by:

Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 6.057, eff. September 1, 2005.

Sec. 40.004. MEMORANDUM OF UNDERSTANDING. (a) The commissioner and the chief administrative law judge of the office by rule shall adopt a memorandum of understanding governing hearings

conducted by the office under this code or another insurance law of this state.

(b) The memorandum of understanding must require the chief administrative law judge and the commissioner to cooperate in conducting hearings under this chapter and may authorize the office to perform any procedural act, including giving notice, that is required to be performed by the commissioner under this code or another insurance law of this state.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 40.005. CONFLICT WITH OTHER LAW. This chapter prevails over another provision of this code or another insurance law of this state unless the provision or other law states that this chapter does not apply.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

SUBCHAPTER B. PROCEEDINGS RELATING TO PROMULGATION OF RATES

Sec. 40.051. APPLICATION OF SUBCHAPTER. Subject to Section 40.003, a proceeding to promulgate rates is governed by this subchapter.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 40.052. APPLICATION OF ADMINISTRATIVE PROCEDURE ACT. A proceeding to promulgate rates is a contested case under Chapter 2001, Government Code, and to the extent not inconsistent with this subchapter, that chapter and the Texas Rules of Civil Procedure apply.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 40.053. PRESENTATION OF EVIDENCE. The administrative law judge shall provide each interested party an opportunity to respond to and present evidence and argument concerning all issues in the proceeding.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 40.054. WITNESSES AND CROSS-EXAMINATION. (a) The testimony of a witness, other than an expert witness, may be presented either orally by the witness at the hearing or by affidavit.

(b) Each party is entitled to cross-examine each witness called to testify by another party to the proceeding. The attendance of a witness providing testimony by affidavit is required if a party files a written request that the witness appear for cross-examination.

(c) If a witness providing testimony by affidavit fails to appear for cross-examination after the filing of a written request that the witness appear, the administrative law judge shall exclude the affidavit from evidence and may not consider the affidavit for any purpose.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 40.055. TESTIMONY OF EXPERT WITNESS; PREFILING REQUIRED. The direct testimony of each expert witness to be called must be prefiled in accordance with a schedule established by the administrative law judge.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 40.056. DEADLINES. The administrative law judge shall establish reasonable deadlines for the filing of affidavits, the designation of witnesses, and other matters as are necessary or appropriate.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 40.057. INFLUENCE OF COMMISSIONER PROHIBITED. The commissioner may not attempt to influence the administrative law judge's findings of fact, conclusions of law, or application of the law to the facts.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 40.058. PROPOSAL FOR DECISION. The administrative law judge shall:

- (1) prepare a proposal for decision that includes proposed findings of fact and conclusions of law; and
- (2) serve the proposal for decision by registered mail on each party to the proceeding.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 40.059. CONSIDERATION OF PROPOSAL FOR DECISION. (a) The commissioner shall provide to each party an opportunity to file exceptions to the proposal for decision and briefs related to the issues addressed in the proposal.

(b) After the opportunity to file exceptions and briefs under Subsection (a), the commissioner shall, in open meeting, consider:

- (1) the proposal for decision; and
- (2) the exceptions, briefs, and arguments of the parties.

(c) The commissioner may amend the proposal for decision, including any finding of fact. The commissioner shall accompany any amendment with an explanation of the basis of the amendment. The commissioner shall base any amendment and the order adopting the rate solely on the record made before the administrative law judge.

(d) The commissioner may refer the matter back to the administrative law judge to:

- (1) reconsider findings and conclusions in the proposal for decision;
- (2) take additional evidence; or
- (3) make additional findings of fact or conclusions of law.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 40.060. COMMISSIONER'S ORDER. The commissioner shall serve on each party a copy of the commissioner's order, including the commissioner's findings of fact and conclusions of law.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

SUBTITLE B. DISCIPLINE AND ENFORCEMENT**CHAPTER 81. GENERAL PROVISIONS REGARDING DISCIPLINE AND ENFORCEMENT**

Sec. 81.001. LIMITATIONS PERIOD FOR CERTAIN DISCIPLINARY ACTIONS. (a) Except as provided by Subsection (b), the department or commissioner may not begin an action to impose a sanction, penalty, or fine, including an administrative penalty, against an insurer, agent, or other license holder who is subject to the jurisdiction of the department for conduct that is a violation of this code or another insurance law of this state after the earlier of:

(1) the fifth anniversary of the date on which the conduct that is a violation occurred; or

(2) the second anniversary of the earlier of:

(A) the date on which the conduct that is a violation is first discovered by the department; or

(B) the date on which the conduct that is a violation is made known to the department.

(b) The department or commissioner may not begin an action to impose a sanction, penalty, or fine, including an administrative penalty, against an insurer, agent, or other license holder who is subject to the jurisdiction of the department for conduct that is a violation of this code or another insurance law of this state and that involves fraud by the insurer, agent, or license holder after the fifth anniversary of the earlier of:

(1) the date on which the conduct that is a violation is first discovered by the department; or

(2) the date on which the conduct that is a violation is made known to the department.

(c) This section does not apply to conduct that is:

(1) a violation that is ongoing at the time the department seeks to impose the sanction, penalty, or fine;

(2) a violation of Subchapter A, Chapter 544, or Section 541.057, as those provisions relate to discrimination on the basis of race or color, regardless of the time the conduct occurs; or

(3) a violation of Title 5, Labor Code.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Amended by Acts 2001, 77th Leg., ch. 887, Sec. 1, eff. Sept. 1, 2001.

Amended by:

Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 6.058, eff. September 1, 2005.

Sec. 81.002. NOTICE OF CERTAIN ORDERS AND DECISIONS. Notwithstanding Section 2001.142, Government Code, in a contested case before the department or the commissioner the department shall mail to each party and the party's attorney of record, by certified mail, return receipt requested, a copy of the department's or commissioner's written decision or order in that case.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 81.003. NOTIFICATION OF CERTAIN DISCIPLINARY ACTIONS OCCURRING IN OTHER STATES; CIVIL PENALTY. (a) In this section, "insurer" means any organization, corporation, or other person that transacts insurance business, other than an organization, corporation, or other person that is specifically made exempt from this section by a reference to this section, without regard to whether the organization, corporation, or other person is listed in this subsection. The term includes:

- (1) a capital stock company;
- (2) a title insurance company;
- (3) a reciprocal or interinsurance exchange;
- (4) a Lloyd's plan insurer;
- (5) a fraternal benefit society;
- (6) a mutual company, including a mutual assessment company;
- (7) a statewide mutual assessment company;
- (8) a local mutual aid association;
- (9) a burial association;
- (10) a county mutual insurance company;
- (11) a farm mutual insurance company; and
- (12) a fidelity, guaranty, or surety company.

(b) An insurer shall notify the commissioner and shall deliver a copy of any applicable order or judgment to the commissioner not later than the 30th day after the date of the:

- (1) suspension or revocation of the insurer's right to

transact business in another state; or

(2) receipt of an order to show cause why the insurer's license in another state should not be suspended or revoked.

(c) An insurer who violates Subsection (b) is liable for a civil penalty, recoverable by a civil action, in an amount not to exceed \$500 for each violation. In addition to the civil penalty, the commissioner may suspend or revoke the license of an insurer or agent for a wilful violation of Subsection (b).

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 43 (S.B. 1012), Sec. 1, eff. September 1, 2017.

Sec. 81.004. REPORT TO ATTORNEY GENERAL. The department shall report to the attorney general, promptly and in detail, any violation of law relating to insurance companies or the business of insurance.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

CHAPTER 82. SANCTIONS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 82.001. DEFINITION. In this chapter, "authorization" means a permit, license, certificate of authority, certificate of registration, or other authorization issued or existing under the commissioner's authority or this code.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 82.002. APPLICATION OF CHAPTER. (a) This chapter applies to each company regulated by the commissioner, including:

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

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

(3) a Mexican casualty company;

(4) a domestic or foreign Lloyd's plan insurer;

(5) a domestic or foreign reciprocal or interinsurance

exchange;

- (6) a domestic or foreign fraternal benefit society;
- (7) a domestic or foreign title insurance company;
- (8) a stipulated premium insurance company;
- (9) a nonprofit legal service corporation;
- (10) a health maintenance organization;
- (11) a statewide mutual assessment company;
- (12) a local mutual aid association;
- (13) a local mutual burial association;
- (14) an association exempt under Section 887.102;
- (15) a nonprofit hospital, medical, or dental service corporation, including a company subject to Chapter 842;
- (16) a county mutual insurance company; and
- (17) a farm mutual insurance company.

(b) This chapter also applies to:

- (1) an agent of an entity described by Subsection (a); and
- (2) an individual or a corporation, association, partnership, or other artificial person who:
 - (A) is engaged in the business of insurance;
 - (B) holds an authorization; or
 - (C) is regulated by the commissioner.

(c) The commissioner's authority under this chapter applies to each form of authorization and each person or entity holding an authorization.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.
Amended by Acts 2001, 77th Leg., ch. 1419, Sec. 18, eff. June 1, 2003; Acts 2001, 77th Leg., ch. 1420, Sec. 11.002, eff. Sept. 1, 2001.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2B.010, eff. April 1, 2009.

Acts 2017, 85th Leg., R.S., Ch. 967 (S.B. 2065), Sec. 5.002, eff. September 1, 2017.

Sec. 82.003. PROCEEDINGS UNDER OTHER LAW. The commissioner's authority under this chapter is in addition to any other authority to enforce a sanction, penalty, fine, forfeiture, denial, suspension, or revocation otherwise authorized by law.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

SUBCHAPTER B. IMPOSITION OF SANCTIONS

Sec. 82.051. CANCELLATION OR REVOCATION OF AUTHORIZATION.

After notice and opportunity for a hearing, the commissioner may cancel or revoke an authorization if the holder of the authorization is found to be in violation of, or to have failed to comply with, this code or a rule of the commissioner.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 82.052. OTHER SANCTIONS. In addition to the cancellation or revocation of an authorization under Section 82.051, the commissioner may:

- (1) suspend the authorization for a specified time not to exceed one year;
- (2) order the holder of the authorization to cease and desist from:
 - (A) the activity determined to be in violation of this code or a rule of the commissioner; or
 - (B) the failure to comply with this code or a rule of the commissioner;
- (3) direct the holder of the authorization to pay an administrative penalty under Chapter 84;
- (4) direct the holder of the authorization to make restitution under Section 82.053; or
- (5) take any combination of those actions.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 82.053. RESTITUTION. (a) The commissioner may direct the holder of an authorization to make complete restitution to each Texas resident, each Texas insured, and each entity operating in this state that is harmed by a violation of, or failure to comply with, this code or a rule of the commissioner.

(b) The holder of the authorization shall make the restitution in the form and amount and within the period determined by the commissioner.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 82.054. CANCELLATION ON FAILURE TO COMPLY. If it is found after hearing that a holder of an authorization has failed to comply with an order issued under Section 82.052, the commissioner shall cancel each authorization held by the holder.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 82.055. INFORMAL DISPOSITION. (a) The commissioner may informally dispose of a matter under this subchapter by consent order, agreed settlement, stipulation, or default.

(b) An informal disposition may include a provision under which the holder of the authorization agrees to a sanction under this subchapter with the express reservation that:

- (1) the holder does not admit a violation of this code or of a rule; and
- (2) the existence of a violation is in dispute.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 82.056. NOTICE TO OTHER STATES. The commissioner shall give notice of an action taken under this subchapter to the insurance commissioner or other similar officer of each state.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

CHAPTER 83. EMERGENCY CEASE AND DESIST ORDERS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 83.001. DEFINITIONS. In this chapter:

- (1) "Authorized person" means an individual or entity described by Section 83.002.
- (2) "Emergency" means a sudden, urgent occurrence that requires immediate action.
- (3) "Unauthorized person" means an individual or a corporation, association, partnership, or other artificial person who directly or indirectly does an act of insurance business that is:

(A) described by Section 101.051 or 101.052; and
 (B) not done in accordance with specific authorization
 of law.

(4) "Unfair act" means an unfair method of competition, an unfair or deceptive act or practice, or an unfair claim settlement practice as defined under Chapter 541 or 542 or a rule adopted under either chapter.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.
 Amended by Acts 2001, 77th Leg., ch. 1419, Sec. 19, eff. June 1, 2003; Acts 2001, 77th Leg., ch. 1420, Sec. 11.003, eff. Sept. 1, 2001.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2B.011, eff. April 1, 2009.

Sec. 83.002. APPLICATION OF CHAPTER. (a) This chapter applies to each company regulated by the commissioner, including:

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

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

(3) a Mexican casualty company;

(4) a domestic or foreign Lloyd's plan insurer;

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

(6) a domestic or foreign fraternal benefit society;

(7) a domestic or foreign title insurance company;

(8) a stipulated premium insurance company;

(9) a nonprofit legal service corporation;

(10) a statewide mutual assessment company;

(11) a local mutual aid association;

(12) a local mutual burial association;

(13) an association exempt under Section 887.102;

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

(15) a county mutual insurance company; and

(16) a farm mutual insurance company.

(b) This chapter also applies to:

- (1) an agent of an entity described by Subsection (a); and
 - (2) an individual or a corporation, association, partnership, or other artificial person who:
 - (A) is engaged in the business of insurance;
 - (B) holds a permit, certificate, registration, license, or other authority under this code; or
 - (C) is regulated by the commissioner.
- (c) This chapter also applies to:
- (1) a person appointed as a qualified inspector under Section 2210.254; and
 - (2) a person acting as a qualified inspector under Section 2210.254 without being appointed as a qualified inspector under either of those sections.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.
 Amended by Acts 2001, 77th Leg., ch. 1419, Sec. 20, eff. June 1, 2003; Acts 2001, 77th Leg., ch. 1420, Sec. 11.004, eff. Sept. 1, 2001.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2B.012, eff. April 1, 2009.

Acts 2011, 82nd Leg., 1st C.S., Ch. 2 (H.B. 3), Sec. 1, eff. September 28, 2011.

Acts 2015, 84th Leg., R.S., Ch. 1073 (H.B. 2439), Sec. 8, eff. September 1, 2015.

Acts 2017, 85th Leg., R.S., Ch. 967 (S.B. 2065), Sec. 5.003, eff. September 1, 2017.

Sec. 83.003. RULES. The commissioner may adopt reasonable rules to implement this chapter, including rules that provide, to the extent possible, uniformity of procedures between this state and other states, the United States, or the National Association of Insurance Commissioners.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 83.004. PROCEEDINGS UNDER OTHER LAW. The commissioner may proceed solely under this chapter or under this chapter in conjunction with other applicable law.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

SUBCHAPTER B. ISSUANCE OF ORDERS

Sec. 83.051. AUTHORITY OF COMMISSIONER TO ISSUE ORDER. (a) The commissioner ex parte may issue an emergency cease and desist order if:

(1) the commissioner believes that:

(A) an authorized person engaging in the business of insurance is:

(i) committing an unfair act; or

(ii) in a hazardous condition or a hazardous financial condition under Section 843.406 or Subchapter A, Chapter 404, as determined by the commissioner; or

(B) an unauthorized person:

(i) is engaging in the business of insurance in violation of Chapter 101 or in violation of a rule adopted under that chapter; and

(ii) does not meet a statutory exception or exemption; and

(2) with respect to conduct described by Subdivision (1)(A), it appears to the commissioner that the alleged conduct:

(A) is fraudulent;

(B) is hazardous or creates an immediate danger to the public safety; or

(C) is causing or can be reasonably expected to cause public injury that:

(i) is likely to occur at any moment;

(ii) is incapable of being repaired or rectified;

and

(iii) has or is likely to have influence or effect.

(b) An order is final on the 61st day after the date it is served, unless the affected person requests a hearing under Section 83.053.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2B.013, eff. April 1, 2009.

Acts 2021, 87th Leg., R.S., Ch. 60 (S.B. 1809), Sec. 3, eff.

September 1, 2021.

Sec. 83.052. NOTICE. (a) On issuance of an order under Section 83.051, the commissioner shall serve on the affected person an order that:

- (1) contains a statement of the charges; and
- (2) requires the person immediately to cease and desist from the acts, methods, or practices stated in the order.

(b) The commissioner shall serve the order by registered or certified mail, return receipt requested, to the affected person's last known address.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 83.053. REQUEST FOR HEARING. (a) A person affected by an order is entitled to request a hearing to contest the order.

(b) The affected person must request the hearing not later than the 60th day after the date on which the person is served with an order required by Section 83.052.

(c) A request to contest an order must:

- (1) be in writing;
- (2) be directed to the commissioner; and
- (3) state the grounds for the request to set aside or modify the order.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Amended by:

Acts 2021, 87th Leg., R.S., Ch. 60 (S.B. 1809), Sec. 4, eff. September 1, 2021.

Sec. 83.054. HEARING. (a) On receiving a timely request for a hearing under Section 83.053, the department shall docket the case at the State Office of Administrative Hearings not later than the 30th day after the date the department receives the request.

(b) The hearing is subject to the procedures for contested cases under Chapter 2001, Government Code.

(c) At the hearing, the person requesting the hearing must show why the order should not be affirmed.

(d) Following receipt of the proposal for decision from the State Office of Administrative Hearings regarding the hearing, the commissioner shall affirm, modify, or set aside in whole or in part the order.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.
Amended by:

Acts 2021, 87th Leg., R.S., Ch. 60 (S.B. 1809), Sec. 5, eff. September 1, 2021.

Sec. 83.055. EFFECT OF ORDER PENDING HEARING. Pending a hearing under this subchapter, an order continues in effect unless the order is stayed by the commissioner.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

SUBCHAPTER C. ENFORCEMENT

Sec. 83.101. AUTHORITY OF COMMISSIONER. If the commissioner reasonably believes that a person has violated an order issued under this chapter, the commissioner may:

- (1) initiate proceedings under this subchapter to impose an administrative penalty or direct restitution;
- (2) refer the matter to the attorney general for enforcement;
- (3) initiate a proceeding to revoke the person's certificate of authority; or
- (4) pursue another action the commissioner considers appropriate under applicable law.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 83.102. DETERMINATION OF VIOLATION. In determining whether an order has been violated, the commissioner shall consider the maintenance of procedures reasonably adopted to ensure compliance with the order.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 83.103. HEARING ON ADMINISTRATIVE PENALTY. (a) If the commissioner pursues action to impose an administrative penalty under Section 83.101(1), the commissioner shall serve on the person notice of the time and place of a hearing to be held not earlier than the 21st day after the date the notice is received.

(b) The notice must contain a statement of the facts or conduct alleged to violate the order.

(c) The commissioner shall serve the notice by registered or certified mail, return receipt requested, to the person's last known address.

(d) The hearing is subject to the procedures for contested cases under Chapter 2001, Government Code.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 83.104. IMPOSITION OF ADMINISTRATIVE PENALTY; RESTITUTION. (a) After a hearing, if the commissioner determines that an order has been violated, the commissioner may:

(1) impose an administrative penalty of \$25,000 for each act of violation;

(2) direct the person against whom the order was issued to make complete restitution to each Texas resident, Texas insured, and entity operating in this state that is harmed by the violation; or

(3) impose the penalty and direct restitution.

(b) A person directed to make restitution shall make the restitution in the form and amount and within the period determined by the commissioner.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 83.105. FAILURE TO PAY PENALTY. If a person fails to pay a penalty assessed under this subchapter, the commissioner may:

(1) refer the matter to the attorney general for enforcement; or

(2) cancel or revoke any permit, license, certificate of authority, certificate of registration, or other authorization issued under this code as provided by Chapter 82.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

SUBCHAPTER D. JUDICIAL REVIEW; JUDICIAL ACTION

Sec. 83.151. APPEAL. A person affected by an order of the commissioner under Section 83.051 or 83.104 may appeal the order by filing suit in a district court in Travis County not later than the 20th day after the date of the order.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 83.152. EFFECT OF PETITION ON ORDER OR RELATED DECISION. A petition for appeal filed under Section 83.151 does not stay or vacate an order or a decision made under Subchapter B unless the court, after hearing, issues an order that specifically stays or vacates the order or decision.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 83.153. JUDICIAL ACTION FOR ENFORCEMENT OF ORDER; ATTORNEY'S FEES. The department may recover reasonable attorney's fees if judicial action is necessary to enforce an order issued under Section 83.051 or 83.104.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

CHAPTER 84. ADMINISTRATIVE PENALTIES**SUBCHAPTER A. GENERAL PROVISIONS**

Sec. 84.001. DEFINITION. In this chapter, "person" means an individual, corporation, trust, partnership, association, or any other legal entity.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 84.002. APPLICATION OF CHAPTER TO ADMINISTRATIVE PENALTY.
(a) This chapter applies to each monetary penalty the department or commissioner imposes under this code or another insurance law of this state.

(b) For purposes of this chapter, each of the monetary penalties is an administrative penalty.

(c) This chapter applies to a monetary penalty the department or the commissioner of workers' compensation imposes under Title 5, Labor Code, only as provided by that title.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.
Amended by:

Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 6.059, eff. September 1, 2005.

Sec. 84.003. APPLICATION OF ADMINISTRATIVE PROCEDURE ACT. A proceeding under this chapter is subject to Chapter 2001, Government Code.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 84.004. RULEMAKING AUTHORITY. (a) The commissioner may adopt and enforce reasonable rules that the commissioner determines necessary to accomplish the purposes of this chapter.

(b) The commissioner may establish by rule the amount of an administrative penalty to be imposed under Section 84.022 for a specific violation.

(c) The existence or absence of a rule adopted under this chapter does not limit the commissioner's authority to take any action authorized by law.

Added by Acts 2009, 81st Leg., R.S., Ch. 1029 (H.B. 4358), Sec. 1, eff. June 19, 2009.

SUBCHAPTER B. IMPOSITION OF ADMINISTRATIVE PENALTY

Sec. 84.021. IMPOSITION OF PENALTY. The commissioner may impose an administrative penalty on a person licensed or regulated under this code or another insurance law of this state, including an unauthorized person as defined by Section 83.001, who violates:

- (1) this code;
- (2) another insurance law of this state; or
- (3) a rule or order adopted under this code or another

insurance law of this state.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Amended by:

Acts 2021, 87th Leg., R.S., Ch. 60 (S.B. 1809), Sec. 6, eff. September 1, 2021.

Sec. 84.022. PENALTY AMOUNT. (a) The penalty for a violation may not exceed \$25,000, unless a greater or lesser penalty is specified by this code or another insurance law of this state.

(b) The amount of the penalty shall 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.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

SUBCHAPTER C. PROCEDURAL REQUIREMENTS

Sec. 84.041. REPORT AND NOTICE OF VIOLATION AND PENALTY. (a) If the department determines that a violation has occurred, the department may issue to the commissioner a report that states the facts on which the determination is based and the department's recommendation on the imposition of an administrative penalty, including a recommendation on the amount of the penalty.

(b) Not later than the 14th day after the date the report is issued, the department shall give written notice of the report to the affected person. The notice may be given by certified mail. The notice must:

(1) include:

(A) a brief summary of the alleged violation; and

(B) a statement of the amount of the recommended penalty; and

(2) inform the person that the person has a right to a hearing on the occurrence of the violation, the amount of the penalty, or both the occurrence of the violation and the amount of the penalty.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 84.042. PENALTY TO BE PAID OR HEARING REQUESTED. (a) Not later than the 20th day after the date the person receives the notice, the person, in writing, may:

(1) accept the department's determination and recommended administrative penalty; or

(2) request a hearing on the occurrence of the violation, the amount of the penalty, or both the occurrence of the violation and the amount of the penalty.

(b) If the person accepts the department's determination and recommended penalty, the commissioner by order shall approve the determination and require the person to pay the recommended penalty.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 84.043. HEARING AND DECISION. (a) If the person requests a hearing or fails to respond in a timely manner to the notice, the department shall set a hearing and give notice of the hearing to the person.

(b) An administrative law judge of the State Office of Administrative Hearings shall conduct the hearing.

(c) The administrative law judge shall make findings of fact and conclusions of law and promptly issue to the commissioner a proposal for a decision about the occurrence of the violation and the amount of a proposed administrative penalty.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 84.044. DECISION BY COMMISSIONER. (a) Based on the findings of fact, conclusions of law, and proposal for decision, the

commissioner by order may:

(1) find that a violation occurred and impose an administrative penalty; or

(2) find that a violation did not occur.

(b) The notice of the commissioner's order must include a statement of the right of the person to judicial review of the order.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 84.045. OPTIONS FOLLOWING DECISION: PAY OR APPEAL. Not later than the 30th day after the date the commissioner's order becomes final, the person shall:

(1) pay the administrative penalty; or

(2) file a petition for judicial review contesting the occurrence of the violation or the amount of the penalty, or both, and either pay or not pay the penalty.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 84.046. STAY OF ENFORCEMENT OF PENALTY. (a) A person who files a petition for judicial review without paying the administrative penalty may, within the 30-day period prescribed by Section 84.045:

(1) stay enforcement of the penalty by:

(A) paying the penalty to the court for placement in an escrow account; or

(B) giving the court a supersedeas bond approved by the court that:

(i) is for the amount of the penalty; and

(ii) is effective until all judicial review of the board's order is final; or

(2) request the court to stay enforcement of the penalty by:

(A) filing with the court an affidavit stating that the person is financially unable to pay the penalty and is financially unable to give the supersedeas bond; and

(B) giving a copy of the affidavit to the commissioner by certified mail.

(b) If the commissioner receives a copy of an affidavit under

Subsection (a)(2), the commissioner may file with the court, not later than the fifth day after the date the copy is received, a contest to the affidavit. The court shall hold a hearing on the facts alleged in the affidavit as soon as practicable and shall stay the enforcement of the penalty on finding that the alleged facts are true. The person who files an affidavit has the burden of proving that the person is financially unable to pay the penalty and to give a supersedeas bond.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 84.047. COLLECTION OF PENALTY. If the person does not pay the administrative penalty and the enforcement of the penalty is not stayed, the commissioner may refer the matter to the attorney general for collection of the penalty.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 84.048. STANDARD OF JUDICIAL REVIEW. The order of the commissioner is subject to judicial review under the substantial evidence rule.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 84.049. DECISION BY COURT. (a) If the court sustains the finding that a violation occurred, the court may uphold or reduce the amount of the administrative penalty and order the person to pay the full or reduced amount of the penalty.

(b) If the court does not sustain the finding that a violation occurred, the court shall order that a penalty is not owed.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 84.050. REMITTANCE OF PENALTY AND INTEREST. (a) If the person paid the administrative penalty and if the amount of the penalty is reduced or the penalty is not upheld by the court, the court shall order, when the judgment becomes final, that the

appropriate amount plus accrued interest be remitted to the person.

(b) The interest accrues at the rate charged on loans to depository institutions by the New York Federal Reserve Bank.

(c) The interest shall be paid for the period beginning on the date the penalty is paid and ending on the date the penalty is remitted.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 84.051. RELEASE OF BOND. (a) If the person gave a supersedeas bond and if the administrative penalty is not upheld by the court, the court shall order, when the judgment becomes final, the release of the bond.

(b) If the person gave a supersedeas bond and if the amount of the penalty is reduced, the court shall order the release of the bond after the person pays the reduced amount.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

CHAPTER 85. GENERAL CRIMINAL ENFORCEMENT

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 85.001. VIOLATION OF CERTAIN LAWS FOR WHICH PUNISHMENT IS NOT PROVIDED; OFFENSE. (a) A person commits an offense if the person violates a law of this state regulating the business of life, fire, or marine insurance.

(b) Unless another penalty is provided by law, an offense under this section is a misdemeanor punishable by a fine of not less than \$500 or more than \$1,000.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

SUBCHAPTER B. PROSECUTION OF OFFENSES

Sec. 85.051. VENUE FOR PROSECUTION. (a) A person who violates the Penal Code or a penal provision of this code while engaged in the business of insurance may be prosecuted in:

(1) Travis County; or

(2) a county in which prosecution is authorized under the Code of Criminal Procedure.

(b) A law limiting regulation by the department under this code or another insurance law of this state does not restrict the application of this section.

(c) This section controls if there is a conflict or ambiguity between this section and another provision of this code or another insurance law of this state.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 85.052. ELECTION OF PROSECUTION. A person who commits an offense under this code may be prosecuted under this code or any other law of this state under which the person may be prosecuted.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

**CHAPTER 86. REVOCATION OR MODIFICATION OF CERTIFICATE OF AUTHORITY;
AUTHORITY TO BRING CERTAIN ACTIONS**

**SUBCHAPTER A. REVOCATION OR MODIFICATION OF CERTIFICATE
OF AUTHORITY**

Sec. 86.001. AUTHORITY TO REVOKE OR MODIFY CERTIFICATE OF AUTHORITY. The commissioner may revoke or modify a certificate of authority if a condition or requirement prescribed by law for granting the certificate is no longer satisfied.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. [2017](#)), Sec. 12, eff. April 1, 2007.

Sec. 86.002. NOTICE OF INTENT TO REVOKE OR MODIFY CERTIFICATE OF AUTHORITY. (a) The commissioner must notify an insurance carrier in writing of the commissioner's intent to revoke or modify the carrier's certificate of authority.

(b) The commissioner must provide the notice not later than the 10th day before the date the revocation or modification is to occur.

(c) The commissioner must specifically state in the notice the reason for the action.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. [2017](#)), Sec. 12, eff. April 1, 2007.

SUBCHAPTER B. AUTHORITY TO BRING CERTAIN ACTIONS

Sec. 86.051. AUTHORITY TO BRING ACTION FOR OR PROSECUTE VIOLATION OF LAW. The department, through the attorney general or an attorney designated by the attorney general, may institute an action relating to or initiate a prosecution for a violation of a law of this state relating to insurance.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 12, eff. April 1, 2007.

Sec. 86.052. AUTHORITY TO BRING ACTION TO CLOSE AFFAIRS OR RESTRAIN BUSINESS OF DOMESTIC INSURANCE COMPANY. Only the department may bring an action to:

- (1) close the affairs of an insurance company organized under the laws of this state; or
- (2) enjoin, restrain, or interfere with the prosecution of the business of an insurance company organized under the laws of this state.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 12, eff. April 1, 2007.

CHAPTER 101. UNAUTHORIZED INSURANCE**SUBCHAPTER A. GENERAL PROVISIONS**

Sec. 101.001. STATE POLICY AND PURPOSE. (a) It is a state concern that many residents of this state hold insurance policies issued by persons or insurers who are not authorized to do insurance business in this state and who are not qualified as eligible surplus lines insurers under Chapter 981. These residents face often insurmountable obstacles in asserting legal rights under the policies in foreign forums under unfamiliar laws and rules of practice.

(b) It is the policy of this state to protect residents against acts by a person or insurer who is not authorized to do insurance business in this state by:

- (1) maintaining fair and honest insurance markets;
- (2) protecting the premium tax revenues of this state;
- (3) protecting authorized persons and insurers, who are

subject to strict regulation, from unfair competition by unauthorized persons and insurers; and

(4) protecting against evasion of the insurance regulatory laws of this state.

(c) The purpose of this chapter is to subject certain insurers and persons to the jurisdiction of:

(1) the commissioner and proceedings before the commissioner; and

(2) the courts of this state in suits by or on behalf of the state or an insured or beneficiary under an insurance contract.

(d) It is also a concern that this state not become a safe harbor for persons or insurers engaged in the unauthorized business of insurance in this state, regardless of whether the insureds or other persons affected by the unauthorized business of insurance are residents of this state.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.
Amended by Acts 2001, 77th Leg., ch. 671, Sec. 1, eff. Sept. 1, 2001;
Acts 2001, 77th Leg., ch. 1419, Sec. 21, eff. June 1, 2003; Acts
2001, 77th Leg., ch. 1420, Sec. 11.005, eff. Sept. 1, 2001.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 2B.014,
eff. April 1, 2009.

Sec. 101.002. DEFINITIONS. In this chapter:

(1) "Insurer" includes:

(A) a corporation, association, partnership, or individual engaged as a principal in the business of insurance;

(B) an interinsurance exchange or mutual benefit society; or

(C) an insurance exchange or syndicate.

(2) "Unfair act" means an unfair method of competition or an unfair or deceptive act or practice as defined under Chapter 541 or a rule adopted under that chapter.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 2B.015,
eff. April 1, 2009.

Sec. 101.003. INSURANCE EXCHANGES AND SYNDICATES; RULES. The commissioner shall adopt rules defining insurance exchanges and syndicates that are insurers for purposes of Section 101.002.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 101.004. UNCONSTITUTIONAL APPLICATION PROHIBITED; NOTICE TO COMMISSIONER. (a) Subject to Subsection (b), this chapter does not apply to an insurer or other person to whom, under the constitution or statutes of the United States or the constitution of this state, it may not apply.

(b) Before commencing operations, an insurer or other person claiming an exemption described by Subsection (a) must file with the commissioner:

- (1) notice of the claim; and
- (2) documents supporting the claim.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

SUBCHAPTER B. BUSINESS OF INSURANCE; EXCEPTIONS

Sec. 101.051. CONDUCT THAT CONSTITUTES THE BUSINESS OF INSURANCE. (a) In this section, "medical expense" includes surgical, chiropractic, physical therapy, speech pathology, audiology, professional mental health, dental, hospital, or optometric expenses.

(b) The following acts in this state constitute the business of insurance in this state:

- (1) making or proposing to make, as an insurer, an insurance contract;
- (2) making or proposing to make, as guarantor or surety, a guaranty or suretyship contract as a vocation and not merely incidental to another legitimate business or activity of the guarantor or surety;
- (3) taking or receiving an insurance application;
- (4) receiving or collecting any consideration for insurance, including:
 - (A) a premium;
 - (B) a commission;
 - (C) a membership fee;

- (D) an assessment; or
 - (E) dues;
 - (5) issuing or delivering an insurance contract to:
 - (A) a resident of this state; or
 - (B) a person authorized to do business in this state;
 - (6) directly or indirectly acting as an agent for or otherwise representing or assisting an insurer or person in:
 - (A) soliciting, negotiating, procuring, or effectuating insurance or a renewal of insurance;
 - (B) disseminating information relating to coverage or rates;
 - (C) forwarding an insurance application;
 - (D) delivering an insurance policy or contract;
 - (E) inspecting a risk;
 - (F) setting a rate;
 - (G) investigating or adjusting a claim or loss;
 - (H) transacting a matter after the effectuation of the contract that arises out of the contract; or
 - (I) representing or assisting an insurer or person in any other manner in the transaction of insurance with respect to a subject of insurance that is resident, located, or to be performed in this state;
 - (7) contracting to provide in this state indemnification or expense reimbursement for a medical expense by direct payment, reimbursement, or otherwise to a person domiciled in this state or for a risk located in this state, whether as an insurer, agent, administrator, trust, or funding mechanism or by another method;
 - (8) doing any kind of insurance business specifically recognized as constituting insurance business within the meaning of statutes relating to insurance;
 - (9) doing or proposing to do any insurance business that is in substance equivalent to conduct described by Subdivisions (1)-(8) in a manner designed to evade statutes relating to insurance or a claimed exception or exemption to insurance regulation; or
 - (10) any other transaction of business in this state by an insurer.
- (c) An act described by Subsection (b) by an unlicensed or unauthorized person or insurer that occurs in this state and that affects a person in another state or jurisdiction constitutes the business of insurance in this state.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.
Amended by Acts 2001, 77th Leg., ch. 671, Sec. 2, eff. Sept. 1, 2001;
Acts 2001, 77th Leg., ch. 1419, Sec. 22, eff. June 1, 2003; Acts
2001, 77th Leg., ch. 1420, Sec. 11.006, eff. Sept. 1, 2001.

Amended by:

Acts 2021, 87th Leg., R.S., Ch. 60 (S.B. 1809), Sec. 7, eff.
September 1, 2021.

Sec. 101.052. ADVERTISING RELATING TO MEDICARE SUPPLEMENT BENEFIT PLANS. With respect to a Medicare supplement benefit plan authorized under Chapter 1652, the business of insurance in this state includes using, creating, publishing, mailing, or disseminating in this state an advertisement relating to an act that constitutes the business of insurance under Section 101.051 unless the advertisement is used, created, published, mailed, or disseminated on behalf of an insurer or person who:

(1) is authorized under this code to engage in the business of insurance in this state;

(2) has actual knowledge of the content of the advertisement;

(3) has authorized the advertisement to be used, created, published, mailed, or disseminated on that insurer's or person's behalf; and

(4) is clearly identified by name in the advertisement as the sponsor of the advertisement.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.
Amended by Acts 2001, 77th Leg., ch. 1419, Sec. 23, eff. June 1, 2003; Acts 2001, 77th Leg., ch. 1420, Sec. 11.007, eff. Sept. 1, 2001.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2B.016, eff. April 1, 2009.

Sec. 101.053. APPLICATION OF SUBCHAPTER. (a) Sections 101.051 and 101.052 apply to an act whether performed by mail or otherwise. Venue for an act performed by mail is at the place where the matter transmitted by mail is delivered and takes effect.

- (b) Sections 101.051 and 101.052 do not apply to:
- (1) the lawful transaction of surplus lines insurance under Chapter 981;
 - (2) the lawful transaction of reinsurance by insurers;
 - (3) a transaction in this state that:
 - (A) involves a policy that:
 - (i) is lawfully solicited, written, and delivered outside this state; and
 - (ii) covers, at the time the policy is issued, only subjects of insurance that are not resident, located, or expressly to be performed in this state; and
 - (B) takes place after the policy is issued;
 - (4) a transaction:
 - (A) that involves an insurance contract independently procured by the insured from an insurance company not authorized to do insurance business in this state through negotiations occurring entirely outside this state;
 - (B) that is reported; and
 - (C) on which premium tax, if applicable, is paid in accordance with Chapter 226;
 - (5) a transaction in this state that:
 - (A) involves group life, health, or accident insurance, other than credit insurance, and group annuities in which the master policy for the group was lawfully issued and delivered in a state in which the insurer or person was authorized to do insurance business; and
 - (B) is authorized by a statute of this state;
 - (6) an activity in this state by or on the sole behalf of a nonadmitted captive insurance company that insures solely:
 - (A) directors' and officers' liability insurance for the directors and officers of the company's parent and affiliated companies;
 - (B) the risks of the company's parent and affiliated companies; or
 - (C) both the individuals and entities described by Paragraphs (A) and (B);
 - (7) the issuance of a qualified charitable gift annuity under Chapter 102; or
 - (8) a lawful transaction by a servicing company of the Texas workers' compensation employers' rejected risk fund under

Section 4.08, Article 5.76-2, as that article existed before its repeal.

(c) Subsection (b)(6) does not exempt an insured or insurer from the payment of an applicable tax on premium or from another applicable provision of this code.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.
Amended by Acts 2001, 77th Leg., ch. 411, Sec. 1, eff. Sept. 1, 2001;
Acts 2001, 77th Leg., ch. 1419, Sec. 24,, eff. June 1, 2003; Acts
2001, 77th Leg., ch. 1420, Sec. 11.008, eff. Sept. 1, 2001; Acts
2003, 78th Leg., ch. 209, Sec. 9, eff. Oct. 1, 2003; Acts 2003, 78th
Leg., ch. 1274, Sec. 13, eff. April 1, 2005.

Amended by:

Acts 2011, 82nd Leg., 1st C.S., Ch. 4 (S.B. 1), Sec. 18.01, eff.
September 28, 2011.

Sec. 101.054. EXCEPTION; FULL-TIME SALARIED EMPLOYEE. Section 101.051(b)(6) does not prohibit a full-time salaried employee of a corporate insured from acting as an insurance manager or buyer in placing insurance on behalf of:

- (1) the employee's employer; or
- (2) a parent or affiliated company of the employer.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 101.055. EXCEPTION; CERTAIN ENTITIES THAT REIMBURSE MEDICAL EXPENSES. (a) Section 101.051(b)(7) does not apply to:

- (1) a program otherwise authorized by law that is established:
 - (A) by a political subdivision of this state;
 - (B) by a state agency; or
 - (C) under Chapter 791, Government Code; or
- (2) a multiple employer welfare arrangement that is fully insured as defined by 29 U.S.C. Section 1144(b)(6).

(b) Notwithstanding Subsection (a)(2), the commissioner may apply a law regulating the business of insurance to a multiple employer welfare arrangement described by that subdivision to the extent that the law provides:

- (1) standards requiring the maintenance of specified levels

of contributions that the plan, or a trust established under the plan, must meet to be considered able to pay benefits in full when due; and

(2) provisions to enforce the standards described by Subdivision (1).

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

SUBCHAPTER C. PROHIBITION; ENFORCEMENT

Sec. 101.101. DEFINITION. In this subchapter, "person" means an individual or entity that is a person for purposes of Section 541.002.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 2B.017, eff. April 1, 2009.

Sec. 101.102. UNAUTHORIZED INSURANCE PROHIBITED. (a) A person, including an insurer, may not directly or indirectly do an act that constitutes the business of insurance under this chapter except as authorized by statute.

(b) With respect to insurance of a subject that is resident, located, or to be performed in this state, this section does not prohibit an act performed outside this state, including the collection of premiums, by a person, including an insurer, authorized to do business in this state if the transaction and insurance contract otherwise comply with statute.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 101.103. POWERS OF COMMISSIONER; REMEDIES FOR CERTAIN CONDUCT. (a) If the commissioner has reason to believe a person, including an insurer, has violated or is threatening to violate this chapter or Chapter 226 or a rule adopted under this chapter or Chapter 226, or that a person, including an insurer, violating this chapter or Chapter 226 has engaged in or is threatening to engage in an unfair act, the commissioner may:

- (1) issue a cease and desist order;
- (2) impose an administrative penalty under Chapter 84;
- (3) direct the person to make restitution;
- (4) request the attorney general to recover a civil penalty, seek restitution, or seek injunctive relief, or any combination of those remedies, under this chapter or another law of this state; or
- (5) take any combination of those actions.

(b) This section does not limit the department to the remedies specified in this section. The department and this state may choose at any time, without regard to prior proceedings under this section, any available remedy or action to immediately stop or enjoin a person from engaging in the business of insurance without statutory authorization.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.
Amended by Acts 2003, 78th Leg., ch. 1274, Sec. 14, eff. April 1, 2005.

Amended by:

Acts 2021, 87th Leg., R.S., Ch. 60 (S.B. 1809), Sec. 8, eff. September 1, 2021.

Sec. 101.104. REQUEST FOR INFORMATION. (a) If the commissioner or department has reason to believe that a person, including an insurer, is performing an act described by Section 101.051 or 101.052, the commissioner or department may send the person or insurer a written request for information relating to that act.

(b) A person receiving an inquiry under Subsection (a) must respond to the inquiry in writing not later than the 15th day after the day the person receives the inquiry. If the department or commissioner receives written notice from the person that additional time is required to respond to the inquiry, the department or commissioner shall grant a 10-day extension of the time to respond to the inquiry.

(c) Failure of a person or insurer to provide the information requested constitutes a violation under this chapter and may be used as evidence to support the issuance of a cease and desist order under Chapter 83. The commissioner may adopt as findings of fact allegations made by the department in a hearing under Chapter 83 if

the department sought information on the allegations from the person or insurer who is the respondent in the proceeding in a request for information and the person or insurer failed, wholly or partly, to respond to the request.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.
Amended by:

Acts 2021, 87th Leg., R.S., Ch. 60 (S.B. 1809), Sec. 9, eff. September 1, 2021.

Sec. 101.105. CIVIL PENALTY; RESTITUTION AND INJUNCTIVE RELIEF.

(a) A person or entity, including an insurer, that violates this chapter or Chapter 226 is subject to a civil penalty of not more than \$25,000 for each act of violation and for each day of violation.

(b) The commissioner may request that the attorney general institute a civil suit in a district court in Travis County for injunctive relief to restrain a person or entity, including an insurer, from continuing a violation or threat of violation described by Section 101.103(a). On application for injunctive relief and a finding that a person or entity, including an insurer, is violating or threatening to violate this chapter or Chapter 226, the district court shall grant the injunctive relief and issue an injunction without bond.

(c) On request by the commissioner, the attorney general shall institute and conduct a civil suit in the name of the state for injunctive relief, to recover a civil penalty, for restitution, or for any combination of those remedies, as authorized under this subchapter or another law of this state.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.
Amended by Acts 2003, 78th Leg., ch. 1274, Sec. 15, eff. April 1, 2005.

Amended by:

Acts 2021, 87th Leg., R.S., Ch. 60 (S.B. 1809), Sec. 10, eff. September 1, 2021.

Acts 2021, 87th Leg., R.S., Ch. 60 (S.B. 1809), Sec. 11, eff. September 1, 2021.

Sec. 101.106. CRIMINAL PENALTY. (a) A person, including an

insurer, who intentionally, knowingly, or recklessly violates Section 101.102 commits an offense.

(b) An offense under this section is a felony of the third degree.

(c) It is a defense to prosecution under this section that Section 101.051 or 101.052, as applicable, by its terms does not apply to the person charged.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Amended by:

Acts 2005, 79th Leg., Ch. 819 (S.B. 781), Sec. 1, eff. June 17, 2005.

SUBCHAPTER D. CONTESTED CASES; PRIOR PROCEEDINGS; RULES

Sec. 101.151. POWERS OF COMMISSIONER; NOTICE OF HEARING. (a) The commissioner may set a hearing on whether to seek administrative relief under this chapter if the commissioner has reason to believe that:

(1) an insurer or person has violated or is threatening to violate this chapter or a rule adopted under this chapter; or

(2) an insurer or person acting in violation of this chapter has engaged in or is threatening to engage in an unfair act.

(b) A proceeding under this chapter is a contested case for purposes of Chapter 2001, Government Code, and applicable rules.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Amended by Acts 2001, 77th Leg., ch. 1419, Sec. 25, eff. June 1, 2003; Acts 2001, 77th Leg., ch. 1420, Sec. 11.009, eff. Sept. 1, 2001.

Amended by:

Acts 2021, 87th Leg., R.S., Ch. 60 (S.B. 1809), Sec. 13, eff. September 1, 2021.

Sec. 101.154. ENFORCEMENT; REFERRAL TO ATTORNEY GENERAL. The commissioner may refer the matter to the attorney general for enforcement if the commissioner has reason to believe that an insurer or person has:

(1) violated an order issued under this chapter; or

(2) failed to pay an assessed penalty or restitution.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.
Amended by Acts 2001, 77th Leg., ch. 1419, Sec. 27, eff. June 1, 2003; Acts 2001, 77th Leg., ch. 1420, Sec. 11.011, eff. Sept. 1, 2001.

Amended by:

Acts 2021, 87th Leg., R.S., Ch. 60 (S.B. 1809), Sec. 14, eff. September 1, 2021.

Sec. 101.155. EFFECT OF PRIOR PROCEEDINGS. The commissioner and department may proceed under this chapter or any other applicable law without regard to prior proceedings.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 101.156. RULES. The commissioner may adopt reasonable rules necessary to implement this chapter.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Amended by:

Acts 2021, 87th Leg., R.S., Ch. 60 (S.B. 1809), Sec. 15, eff. September 1, 2021.

SUBCHAPTER E. INSURANCE CONTRACTS WITH UNAUTHORIZED INSURERS

Sec. 101.201. VALIDITY OF INSURANCE CONTRACTS. (a) An insurance contract, agreement, or arrangement prohibited by Section 101.102, purported to be effective in this state and entered into by an unauthorized insurer or person, is unenforceable by the unauthorized insurer or person. A person who in any manner assisted directly or indirectly in the procurement, processing, administration, claims handling, adjusting, or claims payment of the contract, agreement, or arrangement is liable to the insured for the full amount of a claim or loss under the terms of the contract, agreement, or arrangement if the unauthorized insurer or person fails to pay the claim or loss.

(b) This section does not apply to insurance procured by a licensed surplus lines agent from an eligible surplus lines insurer, as defined by Chapter 981, and independently procured contracts of insurance, as described in Section 101.053(b)(4), that are reported

and on which premium tax is paid in accordance with Chapter 225 or 226 or to another arrangement expressly authorized by law.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.
Amended by Acts 2001, 77th Leg., ch. 1420, Sec. 11.012, eff. Sept. 1, 2001; Acts 2003, 78th Leg., ch. 1274, Sec. 16, eff. April 1, 2005.
Amended by:

Acts 2021, 87th Leg., R.S., Ch. 60 (S.B. 1809), Sec. 16, eff. September 1, 2021.

Sec. 101.202. ATTORNEY'S FEES. (a) In an action against an unauthorized insurer or unauthorized person on a contract, agreement, or arrangement of insurance issued or delivered in this state to a resident of this state or to a corporation authorized to do business in this state, the court may award to the plaintiff a reasonable attorney's fee if:

(1) the insurer or person failed, for at least 30 days after a demand made before the commencement of the action, to make payment under the terms of the contract, agreement, or arrangement; and

(2) the failure to make the payment was vexatious and without reasonable cause.

(b) An unauthorized insurer's or person's failure to defend an action described by Subsection (a) is prima facie evidence that the failure to make payment was vexatious and without reasonable cause.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.
Amended by Acts 2001, 77th Leg., ch. 1419, Sec. 28, eff. June 1, 2003; Acts 2001, 77th Leg., ch. 1420, Sec. 11.013, eff. Sept. 1, 2001.

Amended by:

Acts 2021, 87th Leg., R.S., Ch. 60 (S.B. 1809), Sec. 17, eff. September 1, 2021.

Sec. 101.203. INVESTIGATION AND DISCLOSURE. (a) If the commissioner has reason to believe that insurance has been effectuated by or for a person in this state with an unauthorized person or insurer, the commissioner shall in writing order the person to:

(1) produce for examination all insurance contracts and other documents evidencing insurance with both authorized and unauthorized persons or insurers; and

(2) disclose to the commissioner:

(A) the amount of insurance;

(B) the name and address of each insurer;

(C) the gross amount of premiums paid or to be paid;

and

(D) the name and address of each person assisting in the solicitation, negotiation, or effectuation of the insurance.

(b) A person who fails to comply with a written order under Subsection (a) before the 31st day after the date of the order or who wilfully makes a disclosure that is untrue, deceptive, or misleading shall forfeit:

(1) \$1,000; and

(2) an additional \$1,000 for each day the person continues to fail to comply after expiration of the 30-day period.

(c) This section does not apply to:

(1) a transaction in this state that:

(A) involves a policy that:

(i) is lawfully solicited, negotiated, written, and delivered outside this state; and

(ii) covers, at the time the policy is issued, only subjects of insurance that are not resident, located, or expressly to be performed in this state; and

(B) takes place after the policy is issued; or

(2) surplus lines insurance procured through eligible surplus lines insurers as defined by Section 981.002.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2B.018, eff. April 1, 2009.

Acts 2021, 87th Leg., R.S., Ch. 60 (S.B. 1809), Sec. 18, eff. September 1, 2021.

SUBCHAPTER G. REPORTING OF UNAUTHORIZED INSURANCE

Sec. 101.301. REPORTING REQUIRED. (a) A person investigating or adjusting a loss or claim on a subject of insurance in this state

shall immediately report to the department an insurance policy or contract that has been entered into by an insurer that is not authorized to transact the insurance in this state.

(b) This section does not apply to:

- (1) a transaction described by Section 101.053(b)(4); or
- (2) surplus lines insurance procured through eligible surplus lines insurers as defined by Section 981.002.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2B.019, eff. April 1, 2009.

SUBCHAPTER H. CERTAIN PROCEEDINGS; BOND REQUIREMENTS

Sec. 101.351. DEFINITIONS. (a) In this subchapter, "court proceeding" includes an action or suit.

(b) The definition of "state" assigned by Section 311.005, Government Code, does not apply in this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 29, eff. June 1, 2003.

Sec. 101.352. APPLICABILITY. This subchapter applies only to a court or administrative proceeding against an unauthorized person or insurer in which the person or insurer was served under Section 804.107.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 29, eff. June 1, 2003.

Sec. 101.353. BOND REQUIREMENT FOR COURT PROCEEDING. (a) Except as provided by Subsection (c), before an unauthorized person or insurer may file a pleading in a court proceeding to which this subchapter applies, the person or insurer must deposit cash or securities or file a bond with good and sufficient sureties approved by the court in an amount determined by the court as sufficient to pay any final judgment that may be rendered in the proceeding.

(b) An unauthorized person or insurer must file the deposit required by this section with the clerk of the court in which the proceeding is pending.

(c) The court may issue an order waiving the deposit or bond required by this section if the unauthorized person or insurer demonstrates to the court's satisfaction that the person or insurer maintains sufficient available funds or securities in a state in the United States, in trust or otherwise, to satisfy any final judgment that may be rendered in the proceeding.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 29, eff. June 1, 2003.

Sec. 101.354. BOND REQUIREMENT FOR ADMINISTRATIVE PROCEEDING.

(a) Except as provided by Subsection (c), before an unauthorized person or insurer may file a pleading in an administrative proceeding of the department to which this subchapter applies, the person or insurer must, if required by statute, deposit cash or securities or file a bond with good and sufficient sureties approved by the commissioner in an amount determined by the commissioner as sufficient to pay any final order that may be entered in the proceeding.

(b) An unauthorized person or insurer must file the deposit required by this section with the chief clerk of the department.

(c) The commissioner may issue an order waiving the deposit or bond required by this section if the unauthorized person or insurer demonstrates to the commissioner's satisfaction that the person or insurer maintains sufficient available funds or securities in a state in the United States, in trust or otherwise, to satisfy any final order that may be entered in the proceeding.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 29, eff. June 1, 2003.

Sec. 101.355. POSTPONEMENT. A court or the commissioner may order any postponement necessary to afford an unauthorized person or insurer a reasonable opportunity to:

- (1) comply with Section 101.353 or 101.354, as appropriate;
- and
- (2) defend that court or administrative proceeding.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 29, eff. June 1, 2003.

Sec. 101.356. MOTION TO QUASH. Sections 101.353 and 101.354 do not prevent an unauthorized person or insurer from filing a motion to quash a writ or to set aside service made under Section 804.107 on the ground that the person or insurer has not engaged in the business of insurance as described by Section 101.051.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 29, eff. June 1, 2003.

CHAPTER 102. CHARITABLE GIFT ANNUITIES

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 102.001. DEFINITIONS. In this chapter:

(1) "Charitable gift annuity" means an annuity:

(A) that is payable over the lives of one or two individuals;

(B) that is made in return for the transfer of cash or other property to a charitable organization; and

(C) the actuarial value of which is less than the value of the cash or other property transferred, with the difference in those values being a charitable deduction for federal tax purposes.

(2) "Charitable organization" means an entity described by:

(A) Section 501(c)(3), Internal Revenue Code of 1986; or

(B) Section 170(c), Internal Revenue Code of 1986.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 102.002. QUALIFIED CHARITABLE GIFT ANNUITY. A charitable gift annuity is a qualified charitable gift annuity for purposes of this chapter if it was issued before September 1, 1995, or if it is:

(1) described by Section 501(m)(5), Internal Revenue Code of 1986; and

(2) issued by a charitable organization that on the date of the annuity agreement:

(A) has, exclusive of the assets funding the annuity agreement, a minimum of \$100,000 in unrestricted cash, cash equivalents, or publicly traded securities; and

(B) has been in continuous operation for at least three years or is a successor or affiliate of a charitable organization that has been in continuous operation for at least three years.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

SUBCHAPTER B. ISSUANCE OF CHARITABLE GIFT ANNUITY

Sec. 102.051. NOT INSURANCE; EFFECT OF CERTAIN LAWS. The issuance of a qualified charitable gift annuity:

- (1) does not constitute engaging in the business of insurance in this state;
- (2) does not violate Section 15.05 or 17.46, Business & Commerce Code; and
- (3) is not an unconscionable action or course of action for purposes of Section 17.50(a)(3), Business & Commerce Code.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

SUBCHAPTER C. NOTICE

Sec. 102.101. NOTICE TO DONOR. (a) A charitable organization that issues a qualified charitable gift annuity shall give to the donor, at the time an agreement for a qualified charitable gift annuity is entered into, written notice that the annuity is not:

- (1) insurance under the laws of this state;
- (2) subject to regulation by the department; and
- (3) protected by a guaranty association affiliated with the department.

(b) The notice must be in a separate paragraph of the annuity agreement in a print size at least as large as the print size generally used in the agreement.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 102.102. NOTICE TO DEPARTMENT. (a) A charitable organization that issues qualified charitable gift annuities shall notify the department's annuities division in writing not later than the date on which the organization enters into the organization's first qualified charitable gift annuity agreement.

- (b) The notice required by this section must:
 - (1) be signed by an officer or director of the organization;
 - (2) identify the organization; and

(3) certify that:

(A) the organization is a charitable organization; and

(B) the annuities issued by the organization are qualified charitable gift annuities.

(c) The charitable organization may not be required to submit additional information except to determine appropriate penalties under Section 102.104.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 102.103. EFFECT ON ANNUITY OF FAILURE TO PROVIDE NOTICE.

A charitable gift annuity that otherwise meets the requirements of Section 102.002 is a qualified charitable gift annuity without regard to whether the charitable organization that issues the annuity complies with the notice requirements of this subchapter.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 102.104. ENFORCEMENT OF NOTICE REQUIREMENTS. (a) The commissioner may enforce the notice requirements of this subchapter by sending by certified mail, return receipt requested, a letter demanding that the charitable organization comply with the notice requirements.

(b) The department may fine the charitable organization in an amount not to exceed \$1,000 for each qualified charitable gift annuity agreement issued by the organization until the time the organization complies with this subchapter.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

SUBCHAPTER D. EFFECT OF CHARITABLE GIFT ANNUITY IN LITIGATION AND CERTAIN OTHER PROCEEDINGS

Sec. 102.151. IMMUNITY. Any person or entity involved in the issuance of a qualified charitable gift annuity shall have immunity from suit, including both a defense to liability and the right not to bear the cost, burden, and risk of discovery and trial, as to any claim brought by or on behalf of the donor or the donor's heirs or distributees alleging that the issuance of a charitable gift annuity

constitutes engaging in the business of insurance in this state. An interlocutory appeal may be taken if a court denies or otherwise fails to grant a motion for summary judgment that is based on an assertion of the immunity provided in this section.

Added by Acts 2001, 77th Leg., ch. 1420, Sec. 11.015(a), eff. Sept. 1, 2001.

Sec. 102.152. TREATMENT OF ANNUITY AS CHARITABLE GIFT ANNUITY; ESTOPPEL. In any litigation or other proceeding brought by or on behalf of a donor or the donor's heirs or distributees, an annuity that the donor has treated as a charitable gift annuity in a filing with the United States Internal Revenue Service shall be considered to be a charitable gift annuity issued by a charitable organization, as described by Subchapters A and B and Section 101.053(b).

Added by Acts 2001, 77th Leg., ch. 1420, Sec. 11.015(a), eff. Sept. 1, 2001.

SUBTITLE C. PROGRAMS AFFECTING MULTIPLE LINES OF INSURANCE

CHAPTER 151. CONSOLIDATED INSURANCE PROGRAMS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 151.001. DEFINITIONS. In this chapter:

(1) "Consolidated insurance program" means a program under which a principal provides general liability insurance coverage, workers' compensation insurance coverage, or both that are incorporated into an insurance program for a single construction project or multiple construction projects.

(2) "Construction project" means construction, remodeling, maintenance, or repair of improvements to real property. The term includes the immediate construction location and areas incidental and necessary to the work as defined in the construction contract documents. A construction project under this chapter does not include a single family house, townhouse, duplex, or land development directly related thereto.

(3) "Contractor" means any person who has entered into a construction contract or a professional services contract and is enrolled in the consolidated insurance program.

(4) "Claim" includes a loss or liability for a claim,

damage, expense, or governmentally imposed fine, penalty, administrative action, or other action.

(5) "Construction contract" means a contract, subcontract, or agreement, or a performance bond assuring the performance of any of the foregoing, entered into or made by an owner, architect, engineer, contractor, construction manager, subcontractor, supplier, or material or equipment lessor for the design, construction, alteration, renovation, remodeling, repair, or maintenance of, or for the furnishing of material or equipment for, a building, structure, appurtenance, or other improvement to or on public or private real property, including moving, demolition, and excavation connected with the real property. The term includes an agreement to which an architect, engineer, or contractor and an owner's lender are parties regarding an assignment of the construction contract or other modifications thereto.

(6) "Indemnitor" means a party to a construction contract that is required to provide indemnification or additional insured status to another party to the construction contract or to a third party.

(7) "Insurer" has the meaning assigned by Section 560.001.

(8) "Principal" means the person who procures the insurance policy under a consolidated insurance program.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1292 (H.B. 2093), Sec. 1, eff. January 1, 2012.

Sec. 151.002. RULES. The commissioner shall adopt rules as necessary to implement and enforce this subchapter and Subchapter B.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1292 (H.B. 2093), Sec. 1, eff. January 1, 2012.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 427 (S.B. 1081), Sec. 1, eff. January 1, 2016.

Sec. 151.003. INFORMATION REQUIRED TO BE PROVIDED BY PRINCIPAL BEFORE ENTERING CONSTRUCTION CONTRACT. If a construction contract requires a person to enroll in a consolidated insurance program, not later than the 10th day before the date a principal enters into the

contract with the person, the principal shall provide the following information about the consolidated insurance program to the person:

- (1) contact information, including phone number and e-mail address, for:
 - (A) the program administrator;
 - (B) the principal's risk manager; and
 - (C) the insurer's contact person for filing a claim for each type of insurance coverage provided in the program;
- (2) the criteria for eligibility of enrollment into the program;
- (3) a description of the project site covered by the program coverages;
- (4) a summary of insurance coverages to be provided to the contractor under the program, including:
 - (A) the policy form number and issuing organization if the policy is a standardized insurance policy or, if the policy is not standardized, a sample policy form;
 - (B) per occurrence and aggregate limits of insurance coverages and any sublimits that may apply;
 - (C) term of coverages for each limit and sublimit, if any; and
 - (D) any material endorsements to the policy described under Paragraph (A);
- (5) a summary of insurance coverages to be provided by the contractor;
- (6) instructions on how to include or exclude costs of insurance provided by the program in the person's proposal for work on the construction project;
- (7) a description of the audit or claims procedures related to the program that may result in additional cost to a contractor, including the method of calculation for any assessment charged to a contractor related to the principal's payment of a policy deductible and any other specific cost amounts; and
- (8) a description of a contractor's duties related to reporting:
 - (A) payroll and retention of documentation; and
 - (B) claims and participation in safety inspections and incident reporting.

Added by Acts 2015, 84th Leg., R.S., Ch. 427 (S.B. [1081](#)), Sec. 2, eff.

January 1, 2016.

Sec. 151.004. INFORMATION REQUIRED TO BE PROVIDED BY CONTRACTOR BEFORE ENTERING CONSTRUCTION CONTRACT. If a construction contract requires a person to enroll in a consolidated insurance program, not later than the 10th day before the date a contractor enters into the contract with the person, the contractor must provide to the person, in an accurate form, the information listed in Section 151.003 that the contractor received under that section.

Added by Acts 2015, 84th Leg., R.S., Ch. 427 (S.B. 1081), Sec. 2, eff. January 1, 2016.

Sec. 151.005. RELIANCE ON INFORMATION PROVIDED. The information required under Section 151.003 must be accurate, and a person who receives the information under Section 151.003 or 151.004 may justifiably rely on the information to decide whether to enter into the construction contract.

Added by Acts 2015, 84th Leg., R.S., Ch. 427 (S.B. 1081), Sec. 2, eff. January 1, 2016.

Sec. 151.006. FAILURE TO FURNISH. (a) A person may not be required to enter into a construction contract that requires enrollment in a consolidated insurance program unless the person is provided the information in compliance with Section 151.003 or 151.004, as applicable. If the information required under Section 151.003 is not provided to a person within the 10-day period under Section 151.003 or 151.004, as applicable, the person may elect not to enroll in the consolidated insurance program.

(b) If a person elects not to enroll in the consolidated insurance program under Subsection (a), a principal or contractor may provide the person with the information required under Section 151.003 after the 10-day period under Section 151.003 or 151.004, as applicable. The person must elect whether to enroll in the consolidated insurance program not later than the 10th day after the date that the information is provided under this subsection.

(c) If a person elects not to enroll in the consolidated

insurance program under Subsection (a) or (b) and enters into a construction contract for the construction project, the person must obtain insurance coverage for the person's work on the project that substantially complies with the coverage terms and liability limits imposed for other persons who work on the construction project but who are not insured under the consolidated insurance program.

(d) The principal or contractor, as applicable, shall compensate a person with whom the principal or contractor contracts and who obtains insurance coverage under Subsection (c) for the actual cost of that insurance coverage.

Added by Acts 2015, 84th Leg., R.S., Ch. 427 (S.B. 1081), Sec. 2, eff. January 1, 2016.

Sec. 151.007. REQUEST FOR INSURANCE POLICY; DEADLINE TO PROVIDE. (a) A contractor may request in writing from the principal, or from the party with which the contractor has a direct contractual relationship, a complete copy of the insurance policy that provides coverage for the contractor under the consolidated insurance program.

(b) The copy described by Subsection (a) must be provided to the requesting contractor not later than the later of:

- (1) the 30th day after the date the request was sent; or
- (2) the 60th day after the date the contractor's work covered by the consolidated insurance program begins on the construction project.

Added by Acts 2015, 84th Leg., R.S., Ch. 427 (S.B. 1081), Sec. 2, eff. January 1, 2016.

Sec. 151.008. FAILURE TO PROVIDE INSURANCE POLICY. It is a material breach of a contractor's construction contract if a complete copy of the insurance policy requested by the contractor under Section 151.007 is not provided before the later of:

- (1) the 75th day after the date the request was sent; or
- (2) the 90th day after the date the contractor's work covered by the consolidated insurance program begins on the construction project.

Added by Acts 2015, 84th Leg., R.S., Ch. 427 (S.B. 1081), Sec. 2, eff. January 1, 2016.

Sec. 151.009. ELECTRONIC DELIVERY. (a) On a person's express request, a principal or contractor shall provide information under this subchapter in hard copy written form.

(b) If a person does not expressly request information be provided in hard copy written form, the principal or contractor may comply with the requirements of this chapter by:

- (1) transmitting the information by facsimile or e-mail; or
- (2) allowing access to the information on the principal's, or the principal's agent's, Internet website.

Added by Acts 2015, 84th Leg., R.S., Ch. 427 (S.B. 1081), Sec. 2, eff. January 1, 2016.

SUBCHAPTER B. GENERAL REQUIREMENTS

Sec. 151.051. DURATION OF GENERAL LIABILITY COVERAGE. A consolidated insurance program that provides general liability insurance coverage must provide completed operations insurance coverage for a policy period of not less than three years.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1292 (H.B. 2093), Sec. 1, eff. January 1, 2012.

SUBCHAPTER C. REQUIREMENTS RELATED TO INDEMNIFICATION

Sec. 151.101. APPLICABILITY. (a) This subchapter applies to a construction contract for a construction project for which an indemnitor is provided or procures insurance subject to:

- (1) this chapter; or
- (2) Title 10.

(b) Subsection (a) applies regardless of whether the insurance is provided or procured before or after execution of the contract.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1292 (H.B. 2093), Sec. 1, eff. January 1, 2012.

Sec. 151.102. AGREEMENT VOID AND UNENFORCEABLE. Except as provided by Section 151.103, a provision in a construction contract, or in an agreement collateral to or affecting a construction contract, is void and unenforceable as against public policy to the extent that it requires an indemnitor to indemnify, hold harmless, or defend a party, including a third party, against a claim caused by the negligence or fault, the breach or violation of a statute, ordinance, governmental regulation, standard, or rule, or the breach of contract of the indemnitee, its agent or employee, or any third party under the control or supervision of the indemnitee, other than the indemnitor or its agent, employee, or subcontractor of any tier.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1292 (H.B. 2093), Sec. 1, eff. January 1, 2012.

Sec. 151.103. EXCEPTION FOR EMPLOYEE CLAIM. Section 151.102 does not apply to a provision in a construction contract that requires a person to indemnify, hold harmless, or defend another party to the construction contract or a third party against a claim for the bodily injury or death of an employee of the indemnitor, its agent, or its subcontractor of any tier.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1292 (H.B. 2093), Sec. 1, eff. January 1, 2012.

Sec. 151.104. UNENFORCEABLE ADDITIONAL INSURANCE PROVISION.

(a) Except as provided by Subsection (b), a provision in a construction contract that requires the purchase of additional insured coverage, or any coverage endorsement, or provision within an insurance policy providing additional insured coverage, is void and unenforceable to the extent that it requires or provides coverage the scope of which is prohibited under this subchapter for an agreement to indemnify, hold harmless, or defend.

(b) This section does not apply to a provision in an insurance policy, or an endorsement to an insurance policy, issued under a consolidated insurance program to the extent that the provision or endorsement lists, adds, or deletes named insureds to the policy.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1292 (H.B. 2093), Sec. 1,

eff. January 1, 2012.

Sec. 151.105. EXCLUSIONS. This subchapter does not affect:

(1) an insurance policy, including a policy issued under an owner-controlled or owner-sponsored consolidated insurance program or a contractor-controlled or contractor-sponsored consolidated insurance program, except as provided by Section 151.104;

(2) a cause of action for breach of contract or warranty that exists independently of an indemnity obligation, including an indemnity obligation in a construction contract under a construction project for which insurance is provided under a consolidated insurance program;

(3) indemnity provisions contained in loan and financing documents, other than construction contracts to which the contractor and owner's lender are parties as provided under Section 151.001(5);

(4) general agreements of indemnity required by sureties as a condition of execution of bonds for construction contracts;

(5) the benefits and protections under the workers' compensation laws of this state;

(6) the benefits or protections under the governmental immunity laws of this state;

(7) agreements subject to Chapter 127, Civil Practice and Remedies Code;

(8) a license agreement between a railroad company and a person that permits the person to enter the railroad company's property as an accommodation to the person for work under a construction contract that does not primarily benefit the railroad company;

(9) an indemnity provision pertaining to a claim based upon copyright infringement;

(10) an indemnity provision in a construction contract, or in an agreement collateral to or affecting a construction contract, pertaining to:

(A) a single family house, townhouse, duplex, or land development directly related thereto; or

(B) a public works project of a municipality; or

(11) a joint defense agreement entered into after a claim is made.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1292 (H.B. 2093), Sec. 1, eff. January 1, 2012.

SUBCHAPTER D. NONWAIVER

Sec. 151.151. NONWAIVER. A provision of this chapter may not be waived by contract or otherwise.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1292 (H.B. 2093), Sec. 1, eff. January 1, 2012.

TITLE 3. DEPARTMENT FUNDS, FEES, AND TAXES

SUBTITLE A. GENERAL PROVISIONS

CHAPTER 201. COLLECTION OF REVENUE AND ADMINISTRATION OF FUNDS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 201.001. TEXAS DEPARTMENT OF INSURANCE OPERATING ACCOUNT.

(a) The Texas Department of Insurance operating account is an account in the general revenue fund. The account includes the following:

(1) taxes and fees received by the commissioner or comptroller that are required by this code to be deposited to the credit of the account; and

(2) money or credits received by the department or commissioner from sales, reimbursements, and fees authorized by law other than this code, including money or credits received from:

(A) charges for providing copies of public information under Chapter 552, Government Code;

(B) the disposition of surplus or salvage property under Subchapters C and D, Chapter 2175, Government Code;

(C) the sale of publications and other printed material under Section 2052.301, Government Code;

(D) miscellaneous transactions and sources under Section 403.011 or 403.012, Government Code;

(E) charges for postage spent to serve legal process under Section 17.025, Civil Practice and Remedies Code;

(F) the comptroller involving warrants for which payment is barred under Chapter 404, Government Code;

(G) sales or reimbursements authorized by the General Appropriations Act; and

(H) the sale of property purchased with money from the account or a predecessor fund or account.

(b) The commissioner shall administer money in the account and may spend money from the account in accordance with state law, rules adopted by the commissioner, and the General Appropriations Act.

(c) Money deposited to the credit of the account may be used for any purpose for which money in the account is authorized to be used by law.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 201.002. ACCOUNTING PROCEDURE. The commissioner shall maintain a procedure to account for the receipt, disbursement, and allocation of money deposited in the Texas Department of Insurance operating account, including recordkeeping procedures adequate for:

(1) the commissioner or comptroller, as applicable, to adjust the tax assessments and fee schedules as authorized by this code; and

(2) the state auditor to determine the source of all receipts and expenditures.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 201.003. REFUNDS. If the department determines that a person, firm, or corporation through mistake of law or fact erroneously paid or overpaid a fee or other amount of money, including any interest or penalty, administered or collected by the department, the department may refund the erroneous payment or overpayment by warrant on the state treasury from any funds appropriated for that purpose.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 201.004. ELECTRONIC TRANSFERS. (a) The commissioner shall adopt rules for the electronic transfer of any fee, guarantee fund, or other money owed to or held for the benefit of this state that the department has the responsibility to administer under this code or another insurance law of this state.

(b) The commissioner shall require the electronic transfer of any amount held or owed that exceeds \$500,000.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 201.005. TRANSFER OF SECURITIES. (a) A transfer by the department of any security that is held in any way by the department is not valid unless the transfer is countersigned by the comptroller.

(b) The comptroller shall:

(1) countersign any security transfer presented by the department;

(2) keep a record of all transfers that includes:

(A) the name of the transferee, unless the security is transferred in blank; and

(B) a description of the security;

(3) when countersigning a security transfer, advise the company concerned by mail of the details of the transaction; and

(4) state, in the comptroller's annual report to the legislature, the countersigned transfers and the amount of the transfers.

(c) To verify the correctness of records:

(1) the department is entitled to free access to the comptroller's records kept under Subsection (b); and

(2) the comptroller is entitled to free access to the books and other department documents relating to securities held by the department.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

SUBCHAPTER B. ADMINISTRATION

Sec. 201.051. POWERS AND DUTIES OF COMPTROLLER. (a) Except as otherwise provided by this code or another insurance law of this state, the comptroller shall administer and enforce the provisions of this code and other insurance laws of this state that relate to the administration, collection, and reporting of taxes and certain fees and assessments imposed under this code or another insurance law of this state, as specifically provided by this code.

(b) The comptroller may:

(1) adopt rules to implement the administration,

collection, reporting, and enforcement responsibilities assigned to the comptroller under this code or another insurance law of this state; and

(2) prescribe appropriate report forms, establish or alter tax report due dates not otherwise specifically prescribed by this code or another insurance law of this state, and otherwise adapt the functions transferred to the comptroller under Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993, to increase efficiency and cost-effectiveness.

(c) A rule adopted by the comptroller that relates to the administration, collection, reporting, or enforcement of taxes imposed under this code prevails over a conflicting rule, policy, or procedure established by the department, the commissioner, or otherwise.

(d) Subtitles A and B, Title 2, Tax Code, apply to the administration, collection, and enforcement by the comptroller of taxes and certain fees and assessments under this code or another insurance law of this state. Except as otherwise provided by this code, the powers granted to the comptroller under those provisions of the Tax Code do not limit and are exclusive of the powers granted to the department or the commissioner in relation to other fees and assessments under this code.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 201.052. REIMBURSEMENT. (a) The department shall reimburse the appropriate portion of the general revenue fund for the amount of expenses incurred by the comptroller in administering taxes imposed under this code or another insurance law of this state.

(b) The comptroller shall certify to the commissioner the total amount of expenses estimated to be required to perform the comptroller's duties under this code or another insurance law of this state for each fiscal biennium. The comptroller shall provide copies of the certification to the budget division of the governor's office and to the Legislative Budget Board.

(c) The amount certified by the comptroller shall be transferred from the Texas Department of Insurance operating account to the appropriate portion of the general revenue fund. It is the legislature's intent that money in the Texas Department of Insurance

operating account to be transferred under this subsection should reflect the revenues from maintenance taxes paid by insurers under this code or another insurance law of this state.

(d) In setting maintenance taxes for each fiscal year, the commissioner shall ensure that the amount of taxes imposed is sufficient to fully reimburse the appropriate portion of the general revenue fund for the amount of expenses incurred by the comptroller in administering taxes imposed under this code or another insurance law of this state.

(e) If the amount of maintenance taxes collected is not sufficient to reimburse the appropriate portion of the general revenue fund for the amount of expenses incurred by the comptroller, other money in the Texas Department of Insurance operating account shall be used to reimburse the appropriate portion of the general revenue fund.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 201.053. COOPERATION BETWEEN DEPARTMENT AND COMPTROLLER. The commissioner and the comptroller shall cooperate fully in performing their respective duties under this code or another insurance law of this state.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 201.054. INFORMATION SHARING; FEDERAL IDENTIFICATION NUMBERS. (a) The department shall comply with each reasonable request from the comptroller relating to the sharing of information gathered or compiled in connection with functions the comptroller performs under this code or another insurance law of this state.

(b) The department shall maintain a record of the federal identification number of each entity subject to regulation under this code or another insurance law of this state and shall include the appropriate number in any communication to or information shared with the comptroller relating to that entity.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 201.055. FILING DATE OF REPORT OR PAYMENT DELIVERED BY POSTAL SERVICE. Except as otherwise specifically provided, for a report, including a tax report, or payment that is required to be filed or made in the offices of the comptroller and that is delivered by the United States Postal Service to the offices of the comptroller after the date on which the report or payment is required to be filed or made, the date of filing or payment is the date of:

- (1) the postal service postmark stamped on the cover in which the report or payment is mailed; or
- (2) any other evidence of mailing authorized by the postal service reflected on the cover in which the report or payment is mailed.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

CHAPTER 202. FEES

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 202.001. APPLICABILITY OF CHAPTER. Except as provided by Section 202.052, the insurers that are subject to a fee imposed under this chapter include:

- (1) stock insurance companies;
- (2) mutual insurance companies;
- (3) local mutual aid associations;
- (4) statewide mutual assessment companies;
- (5) group hospital service corporations; and
- (6) stipulated premium companies.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 202.002. DETERMINATION OF FEES. The department shall, subject to the limits established by this chapter, set the amount of the fees imposed under this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 202.003. FEES FOR COPIES. (a) The department shall set and collect a fee for copying any paper of record with the department. The fee shall be set in an amount sufficient to

reimburse the state for the actual expense.

(b) The department may make and distribute copies of a paper containing rating information without charge or for a fee that the commissioner considers appropriate for administering the premium rating laws by properly distributing rating information.

(c) This section does not affect Article 5.29.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 202.004. REDUCED FEES FOR CERTAIN INSURERS. An insurer to which this chapter applies that had gross premium receipts of less than \$450,000, according to the insurer's annual statement for the preceding year ending December 31, is required to pay only one-half the amount of a fee otherwise required to be paid under this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

SUBCHAPTER B. SPECIFIC MAXIMUM FEES

Sec. 202.051. GENERAL FEES IMPOSED ON INSURERS. The department shall impose and receive fees for the use of the state from each authorized insurer writing insurance in this state. The amount of the fees may not exceed:

- (1) for filing an amendment to a certificate of authority if the charter is not amended \$100;
- (2) for affixing the official seal and certifying to the seal \$20;
- (3) for reservation of name \$200;
- (4) for renewal of reservation of name \$50;
- (5) for filing an application for admission of a foreign or alien insurer \$4,000;
- (6) for filing an original charter of an insurer, including issuance of a certificate of authority \$3,000;
- (7) for filing an amendment to a charter if a hearing is held \$500;
- (8) for filing an amendment to a charter if a hearing is not held \$250;
- (9) for filing a designation of an attorney for service of process or an amendment of a designation \$50;
- (10) for filing a copy of a total reinsurance agreement

\$1,500;

(11) for filing a copy of a partial reinsurance agreement

\$300;

(12) for accepting a security deposit \$200;

(13) for substitution or amendment of a security deposit

\$100;

(14) for certification of a statutory deposit \$20;

(15) for filing a notice of intent to locate books and records outside this state under Chapter 803 \$300;

(16) for filing a statement under Subchapters D and E, Chapter 823, for the first \$9.9 million of the consideration \$1,000;

(17) for filing a statement under Subchapters D and E, Chapter 823, if the amount of the consideration exceeds \$9.9 million . . . an additional \$500 for each additional \$10 million of the consideration that exceeds \$9.9 million, but not more than a total amount of \$10,000 under this subdivision and Subdivision (16);

(18) for filing a registration statement under Subchapter B, Chapter 823 \$300;

(19) for filing for review under Subchapter C, Chapter 823, or Subchapter L, Chapter 884 \$500;

(20) for filing a direct reinsurance agreement under Subchapter K, Chapter 884 \$300;

(21) for filing for approval of a merger under Chapter 824 \$1,500;

(22) for filing for approval of reinsurance under Chapter 828 \$1,500;

(23) for filing restated articles of incorporation for a domestic, foreign, or alien insurer \$500;

(24) for filing a joint control agreement \$100;

(25) for filing a substitution or amendment to a joint control agreement \$40; and

(26) for filing a change of attorney in fact \$500.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 202.052. FEES IMPOSED ON CERTAIN INSURERS. (a) The department shall impose and the comptroller shall collect a fee for the use of the state from each authorized insurer writing a class of

insurance that may be written by an insurer operating under Chapter 841 for filing of the insurer's annual statement. The amount of the fee may not exceed \$500.

(b) Subtitles A and B, Title 2, Tax Code, apply to a fee collected under this section.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 1039 (H.B. 1849), Sec. 1, eff. September 1, 2007.

SUBCHAPTER C. DEPOSIT AND USE OF FEES

Sec. 202.101. DEPOSIT AND USE OF FEES GENERALLY. Amounts collected under Section 202.051:

(1) shall be deposited to the credit of the Texas Department of Insurance operating account; and

(2) may be appropriated only for the use and benefit of the department as provided by the General Appropriations Act to pay salaries and other expenses arising from and in connection with investigations of violations of the insurance laws of this state and the examination or licensing of insurers.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 202.102. DEPOSIT AND USE OF CERTAIN OTHER FEES. Amounts collected by the comptroller under Section 202.052:

(1) shall be deposited to the credit of the general revenue fund; and

(2) are available for appropriation to the department as provided by the General Appropriations Act to pay salaries and other expenses arising from investigations of violations of the insurance laws of this state and the examination or licensing of insurers.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

CHAPTER 203. GENERAL PROVISIONS RELATING TO TAXES

Sec. 203.001. LIMITATION ON CERTAIN ADDITIONAL TAXES. (a)
This section applies to:

(1) an insurer authorized to engage in the business of insurance in this state other than an eligible surplus lines insurer; and

(2) a health maintenance organization authorized to engage in the business of a health maintenance organization in this state.

(b) Except as otherwise provided by this code or the Labor Code, an insurer or health maintenance organization subject to a tax imposed by Chapter 4, 221, 222, 223A, 224, or 257 may not be required to pay any additional tax imposed by this state or a county or municipality in proportion to the insurer's or health maintenance organization's gross premium receipts.

(c) Subsection (b) does not:

(1) limit the applicability of other taxes, fees, and assessments imposed by this code; or

(2) prohibit the imposition and collection of state, county, and municipal taxes on the property of insurers or health maintenance organizations or state, county, and municipal taxes imposed by other laws of this state, unless a specific exemption for insurers or health maintenance organizations is provided in those laws.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 569 (S.B. 734), Sec. 3, eff. June 14, 2013.

Sec. 203.002. TAX PAYMENT REQUIRED FOR CERTAIN CERTIFICATES; UNREPORTED GROSS PREMIUM RECEIPTS. (a) A Life Insurance Company May not receive a certificate of authority to engage in the business of insurance in this state until all taxes imposed under this code or another insurance law of this state are paid.

(b) If the commissioner determines by examining a company or by other means that the company's gross premium receipts in a year exceed the amount reported by the company for that year, the commissioner shall report that determination to the comptroller. The comptroller shall institute a collection action as the comptroller considers appropriate to collect taxes due on unreported gross premium receipts.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

SUBTITLE B. INSURANCE PREMIUM TAXES**CHAPTER 221. PROPERTY AND CASUALTY INSURANCE PREMIUM TAX**

Sec. 221.001. APPLICABILITY OF CHAPTER. (a) This chapter applies to an insurer, organization, or concern that receives gross premiums subject to taxation under Section 221.002, including a reciprocal or interinsurance exchange that elects to be subject to taxation under this chapter in accordance with Section 224.003 and a Lloyd's plan.

(b) This chapter does not apply to:

- (1) a fraternal benefit society, including a fraternal benefit society operating under Chapter 885;
- (2) a group hospital service corporation operating under Chapter 842;
- (3) a stipulated premium company operating under Chapter 884;
- (4) a mutual assessment association, company, or corporation regulated under Chapter 887;
- (5) a purely cooperative or mutual fire insurance company carried on by its members solely for the protection of their own property and not for profit, except as provided by Section 221.002(b)(13); or
- (6) a farm mutual insurance company operating under Chapter 911, unless the company is acting as a fronting insurer.

(c) In this section, "fronting insurer" means a farm mutual insurance company:

- (1) issuing an insurance policy that is the result of:
 - (A) marketing by an insurer not affiliated with the farm mutual insurance company;
 - (B) an application submitted by a consumer to an insurer not affiliated with the farm mutual insurance company; or
 - (C) an agreement with an insurer that is not a farm mutual insurance company solely for the purpose of being regulated under Chapter 911; or
- (2) that cedes 85 percent or more of the farm mutual insurance company's direct written premium to one or more nonaffiliated reinsurers.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 1083 (H.B. 3496), Sec. 1, eff. September 1, 2017.

Sec. 221.002. TAX IMPOSED; RATE. (a) An annual tax is imposed on each insurer that receives gross premiums subject to taxation under this section. The rate of the tax is 1.6 percent of the insurer's taxable premium receipts for a calendar year.

(b) Except as provided by Subsection (c), in determining an insurer's taxable premium receipts, the insurer shall include the total gross amounts of premiums, membership fees, assessments, dues, revenues, and any other considerations for insurance written by the insurer in a calendar year from any kind of insurance written by the insurer on each kind of property or risk located in this state, including:

- (1) fire insurance;
- (2) ocean marine insurance;
- (3) inland marine insurance;
- (4) accident insurance;
- (5) credit insurance;
- (6) livestock insurance;
- (7) fidelity insurance;
- (8) guaranty insurance;
- (9) surety insurance;
- (10) casualty insurance;
- (11) workers' compensation insurance;
- (12) employers' liability insurance;
- (13) crop insurance written by a farm mutual insurance company;
- (14) home warranty insurance; and
- (15) travel insurance.

(c) The following premium receipts are not included in determining an insurer's taxable premium receipts:

- (1) premium receipts received from the business of title insurance;
- (2) premium receipts received from the business of life insurance, personal accident insurance, life and accident insurance, or health and accident insurance for profit, written by a life insurance company, life and accident insurance company, health and

accident insurance company, or for mutual benefit or protection in this state;

- (3) premium receipts received from another authorized insurer for reinsurance;
- (4) returned premiums and dividends paid to policyholders;
- (5) premiums excluded by another law of this state; and
- (6) premiums or service fees retained by a bail bond surety licensed under Chapter 1704, Occupations Code, or by a property and casualty agent in connection with the execution or delivery of a bail bond as defined by Section 1704.001, Occupations Code.

(d) In determining an insurer's taxable premium receipts, an insurer is not entitled to a deduction for premiums paid for reinsurance.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 932 (H.B. 3315), Sec. 1, eff. June 15, 2007.

Acts 2013, 83rd Leg., R.S., Ch. 896 (H.B. 1047), Sec. 1, eff. September 1, 2013.

Acts 2019, 86th Leg., R.S., Ch. 1000 (H.B. 2587), Sec. 6, eff. September 1, 2019.

Sec. 221.003. TAX DUE DATES. (a) The total tax imposed by this chapter is due and payable not later than March 1 after the end of the calendar year for which the tax is due.

(b) An insurer that had a net tax liability for the previous calendar year of more than \$1,000 shall make semiannual prepayments of tax on March 1 and August 1. The tax paid on each date must be equal to 50 percent of the total amount of tax the insurer paid under this chapter for the previous calendar year. If the insurer did not pay a tax under this chapter during the previous calendar year, the tax paid on each date must be equal to the tax that would be owed on the aggregate of the gross premiums for the two previous calendar quarters.

(c) The comptroller may refund any overpayment of taxes that results from the semiannual prepayment system prescribed by this section.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 221.004. TAX REPORT. (a) An insurer liable for the tax imposed by this chapter must file annually with the comptroller a tax report on a form prescribed by the comptroller.

(b) The tax report is due on the date the tax is due under Section 221.003(a).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 221.005. CHANGE IN DUE DATES. (a) The comptroller by rule may change the dates for reporting and paying taxes under this chapter to improve operating efficiencies within the agency.

(b) A change by the comptroller in a reporting or payment date must retain the system of semiannual prepayments prescribed by Section 221.003.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 221.006. CREDIT FOR FEES PAID. (a) An insurer is entitled to a credit on the amount of tax due under this chapter for all examination and evaluation fees paid to this state during the calendar year for which the tax is due. The limitations provided by Sections 803.007(1) and (2)(B) for a domestic insurance company apply to a foreign insurance company.

(b) The credit provided by this section is in addition to any other credit authorized by statute.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.
Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.001(a), eff. September 1, 2005.

Acts 2011, 82nd Leg., 1st C.S., Ch. 4 (S.B. 1), Sec. 2.01, eff. September 28, 2011.

Sec. 221.007. FAILURE TO PAY TAXES. An insurer that fails to pay all taxes imposed by this chapter is subject to Section 203.002.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

CHAPTER 222. LIFE, HEALTH, AND ACCIDENT INSURANCE PREMIUM TAX

Sec. 222.001. APPLICABILITY OF CHAPTER.

Text of subsection effective until April 1, 2025

(a) This chapter applies to any insurer, including a group hospital service corporation, any health maintenance organization, and any managed care organization that receives gross premiums or revenues subject to taxation under Section 222.002, including companies operating under Chapter 841, 842, 843, 861, 881, 882, 883, 884, 941, 942, 982, or 984, Insurance Code, Chapter 533, Government Code, or Title XIX of the federal Social Security Act.

Text of subsection effective on April 1, 2025

(a) This chapter applies to any insurer, including a group hospital service corporation, any health maintenance organization, and any managed care organization that receives gross premiums or revenues subject to taxation under Section 222.002, including companies operating under Chapter 841, 842, 843, 861, 881, 882, 883, 884, 941, 942, 982, or 984, Insurance Code, Chapter 540 or 540A, Government Code, as applicable, or Title XIX of the federal Social Security Act.

(b) This chapter does not apply to:

- (1) a fraternal benefit society, including a fraternal benefit society operating under Chapter 885;
- (2) a local mutual aid association operating under Chapter 886; or
- (3) a society that limits its membership to one occupation.

(c) For purposes of computing the tax imposed by this chapter, a managed care organization is treated in the same manner as a health maintenance organization.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. [2018](#)), Sec. 11.002(a), eff. September 1, 2005.

Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. [4611](#)), Sec. 2.118, eff. April 1, 2025.

Sec. 222.002. TAX IMPOSED. (a) An annual tax is imposed on:

(1) each insurer that receives gross premiums subject to taxation under this section; and

(2) each health maintenance organization that receives gross revenues from the sale of health maintenance certificates or contracts.

(b) Except as otherwise provided by this section, in determining an insurer's taxable gross premiums or a health maintenance organization's taxable gross revenues, the insurer or health maintenance organization shall include the total gross amounts of premiums, membership fees, assessments, dues, revenues, and other considerations received by the insurer or health maintenance organization in a calendar year from any kind of health maintenance organization certificate or contract or insurance policy or contract covering risks on individuals or groups located in this state and arising from the business of a health maintenance organization or the business of life insurance, accident insurance, health insurance, life and accident insurance, life and health insurance, health and accident insurance, life, health, and accident insurance, including variable life insurance, credit life insurance, and credit accident and health insurance for profit or otherwise or for mutual benefit or protection.

(c) The following are not included in determining an insurer's taxable gross premiums or a health maintenance organization's taxable gross revenues:

(1) returned premiums or revenues;

(2) dividends applied to purchase paid-up additions to insurance or to shorten the endowment or premium payment period;

(3) premiums received from an insurer for reinsurance;

(4) premiums or revenues received from the treasury of the United States for insurance or benefits contracted for by the federal government in accordance with or in furtherance of Title XVIII of the Social Security Act (42 U.S.C. Section 1395c et seq.) and its subsequent amendments;

(5) premiums or revenues paid on group health, accident, and life policies or contracts in which the group covered by the policy or contract consists of a single nonprofit trust established to provide coverage primarily for employees of:

(A) a municipality, county, or hospital district in this state; or

(B) a county or municipal hospital, without regard to whether the employees are employees of the county or municipality or of an entity operating the hospital on behalf of the county or municipality; or

(6) premiums or revenues excluded by another law of this state.

(d) For purposes of Subsection (c)(3), a stop-loss or excess loss insurance policy issued to a health maintenance organization is considered reinsurance. In determining an insurer's taxable gross premiums or a health maintenance organization's taxable gross revenues, an insurer or health maintenance organization is not entitled to a deduction for premiums paid for reinsurance.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.
Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.002(b), eff. September 1, 2005.

Acts 2007, 80th Leg., R.S., Ch. 932 (H.B. 3315), Sec. 2, eff. June 15, 2007.

Sec. 222.003. TAX RATES. (a) Except as provided by Subsection (b), the rate of the tax imposed by this chapter on an insurer is 1.75 percent of the insurer's taxable gross premiums received during a calendar year.

(b) The rate of the tax imposed by this chapter on an insurer that receives taxable gross premiums from the business of life insurance is:

(1) 0.875 percent of the first \$450,000 of taxable gross premiums received during a calendar year from the business of life insurance; and

(2) 1.75 percent of the remaining taxable gross premiums received during that calendar year from the business of life insurance.

(c) The rate of the tax imposed by this chapter on a health maintenance organization is:

(1) 0.875 percent of the first \$450,000 of taxable gross revenues received during a calendar year for the issuance of health maintenance certificates or contracts; and

(2) 1.75 percent of the remaining taxable gross revenues

received during that calendar year for the issuance of health maintenance certificates or contracts.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 222.004. TAX DUE DATES. (a) The total tax imposed by this chapter is due and payable not later than:

(1) March 1 after the end of the calendar year for which the tax is due;

(2) the date the annual statement for the insurer or health maintenance organization is required to be filed with the commissioner after the end of the calendar year for which the tax is due; or

(3) another date prescribed by the comptroller.

(b) An insurer or health maintenance organization that had a net tax liability for the previous calendar year of more than \$1,000 shall make semiannual prepayments of tax on March 1 and August 1. The tax paid on each date must be equal to 50 percent of the total amount of tax the insurer or health maintenance organization paid under this chapter for the previous calendar year. If the insurer or health maintenance organization did not pay a tax under this chapter during the previous calendar year, the tax paid on each date must be equal to the tax that would be owed on the aggregate of the taxable gross premiums or taxable gross revenues for the two previous calendar quarters.

(c) The comptroller may refund any overpayment of taxes that results from the semiannual prepayment system prescribed by this section.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 222.005. TAX REPORT. (a) An insurer or health maintenance organization liable for the tax imposed by this chapter must file annually with the comptroller a tax report on a form prescribed by the comptroller.

(b) The tax report is due on the date the tax is due under Section 222.004(a).

(c) The comptroller may require the insurer or health maintenance organization to file any additional relevant information

that is reasonably necessary to verify the amount of tax due.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 222.006. CHANGE IN DUE DATES. (a) The comptroller by rule may change the dates for reporting and paying taxes under this chapter to improve operating efficiencies within the agency.

(b) A change by the comptroller in a reporting or payment date must retain the system of semiannual prepayments prescribed by Section 222.004.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 222.007. CREDIT FOR FEES PAID. (a) Except as otherwise provided by this subsection, an insurer or health maintenance organization is entitled to a credit on the amount of tax due under this chapter for all examination and evaluation fees paid to this state during the calendar year for which the tax is due. An insurer is not entitled to a credit on the amount of tax due under this chapter for fees paid for valuing life insurance policies. The limitations provided by Sections 803.007(1) and (2)(B) for a domestic insurance company apply to a foreign insurance company.

(b) The credit provided by this section is in addition to any other credit authorized by statute.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.003(a), eff. September 1, 2005.

Acts 2007, 80th Leg., R.S., Ch. 1039 (H.B. 1849), Sec. 2, eff. September 1, 2007.

Acts 2011, 82nd Leg., 1st C.S., Ch. 4 (S.B. 1), Sec. 2.02, eff. September 28, 2011.

Sec. 222.008. FAILURE TO PAY TAXES. An insurer or health maintenance organization that fails to pay all taxes imposed by this chapter is subject to Section 203.002.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

CHAPTER 223. TITLE INSURANCE PREMIUM TAX

Sec. 223.001. APPLICABILITY OF CERTAIN DEFINITIONS. In this chapter, a term defined by Chapter 2501 has the meaning assigned by that chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 223.002. APPLICABILITY OF CHAPTER. This chapter applies to a title insurance company that receives premiums subject to taxation under Section 223.003.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 223.003. TAX IMPOSED. (a) An annual tax is imposed on all premiums from the business of title insurance. The rate of the tax is 1.35 percent of title insurance taxable premiums for a calendar year, including any premiums retained by a title insurance agent as provided by Section 223.005. For purposes of this chapter, a person engages in the business of title insurance if the person engages in an activity described by Section 2501.005.

(b) Except as provided by Subsection (c), in determining a title insurance company's taxable premiums, the company shall include the total amounts of premiums received in a calendar year from title insurance written on property located in this state.

(c) The following premiums are not included in determining a title insurance company's taxable premiums:

(1) premiums received from other title insurance companies for reinsurance; and

(2) returned premiums and dividends paid to policyholders.

(d) In determining a title insurance company's taxable premiums, a title insurance company is not entitled to a deduction for premiums paid for reinsurance.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 932 (H.B. [3315](#)), Sec. 3, eff.

June 15, 2007.

Sec. 223.004. LIMITATION ON CERTAIN ADDITIONAL TAXES. (a) Except as otherwise provided by this code or the Labor Code, a title insurance company or title insurance agent subject to the tax imposed by this chapter may not be required to pay any additional tax imposed by this state or a county or municipality in proportion to the company's or agent's gross premium receipts.

(b) This section does not:

(1) limit the applicability of other taxes, fees, and assessments imposed by this code; or

(2) prohibit the imposition and collection of state, county, and municipal taxes on the property of title insurance companies or title insurance agents or state, county, and municipal taxes imposed by other laws of this state, unless a specific exemption for title insurance companies or title insurance agents is provided in those laws.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 223.005. PREMIUMS PAID TO TITLE INSURANCE AGENT. (a) Premiums received from the business of title insurance are subject to the tax under this chapter regardless of whether paid to a title insurance company or retained by a title insurance agent, with the tax being in lieu of the tax on the premiums retained by a title insurance agent.

(b) The state facilitates the collection of the premium tax on the premiums retained by a title insurance agent by establishing the division of the premiums between the title insurance company and title insurance agent so that the company receives the premium tax due on the agent's portion of the premiums and remits it to the state.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 223.006. TAX DUE DATES. (a) The total tax imposed by this chapter is due and payable not later than:

(1) March 1 after the end of the calendar year for which

the tax is due; or

(2) another date prescribed by the comptroller.

(b) A title insurance company that had a net tax liability for the previous calendar year of more than \$1,000 shall make semiannual prepayments of tax on March 1 and August 1. The tax paid on each date must be equal to 50 percent of the total amount of tax the company paid under this chapter for the previous calendar year. If the company did not pay a tax under this chapter during the previous calendar year, the tax paid on each date must be equal to the tax that would be owed on the aggregate of the gross premiums for the two previous calendar quarters.

(c) The comptroller may refund any overpayment of taxes that results from the semiannual prepayment system prescribed by this section.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 223.007. TAX REPORTS. (a) A title insurance company liable for the tax imposed by this chapter must file annually with the comptroller a tax report on a form prescribed by the comptroller.

(b) The tax report is due on the date the tax is due under Section 223.006(a).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 223.008. RULES. (a) The commissioner or the comptroller, as appropriate, may adopt fair and reasonable rules, minimum standards, and limitations as appropriate to augment and implement this chapter.

(b) This section does not affect the comptroller's general authority to adopt rules to promote the efficient administration, collection, enforcement, and reporting of taxes under this code or another insurance law of this state.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 223.009. CREDIT FOR FEES PAID. (a) A title insurance company is entitled to a credit on the amount of tax due under this

chapter for all examination and evaluation fees paid to the state during the calendar year for which the tax is due. The limitations provided by Sections 803.007(1) and (2)(B) for a domestic insurance company apply to a foreign insurance company.

(b) The credit provided by this section is in addition to any other credit authorized by statute.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.
Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.004(a), eff. September 1, 2005.

Acts 2011, 82nd Leg., 1st C.S., Ch. 4 (S.B. 1), Sec. 2.03, eff. September 28, 2011.

Sec. 223.010. FAILURE TO PAY TAXES. A title insurance company that fails to pay all taxes imposed by this chapter is subject to Section 203.002.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 223.011. DISPOSITION OF REVENUE. Chapter 227 applies to the disposition of the revenue from the tax imposed by this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

CHAPTER 223A. CAPTIVE INSURANCE PREMIUM TAX

Sec. 223A.001. DEFINITION. In this chapter, "captive insurance company" means a captive insurance company holding a certificate of authority under Chapter 964.

Added by Acts 2013, 83rd Leg., R.S., Ch. 569 (S.B. 734), Sec. 1, eff. June 14, 2013.

Sec. 223A.002. APPLICABILITY OF CHAPTER. This chapter applies to a captive insurance company holding a certificate of authority under Chapter 964.

Added by Acts 2013, 83rd Leg., R.S., Ch. 569 (S.B. 734), Sec. 1, eff. June 14, 2013.

Sec. 223A.003. TAX IMPOSED; RATE. (a) An annual tax is imposed on each captive insurance company that receives gross premiums subject to taxation under this chapter. The rate of the tax is one-half percent of the company's taxable premium receipts for a calendar year.

(b) Except as provided by Subsection (c), in determining a captive insurance company's taxable premium receipts, the captive insurance company shall include the total gross amounts of premiums, membership fees, assessments, dues, revenues, and other considerations for insurance written by the captive insurance company in a calendar year from any kind of insurance written by the company on each kind of property or risk without regard to the location of the property or risk.

(c) The following premium receipts are not included in determining a captive insurance company's taxable premium receipts:

- (1) premium receipts received from another authorized insurer for reinsurance;
 - (2) returned premiums and dividends paid to policyholders;
- and
- (3) premiums excluded by another law of this state.

(d) In determining a captive insurance company's taxable premium receipts, a company is not entitled to a deduction for premiums paid for reinsurance.

(e) The annual minimum aggregate tax to be paid by a captive insurance company under this chapter is \$7,500 and the annual maximum aggregate tax to be paid by a company under this chapter is \$200,000. Gross premiums subject to taxation under this chapter are not subject to taxes, surcharges, or other regulatory assessments or fees under this code other than insurance maintenance taxes as provided by Section 964.068.

Added by Acts 2013, 83rd Leg., R.S., Ch. 569 (S.B. 734), Sec. 1, eff. June 14, 2013.

Sec. 223A.004. TAX DUE DATES. (a) The total tax imposed by

this chapter is due and payable not later than March 1 after the end of the calendar year for which the tax is due.

(b) A captive insurance company that had a net tax liability for the previous calendar year of more than \$1,000 shall make semiannual prepayments of tax on March 1 and August 1. The tax paid on each date must be equal to 50 percent of the total amount of tax the company paid under this chapter for the previous calendar year. If the company did not pay a tax under this chapter during the previous calendar year, the tax paid on each date must be equal to the tax that would be owed on the aggregate of the gross premiums for the two previous calendar quarters.

(c) The comptroller may refund any overpayment of taxes that results from the semiannual prepayment system prescribed by this section.

Added by Acts 2013, 83rd Leg., R.S., Ch. 569 (S.B. 734), Sec. 1, eff. June 14, 2013.

Sec. 223A.005. TAX REPORT. (a) A captive insurance company liable for the tax imposed by this chapter must file annually with the comptroller a tax report on a form prescribed by the comptroller.

(b) The tax report is due on the date the tax is due under Section 223A.004(a).

Added by Acts 2013, 83rd Leg., R.S., Ch. 569 (S.B. 734), Sec. 1, eff. June 14, 2013.

Sec. 223A.006. CHANGE IN DUE DATES. (a) The comptroller by rule may change the dates for reporting and paying taxes under this chapter to improve operating efficiencies within the agency.

(b) A change by the comptroller in a reporting or payment date must retain the system of semiannual prepayments prescribed by Section 223A.004.

Added by Acts 2013, 83rd Leg., R.S., Ch. 569 (S.B. 734), Sec. 1, eff. June 14, 2013.

Sec. 223A.007. CREDIT FOR FEES PAID. (a) A captive insurance

company is entitled to a credit on the amount of tax due under this chapter for all examination and evaluation fees paid to this state during the calendar year for which the tax is due. The limitations provided by Sections 803.007(1) and (2)(B) for a domestic insurance company apply to a captive insurance company.

(b) The credit provided by this section is in addition to any other credit authorized by statute.

Added by Acts 2013, 83rd Leg., R.S., Ch. 569 (S.B. 734), Sec. 1, eff. June 14, 2013.

Sec. 223A.008. FAILURE TO PAY TAXES. A captive insurance company that fails to pay all taxes imposed by this chapter is subject to Section 203.002 of this code and Subtitles A and B, Title 2, Tax Code.

Added by Acts 2013, 83rd Leg., R.S., Ch. 569 (S.B. 734), Sec. 1, eff. June 14, 2013.

CHAPTER 224. RECIPROCAL AND INTERINSURANCE EXCHANGE PREMIUM TAX

Sec. 224.001. APPLICABILITY OF CHAPTER. This chapter applies to a reciprocal or interinsurance exchange that has a certificate of authority to engage in business in this state.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 224.002. TAX IMPOSED; RATE. (a) An annual tax is imposed on each reciprocal or interinsurance exchange that:

(1) does not file an election to be subject to the tax imposed by Chapter 221 in accordance with Section 224.003; or
(2) withdraws that election.

(b) The rate of the tax is 1.7 percent of the reciprocal or interinsurance exchange's gross premium receipts.

(c) A reciprocal or interinsurance exchange that is subject to the tax imposed by this chapter is not subject to the tax imposed by Chapter 221.

(d) Except as provided by Subsection (b), Chapter 221 applies to the imposition, computation, and administration of the tax imposed

by this chapter in the same manner that Chapter 221 applies to the tax imposed by that chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 224.003. TAXATION ELECTION. (a) A reciprocal or interinsurance exchange may elect to be subject to the tax imposed by Chapter 221.

(b) A reciprocal or interinsurance exchange that elects to be subject to the tax imposed by Chapter 221 must file with the comptroller on a form prescribed by the comptroller a written statement that the exchange has elected to be subject to that tax. The exchange must file the form not later than the 31st day before the date on which the tax year for which the election is to be effective begins.

(c) A reciprocal or interinsurance exchange that elects to be subject to the tax imposed by Chapter 221 continues to be subject to that tax for each tax year until the exchange withdraws the election under Subsection (d).

(d) A reciprocal or interinsurance exchange may withdraw an election made under Subsection (b) by filing with the comptroller written notice of the withdrawal. The exchange must file the notice not later than the 31st day before the date on which the tax year for which the withdrawal is to be effective begins.

(e) A reciprocal or interinsurance exchange that elects to be subject to the tax imposed by Chapter 221 is not subject to the tax imposed by Section 224.002.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

CHAPTER 225. SURPLUS LINES INSURANCE PREMIUM TAX

Sec. 225.001. DEFINITIONS. In this chapter:

(1) "Affiliate" means, with respect to an insured, a person or entity that controls, is controlled by, or is under common control with the insured.

(2) "Affiliated group" means a group of entities whose members are all affiliated.

(3) "Control" means, with respect to determining the home state of an affiliated entity:

(A) to directly or indirectly, acting through one or more persons, own, control, or hold the power to vote at least 25 percent of any class of voting security of the affiliated entity; or

(B) to control in any manner the election of the majority of directors or trustees of the affiliated entity.

(4) "Home state" means:

(A) for an insured that is not an affiliated group described by Paragraph (B):

(i) the state in which the insured maintains the insured's principal residence, if the insured is an individual;

(ii) the state in which an insured that is not an individual maintains its principal place of business; or

(iii) if 100 percent of the insured risk is located outside of the state in which the insured maintains the insured's principal residence or maintains the insured's principal place of business, as applicable, the state to which the largest percentage of the insured's taxable premium for the insurance contract that covers the risk is allocated; or

(B) for an affiliated group with respect to which more than one member is a named insured on a single insurance contract subject to this chapter, the home state of the member, as determined under Paragraph (A), that has the largest percentage of premium attributed to it under the insurance contract.

(5) "Premium" means any payment made in consideration for insurance and includes:

(A) a premium;

(B) premium deposits;

(C) a membership fee;

(D) a registration fee;

(E) an assessment;

(F) dues; and

(G) any other compensation given in consideration for surplus lines insurance.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.
Amended by:

Acts 2011, 82nd Leg., 1st C.S., Ch. 4 (S.B. 1), Sec. 18.02, eff. September 28, 2011.

Sec. 225.002. APPLICABILITY OF CHAPTER. This chapter applies to a surplus lines agent who collects gross premiums for surplus lines insurance for any risk in which this state is the home state of the insured.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Amended by:

Acts 2011, 82nd Leg., 1st C.S., Ch. 4 (S.B. 1), Sec. 18.03, eff. September 28, 2011.

Sec. 225.003. APPLICABILITY OF GENERAL PROVISIONS OF OTHER LAW. The provisions of Chapter 981, including provisions relating to the applicability and enforcement of that chapter, rulemaking authority under that chapter, and definitions of terms applicable in that chapter, apply to this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 225.004. TAX IMPOSED; RATE. (a) A tax is imposed on gross premiums for surplus lines insurance. The rate of the tax is 4.85 percent of the gross premiums.

(a-1) Consistent with 15 U.S.C. Section 8201 et seq., this state may not impose a premium tax on nonadmitted insurance premiums other than premiums paid for insurance in which this state is the home state of the insured.

(b) Taxable gross premiums under this section are based on gross premiums written or received for surplus lines insurance placed through an eligible surplus lines insurer during a calendar year. Notwithstanding the tax basis described by this subsection, the comptroller by rule may establish an alternate basis for taxation for multistate and single-state policies for the purpose of achieving uniformity.

(c) If a surplus lines insurance policy covers risks or exposures only partially located in this state, and this state has not entered into a cooperative agreement, reciprocal agreement, or compact with another state for the collection of surplus lines tax as authorized by Chapter 229, the tax is computed on the entire policy premium for any policy in which this state is the home state of the insured.

(d) Repealed by Acts 2011, 82nd Leg., 1st C.S., Ch. 4, Sec. 18.11(1), eff. September 28, 2011.

(d-1) Repealed by Acts 2011, 82nd Leg., 1st C.S., Ch. 4, Sec. 18.11(1), eff. September 28, 2011.

(e) Premiums on risks or exposures that are properly allocated to federal or international waters or are under the jurisdiction of a foreign government are not taxable in this state.

(f) If this state enters a cooperative agreement, reciprocal agreement, or compact with another state for the allocation of surplus lines tax as authorized by Chapter 229, taxes due on multistate policies shall be allocated and reported in accordance with the agreement or compact.

(g) Premiums on risks or exposures under ocean marine insurance coverage of stored or in-transit baled cotton for export are not subject to the tax imposed by this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 932 (H.B. 3315), Sec. 4, eff. June 15, 2007.

Acts 2011, 82nd Leg., 1st C.S., Ch. 4 (S.B. 1), Sec. 18.04, eff. September 28, 2011.

Acts 2011, 82nd Leg., 1st C.S., Ch. 4 (S.B. 1), Sec. 18.11(1), eff. September 28, 2011.

Acts 2013, 83rd Leg., R.S., Ch. 1043 (H.B. 2972), Sec. 1, eff. January 1, 2014.

Sec. 225.005. TAX EXCLUSIVE. The tax imposed by this chapter is a transaction tax collected by the surplus lines agent of record and is in lieu of any other transaction taxes on these premiums.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Amended by:

Acts 2011, 82nd Leg., 1st C.S., Ch. 4 (S.B. 1), Sec. 18.05, eff. September 28, 2011.

Sec. 225.006. COLLECTION OF TAX BY AGENT. (a) Except as otherwise provided by this section, the surplus lines agent shall collect from the insured the tax imposed by this chapter at the time

of delivery of the cover note, certificate of insurance, policy, or other initial confirmation of insurance and the full amount of the gross premium charged by the eligible surplus lines insurer for the insurance.

(b) Subject to Subsection (c) and notwithstanding any other law, if a surplus lines agent places an insurance policy with a managing underwriter, as defined by Section 981.002, the managing underwriter shall collect, report, and pay the tax imposed by this chapter.

(c) A surplus lines agent and a managing underwriter may enter into an agreement to provide that the surplus lines agent is responsible for filing, reporting, collection, payment, and all other requirements imposed by this chapter and Chapter 981, including the requirement to pay the tax and file the tax report imposed by this chapter. An agreement under this subsection must be in writing and must be entered into at or before the time coverage is bound under the policy. The agreement may apply to multiple policies or all policies between a surplus lines agent and a managing underwriter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.
Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 837 (H.B. [3410](#)), Sec. 1, eff. January 1, 2012.

Acts 2013, 83rd Leg., R.S., Ch. 920 (H.B. [1405](#)), Sec. 1, eff. January 1, 2014.

Sec. 225.007. COLLECTED TAXES HELD IN TRUST. A surplus lines agent holds taxes collected under this chapter in trust.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 225.008. TAX PAYMENT, REPORT, AND DUE DATE. (a) The tax imposed by this chapter is due and payable on or before March 1. A surplus lines agent shall file a tax report with the tax payment.

(b) A surplus lines agent shall pay the tax imposed by this chapter and file the report using forms prescribed by the comptroller.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 225.009. PREPAYMENT OF TAX. (a) A surplus lines agent shall prepay the tax imposed by this chapter when the amount of the accrued taxes due is equal to at least \$70,000.

(b) A surplus lines agent shall prepay the taxes using a form prescribed by the comptroller. The prepayment is due on or before the 15th day of the month following the month in which the amount of taxes described by this section accrues.

(c) The comptroller by rule may change the accrued tax amount for which prepayment is required under Subsection (a) and the prepayment deadline under Subsection (b).

(d) Notwithstanding Subsections (a), (b), and (c), if this state enters a cooperative agreement, reciprocal agreement, or compact with another state for the allocation of surplus lines tax as authorized by Chapter 229, the tax shall be allocated and reported in accordance with the terms of the agreement or compact.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 932 (H.B. 3315), Sec. 5, eff. June 15, 2007.

Acts 2011, 82nd Leg., 1st C.S., Ch. 4 (S.B. 1), Sec. 18.06, eff. September 28, 2011.

Sec. 225.010. TAX ABSORPTION AND REBATES PROHIBITED. (a) A surplus lines agent may not absorb the tax imposed by this chapter.

(b) A surplus lines agent may not rebate all or part of the tax or the agent's commission as an inducement for insurance or for any other reason.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 225.011. CANCELED OR REWRITTEN INSURANCE CONTRACT. If a surplus lines insurance contract is canceled and rewritten, the additional premium for purposes of the tax imposed by this chapter is the premium amount that exceeds the unearned premium of the canceled contract.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 225.012. STATE AS PREFERRED CREDITOR. If the property of a surplus lines agent is seized as the result of an intermediate or final decision of a court in this state, or if the business of a surplus lines agent is suspended by the action of a creditor or turned over to an assignee, receiver, or trustee, the tax imposed by this chapter and penalties due the state from the agent are preferred claims and the state is a preferred creditor and must be paid in full.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 225.013. FAILURE TO PAY TAXES; CRIMINAL PENALTY. (a) A surplus lines agent who does not pay the tax imposed by this chapter on or before the due date required by this chapter or who fraudulently withholds, appropriates, or otherwise uses any portion of the tax commits the offense of theft, regardless of whether the surplus lines agent has or claims an interest in the tax.

(b) An offense under this section is punishable as provided by law.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 225.014. LIMITATION ON RULEMAKING. In adopting rules under this chapter, the comptroller may not adopt a rule that exceeds the requirements of this chapter.

Added by Acts 2007, 80th Leg., R.S., Ch. 932 (H.B. 3315), Sec. 6, eff. June 15, 2007.

CHAPTER 226. UNAUTHORIZED AND INDEPENDENTLY PROCURED INSURANCE PREMIUM TAX

SUBCHAPTER A. UNAUTHORIZED INSURANCE PREMIUM TAX

Sec. 226.001. DEFINITIONS. In this subchapter:

(1) "Insurer" has the meaning assigned by Section 101.002 and includes:

(A) an insurer that does not hold a certificate of authority in this state;
(B) an eligible surplus lines insurer; and
(C) an insurer that holds a certificate of authority in this state.

(2) "Premium" includes any consideration for insurance, including:

- (A) a premium;
- (B) a membership fee;
- (C) an assessment; or
- (D) dues.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.
Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.005(a), eff. September 1, 2005.

Sec. 226.002. APPLICABILITY OF SUBCHAPTER. This subchapter applies to an insurer who charges gross premiums for insurance on a subject resident, located, or to be performed in this state.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.
Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.005(b), eff. September 1, 2005.

Sec. 226.003. TAX IMPOSED; RATE. (a) A tax is imposed on each insurer that charges gross premiums subject to taxation under this section. The rate of the tax is 4.85 percent of the gross premiums charged by the insurer.

(b) Except as otherwise provided by this section, in determining an insurer's taxable gross premiums, the insurer shall include any premium for insurance on a subject resident, located, or to be performed in this state.

(c) If a policy covers risks or exposures only partially located in this state, the tax is computed on the portion of the premium that is properly allocated to a risk or exposure located in this state.

(d) In determining the amount of taxable premiums under

Subsection (c), a premium, other than a premium properly allocated or apportioned and reported as a taxable premium of another state, is considered to be written on property or risks located or resident in this state if the premium:

- (1) is written, procured, or received in this state; or
- (2) is for a policy negotiated in this state.

(d-1) Notwithstanding Subsections (b) through (d), the comptroller by rule may establish that all premiums are considered to be on risks located in this state:

- (1) if the insured's home office or state of domicile or residence is located in this state; or
- (2) to accommodate changes in federal statutes or regulations that would otherwise limit the comptroller's ability to directly collect the taxes due under this section.

(e) Insurance on a subject resident, located, or to be performed in this state is considered to be insurance procured, continued, or renewed in this state regardless of the location from which:

- (1) the application is made;
- (2) the negotiations are conducted; or
- (3) the premiums are remitted.

(f) Premiums on risks or exposures that are properly allocated to federal waters or international waters or are under the jurisdiction of a foreign government are not taxable by this state.

(g) The following premiums are not subject to the tax imposed by this subchapter:

- (1) premiums on insurance procured by a licensed surplus lines agent from an eligible surplus lines insurer as defined by Chapter 981 on which premium tax is paid in accordance with Chapter 225;
- (2) premiums on an independently procured contract of insurance on which premium tax is paid in accordance with Subchapter B; and
- (3) premiums on a contract of insurance written by an insurer that holds a certificate of authority in this state and that is authorized to write the contract.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.
Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.005(c), eff.

September 1, 2005.

Acts 2007, 80th Leg., R.S., Ch. 932 (H.B. 3315), Sec. 7, eff. June 15, 2007.

Sec. 226.004. TAX EXCLUSIVE. The tax imposed by this subchapter is in lieu of all other insurance taxes.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 226.005. TAX PAYMENT; DUE DATE. (a) The tax imposed by this subchapter is due and payable not later than:

(1) March 1 after the end of the calendar year in which the insurance was effectuated, continued, or renewed; or

(2) another date prescribed by the comptroller.

(b) An insurer shall pay the tax imposed by this subchapter using a form prescribed by the comptroller.

(c) The tax imposed by this subchapter, if not paid when due, is a liability of the insurer, the insurer agent, and the insured.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.005(d), eff. September 1, 2005.

Sec. 226.006. LIMITATION ON RULEMAKING. In adopting rules under this subchapter, the comptroller may not adopt a rule that exceeds the requirements of this chapter.

Added by Acts 2007, 80th Leg., R.S., Ch. 932 (H.B. 3315), Sec. 8, eff. June 15, 2007.

SUBCHAPTER B. INDEPENDENTLY PROCURED INSURANCE PREMIUM TAX

Sec. 226.051. DEFINITIONS. In this subchapter:

(1) "Affiliate" means, with respect to an insured, a person or entity that controls, is controlled by, or is under common control with the insured.

(2) "Affiliated group" means a group of entities whose

members are all affiliated.

(3) "Control" means, with respect to determining the home state of an affiliated entity:

(A) to directly or indirectly, acting through one or more persons, own, control, or hold the power to vote at least 25 percent of any class of voting security of the affiliated entity; or

(B) to control in any manner the election of the majority of directors or trustees of the affiliated entity.

(4) "Home state" means:

(A) for an insured that is not an affiliated group described by Paragraph (B):

(i) the state in which the insured maintains the insured's principal residence, if the insured is an individual;

(ii) the state in which an insured that is not an individual maintains its principal place of business; or

(iii) if 100 percent of the insured risk is located outside of the state in which the insured maintains the insured's principal residence or maintains the insured's principal place of business, as applicable, the state to which the largest percentage of the insured's taxable premium for the insurance contract that covers the risk is allocated; or

(B) for an affiliated group with respect to which more than one member is a named insured on a single insurance contract subject to this chapter, the home state of the member, as determined under Paragraph (A), that has the largest percentage of premium attributed to it under the insurance contract.

(5) "Independently procured insurance" means insurance procured directly by an insured from a nonadmitted insurer.

(6) "Premium" means any payment made in consideration for insurance and includes:

(A) a premium;

(B) premium deposits;

(C) a membership fee;

(D) a registration fee;

(E) an assessment;

(F) dues; and

(G) any other compensation given in consideration for insurance.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Amended by:

Acts 2011, 82nd Leg., 1st C.S., Ch. 4 (S.B. 1), Sec. 18.07, eff. September 28, 2011.

Sec. 226.052. APPLICABILITY OF SUBCHAPTER. This subchapter applies to an insured who procures an independently procured insurance contract for any risk in which this state is the home state of the insured.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Amended by:

Acts 2011, 82nd Leg., 1st C.S., Ch. 4 (S.B. 1), Sec. 18.08, eff. September 28, 2011.

Sec. 226.053. TAX IMPOSED; RATE. (a) A tax is imposed on each insured at the rate of 4.85 percent of the premium paid for the insurance contract procured in accordance with Section 226.052.

(b) If an independently procured insurance policy covers risks or exposures only partially located in this state and this state has not joined a cooperative agreement, reciprocal agreement, or compact with another state for the allocation of nonadmitted insurance taxes as authorized by Chapter 229, the tax is computed on the entire policy premium for any policy in which this state is the home state of the insured.

(b-1) Repealed by Acts 2011, 82nd Leg., 1st C.S., Ch. 4, Sec. 18.11(2), eff. September 28, 2011.

(c) Premiums for individual life or individual disability insurance are not included in determining an insured's taxable premiums.

(d) If this state enters into a cooperative agreement, reciprocal agreement, or compact with another state for the allocation of nonadmitted insurance taxes as authorized by Chapter 229, the tax due on multistate policies shall be allocated and reported in accordance with the agreement or compact.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 932 (H.B. 3315), Sec. 9, eff. June 15, 2007.

Acts 2011, 82nd Leg., 1st C.S., Ch. 4 (S.B. 1), Sec. 18.09, eff. September 28, 2011.

Acts 2011, 82nd Leg., 1st C.S., Ch. 4 (S.B. 1), Sec. 18.11(2), eff. September 28, 2011.

Sec. 226.054. TAX PAYMENT BY CERTAIN INSUREDS. (a) Except as provided by Section 226.055, the tax imposed by this subchapter is due and payable not later than:

(1) May 15 after the end of the calendar year in which the insurance was procured, continued, or renewed; or

(2) another date prescribed by the comptroller.

(b) An insured who fails to withhold from the premium the amount of tax imposed by this subchapter is liable for the amount of the tax and shall pay the tax due.

(c) The insured shall file a tax report and pay the tax.

(d) The insured may designate another person to file the report and pay the tax.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 226.055. TAX PAYMENT BY CERTAIN CORPORATIONS. The amount of tax due and payable under this subchapter by a corporation that files a franchise tax report shall be reported directly to the comptroller and is due:

(1) at the time the franchise tax report is due; or

(2) on another date prescribed by the comptroller.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 226.056. EFFECT ON OTHER LAW. Sections 226.051-226.054 do not abrogate or modify any other provision of this chapter or Chapter 101.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 226.057. LIMITATION ON RULEMAKING. In adopting rules under this subchapter, the comptroller may not adopt a rule that

exceeds the requirements of this chapter.

Added by Acts 2007, 80th Leg., R.S., Ch. 932 (H.B. 3315), Sec. 10, eff. June 15, 2007.

CHAPTER 227. DISPOSITION OF PROCEEDS OF CERTAIN PREMIUM TAXES

Sec. 227.001. DISPOSITION OF TAX PROCEEDS. (a) The proceeds of the taxes imposed under Chapter 221, 222, 224, or 226 shall be deposited to the credit of the general revenue fund.

(b) An amount equal to one-fourth of the proceeds deposited under Subsection (a) shall be transferred to the credit of the foundation school fund.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

CHAPTER 228. PREMIUM TAX CREDIT FOR CERTAIN INVESTMENTS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 228.001. GENERAL DEFINITIONS. In this chapter:

(1) "Allocation date" means the date on which certified investors are allocated premium tax credits.

(2) "Certified capital" means cash invested by a certified investor that fully funds the purchase price of an equity interest in a certified capital company or a qualified debt instrument issued by the company.

(3) "Certified capital company" means a partnership, corporation, or trust or limited liability company, whether organized on a profit or nonprofit basis, that:

(A) has as the company's primary business activity the investment of cash in qualified businesses; and

(B) is certified as meeting the criteria of this chapter.

(4) "Certified investor" means an insurer or other person that has state premium tax liability and that contributes certified capital pursuant to a premium tax credit allocation under this chapter.

(5) "Early stage business" means a business described by Section 228.152(a).

(5-a) "Low-income community" has the meaning assigned by Section 45D(e), Internal Revenue Code of 1986.

(6) "Person" means an individual or entity, including a corporation, general or limited partnership, or trust or limited liability company.

(7) "Premium tax credit allocation claim" means a claim for allocation of premium tax credits.

(7-a) "Program One" means the program for allocation and investment of certified capital under this chapter before January 1, 2007.

(7-b) "Program Two" means the program for allocation and investment of certified capital under this chapter on or after January 1, 2007.

(8) "Qualified business" means a business described by Section 228.201.

(9) "Qualified debt instrument" means a debt instrument issued by a certified capital company, at par value or a premium, that:

(A) has an original maturity date that is a date on or after the fifth anniversary of the date of issuance;

(B) has a repayment schedule that is not faster than a level principal amortization over five years; and

(C) does not have interest, distribution, or payment features that are related to:

(i) the profitability of the company; or

(ii) the performance of the company's investment portfolio.

(10) "Qualified investment" means the investment of cash by a certified capital company in a qualified business for the purchase of any debt, debt participation, equity, or hybrid security of any nature or description, including a debt instrument or security that has the characteristics of debt but that provides for conversion into equity or equity participation instruments such as options or warrants.

(11) "State premium tax liability" means:

(A) any liability incurred by any person under Chapter 221, 222, 223, 223A, or 224; or

(B) if the tax liability imposed under Chapter 221, 222, 223, or 224 is eliminated or reduced, any tax liability imposed on an insurer or other person that had premium tax liability under Subchapter A, Chapter 4, or Article 9.59 as those laws existed on January 1, 2003.

(12) "Strategic investment business" means a business described by Section 228.153(a).

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1B.001, eff. April 1, 2009.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 87 (S.B. 1969), Sec. 14.001(a), eff. September 1, 2009.

Acts 2013, 83rd Leg., R.S., Ch. 569 (S.B. 734), Sec. 4, eff. June 14, 2013.

Sec. 228.002. DEFINITION OF AFFILIATE. In this chapter, "affiliate" of another person means:

(1) a person that is an affiliate for purposes of Section 823.003;

(2) a person that directly or indirectly:

(A) beneficially owns 10 percent or more of the outstanding voting securities or other voting or management interests of the other person, whether through rights, options, convertible interests, or otherwise; or

(B) controls or holds power to vote 10 percent or more of the outstanding voting securities or other voting or management interests of the other person;

(3) a person 10 percent or more of the outstanding voting securities or other voting or management interests of which are directly or indirectly:

(A) beneficially owned by the other person, whether through rights, options, convertible interests, or otherwise; or

(B) controlled or held with power to vote by the other person;

(4) a partnership in which the other person is a general partner;

(5) an officer, director, employee, or agent of the other person; or

(6) an immediate family member of an officer, director, employee, or agent described by Subdivision (5).

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1B.001, eff. April 1, 2009.

SUBCHAPTER B. ADMINISTRATION AND PROMOTION

Sec. 228.051. ADMINISTRATION BY COMPTROLLER. The comptroller shall administer this chapter.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1B.001, eff. April 1, 2009.

Sec. 228.052. RULES; FORMS. The comptroller shall adopt rules and forms as necessary to implement this chapter, including rules that:

- (1) establish the application procedures for certified capital companies; and
- (2) facilitate the transfer or assignment of premium tax credits by certified investors.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1B.001, eff. April 1, 2009.

Sec. 228.053. REPORT TO LEGISLATURE. (a) The comptroller shall prepare a biennial report concerning the results of the implementation of this chapter. The report must include:

- (1) the number of certified capital companies holding certified capital;
- (2) the amount of certified capital invested in each certified capital company;
- (3) the amount of certified capital the certified capital company invested in qualified businesses as of January 1, 2006, and the cumulative total for each subsequent year;
- (4) the total amount of tax credits granted under this chapter for each year that credits have been granted;
- (5) the performance of each certified capital company with respect to renewal and reporting requirements imposed under this chapter;
- (6) with respect to the qualified businesses in which certified capital companies have invested:
 - (A) the classification of the qualified businesses according to the industrial sector and size of the business;
 - (B) the total number of jobs created by the investment and the average wages paid for the jobs; and

(C) the total number of jobs retained as a result of the investment and the average wages paid for the jobs; and

(7) the certified capital companies that have been decertified or that have failed to renew the certification and the reason for any decertification.

(b) The comptroller shall file the report with the governor, the lieutenant governor, and the speaker of the house of representatives not later than December 15 of each even-numbered year.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1B.001, eff. April 1, 2009.

Sec. 228.054. PROMOTION OF PROGRAM. The Texas Economic Development and Tourism Office shall promote the program established under this chapter in the Texas Business and Community Economic Development Clearinghouse.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1B.001, eff. April 1, 2009.

SUBCHAPTER C. APPLICATION FOR AND GENERAL OPERATION OF CERTIFIED CAPITAL COMPANIES

Sec. 228.101. APPLICATION FOR CERTIFICATION. (a) An applicant for certification must file the application in the form prescribed by the comptroller. The application must be accompanied by a nonrefundable application fee of \$7,500.

(b) The application must include an audited balance sheet of the applicant, with an unqualified opinion from an independent certified public accountant, as of a date not more than 35 days before the date of the application.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1B.001, eff. April 1, 2009.

Sec. 228.102. QUALIFICATION. To qualify as a certified capital company:

(1) the applicant must have, at the time of application for

certification, an equity capitalization of at least \$500,000 in unencumbered cash or cash equivalents;

(2) at least two principals or persons employed to manage the funds of the applicant must have at least four years of experience in the venture capital industry; and

(3) the applicant must satisfy any additional requirement imposed by the comptroller by rule.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1B.001, eff. April 1, 2009.

Sec. 228.103. MANAGEMENT BY AND CERTAIN OWNERSHIP INTERESTS OF INSURANCE ENTITIES PROHIBITED. (a) An insurer, group of insurers, or other persons who may have state premium tax liability or the insurer's or person's affiliates may not directly or indirectly:

(1) manage a certified capital company;

(2) beneficially own, whether through rights, options, convertible interests, or otherwise, more than 10 percent of the outstanding voting securities of a certified capital company; or

(3) control the direction of investments for a certified capital company.

(b) Subsection (a) applies without regard to whether the insurer or other person or the affiliate of the insurer or other person is authorized by or engages in business in this state.

(c) Subsections (a) and (b) do not preclude an insurer, certified investor, or any other party from exercising its legal rights and remedies, including interim management of a certified capital company, if authorized by law, with respect to a certified capital company that is in default of the company's statutory or contractual obligations to the insurer, certified investor, or other party.

(d) This chapter does not limit an insurer's ownership of nonvoting equity interests in a certified capital company.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1B.001, eff. April 1, 2009.

Sec. 228.104. ACTION ON APPLICATION. (a) The comptroller shall:

(1) review the application, organizational documents, and business history of each applicant; and

(2) ensure that the applicant satisfies the requirements of this chapter.

(b) Not later than the 30th day after the date an application is filed, the comptroller shall:

(1) issue the certification; or

(2) refuse to issue the certification and communicate in detail to the applicant the grounds for the refusal, including suggestions for the removal of those grounds.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1B.001, eff. April 1, 2009.

Sec. 228.105. CONTINUATION OF CERTIFICATION. To continue to be certified, a certified capital company must make qualified investments according to the schedule established by Section 228.151.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1B.001, eff. April 1, 2009.

Sec. 228.106. REPORTS TO COMPTROLLER; AUDITED FINANCIAL STATEMENT. (a) Each certified capital company shall report to the comptroller as soon as practicable after the receipt of certified capital:

(1) the name of each certified investor from whom the certified capital was received, including the certified investor's insurance premium tax identification number;

(2) the amount of each certified investor's investment of certified capital and premium tax credits; and

(3) the date on which the certified capital was received.

(b) Not later than January 31 of each year, each certified capital company shall report to the comptroller:

(1) the amount of the company's certified capital at the end of the preceding year;

(2) whether or not the company has invested more than 15 percent of the company's total certified capital in a single business;

(3) each qualified investment that the company made during

the preceding year and, with respect to each qualified investment, the number of employees of the qualified business at the time the qualified investment was made; and

(4) any other information required by the comptroller, including any information required by the comptroller to comply with Section 228.053.

(c) Not later than April 1 of each year, each certified capital company shall provide to the comptroller an annual audited financial statement that includes the opinion of an independent certified public accountant. The audit must address the methods of operation and conduct of the business of the company to determine whether:

(1) the company is complying with this chapter and the rules adopted under this chapter;

(2) the funds received by the company have been invested as required within the time provided by Section 228.151; and

(3) the company has invested the funds in qualified businesses.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1B.001, eff. April 1, 2009.

Sec. 228.107. RENEWAL FEE; LATE FEE; EXCEPTION. (a) Not later than January 31 of each year, each certified capital company shall pay a nonrefundable renewal fee of \$5,000 to the comptroller.

(b) If a certified capital company fails to pay the renewal fee on or before the date specified by Subsection (a), the company must pay, in addition to the renewal fee, a late fee of \$5,000 to continue the company's certification.

(c) Notwithstanding Subsection (a), a renewal fee is not required within six months of the date on which a certified capital company's initial certification is issued under Section 228.104(b).

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1B.001, eff. April 1, 2009.

Sec. 228.108. OFFERING MATERIAL USED BY CERTIFIED CAPITAL COMPANY. Any offering material involving the sale of securities of the certified capital company must include the following statement:

By authorizing the formation of a certified

capital company, the State of Texas does not endorse the quality of management or the potential for earnings of the company and is not liable for damages or losses to a certified investor in the company. Use of the word "certified" in an offering does not constitute a recommendation or endorsement of the investment by the comptroller of public accounts. If applicable provisions of law are violated, the State of Texas may require forfeiture of unused premium tax credits and repayments of used premium tax credits.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1B.001, eff. April 1, 2009.

SUBCHAPTER D. INVESTMENT BY CERTIFIED CAPITAL COMPANIES

Sec. 228.151. REQUIRED SCHEDULE OF INVESTMENT. (a) Before the third anniversary of a certified capital company's allocation date, the company must make qualified investments in an amount cumulatively equal to at least 30 percent of the company's certified capital, subject to Section 228.153(b).

(b) Before the fifth anniversary of a certified capital company's allocation date, the company must make qualified investments in an amount cumulatively equal to at least 50 percent of the company's certified capital, subject to Sections 228.152(b) and 228.153(b).

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1B.001, eff. April 1, 2009.

Sec. 228.152. INVESTMENT IN EARLY STAGE BUSINESS REQUIRED. (a) In this section, "early stage business" means a qualified business that:

(1) is involved, at the time of a certified capital company's first investment, in activities related to the development of initial product or service offerings, such as prototype development or establishment of initial production or service processes;

(2) was initially organized less than two years before the

date of the certified capital company's first investment; or

(3) during the fiscal year immediately preceding the year of the certified capital company's first investment had, on a consolidated basis with the business's affiliates, gross revenues of not more than \$2 million as determined in accordance with generally accepted accounting principles.

(b) A certified capital company must place at least 50 percent of the amount of qualified investments required by Section 228.151(b) in early stage businesses.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1B.001, eff. April 1, 2009.

Sec. 228.153. INVESTMENT IN STRATEGIC INVESTMENT BUSINESS REQUIRED. (a) In this section:

(1) "Strategic investment area" means an area of this state that qualifies as a strategic investment area under Subchapter O, Chapter 171, Tax Code, or, after the date that subchapter expires, an area that qualified as a strategic investment area under that subchapter immediately before that date.

(2) "Strategic investment business" means a qualified business that:

(A) has the business's principal business operations located in one or more strategic investment areas; and

(B) intends to maintain business operations in the strategic investment areas after receipt of the investment by the certified capital company.

(b) A certified capital company must place at least 30 percent of the amount of qualified investments required by Sections 228.151(a) and (b) in a strategic investment business.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1B.001, eff. April 1, 2009.

Sec. 228.154. CERTIFIED CAPITAL NOT INVESTED IN QUALIFIED INVESTMENTS. A certified capital company shall invest any certified capital not invested in qualified investments only in:

(1) cash deposited with a federally insured financial institution;

- (2) certificates of deposit in a federally insured financial institution;
- (3) investment securities that are:
 - (A) obligations of the United States or agencies or instrumentalities of the United States; or
 - (B) obligations that are guaranteed fully as to principal and interest by the United States;
- (4) debt instruments rated at least "A" or the equivalent by a nationally recognized credit rating organization, or issued by, or guaranteed with respect to payment by, an entity whose unsecured indebtedness is rated at least "A" or the equivalent by a nationally recognized credit rating organization, and which indebtedness is not subordinated to other unsecured indebtedness of the issuer or the guarantor;
- (5) obligations of this state or a municipality or political subdivision of this state; or
- (6) any other investment approved in advance in writing by the comptroller.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1B.001, eff. April 1, 2009.

Sec. 228.155. COMPUTATION OF AMOUNT OF INVESTMENTS. (a) The aggregate cumulative amount of all qualified investments made by a certified capital company after the company's allocation date shall be considered in the computation of the percentage requirements under this subchapter.

(b) A certified capital company may invest proceeds received from a qualified investment in another qualified investment, and that investment counts toward any requirement of this chapter with respect to investments of certified capital.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1B.001, eff. April 1, 2009.

Sec. 228.156. LIMIT ON QUALIFIED INVESTMENT. A certified capital company may not make a qualified investment at a cost to the company that is greater than 15 percent of the company's total certified capital at the time of investment.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1B.001, eff. April 1, 2009.

Sec. 228.157. DISTRIBUTIONS BY CERTIFIED CAPITAL COMPANY. (a) In this section, "qualified distribution" means any distribution or payment from certified capital by a certified capital company in connection with:

(1) the reasonable costs and expenses of forming, syndicating, managing, and operating the company, provided that the distribution or payment is not made directly or indirectly to a certified investor, including:

(A) reasonable and necessary fees paid for professional services, including legal and accounting services, related to the company's formation and operation; and

(B) an annual management fee in an amount that does not exceed 2.5 percent of the company's certified capital; and

(2) a projected increase in federal or state taxes, including penalties and interest related to state and federal income taxes, of the company's equity owners resulting from the earnings or other tax liability of the company to the extent that the increase is related to the ownership, management, or operation of the company.

(b) A certified capital company may make a qualified distribution at any time. To make a distribution or payment other than a qualified distribution, a company must have made qualified investments in an amount cumulatively equal to 100 percent of the company's certified capital.

(c) If a business in which a qualified investment is made relocates the business's principal business operations to another state during the term of the certified capital company's investment in the business, the cumulative amount of qualified investments made by the certified capital company for purposes of satisfying the requirements of Subsection (b) only is reduced by the amount of the certified capital company's qualified investments in the business that has relocated.

(d) Subsection (c) does not apply if the business demonstrates that the business has returned the business's principal business operations to this state not later than the 90th day after the date of the relocation.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1B.001, eff. April 1, 2009.

Sec. 228.158. REPAYMENT OF DEBT. Notwithstanding Section 228.157(b), a certified capital company may make repayments of principal and interest on the company's indebtedness without any restriction, including repaying the company's indebtedness on which certified investors earned premium tax credits.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1B.001, eff. April 1, 2009.

SUBCHAPTER E. QUALIFIED BUSINESS

Sec. 228.201. DEFINITION OF QUALIFIED BUSINESS. (a) In this chapter, "qualified business" means a business that complies with this section at the time of a certified capital company's first investment in the business.

(b) A qualified business must:

(1) be headquartered in this state and intend to remain in this state after receipt of the certified capital company's investment; and

(2) have the business's principal business operations located in this state and intend to maintain business operations in this state after receipt of the certified capital company's investment.

(c) A qualified business must agree to use the qualified investment primarily to:

(1) support business operations in this state, other than advertising, promotion, and sales operations which may be conducted outside of this state; or

(2) in the case of a start-up company, establish and support business operations in this state, other than advertising, promotion, and sales operations which may be conducted outside of this state.

(d) A qualified business may not have more than 100 employees and must:

(1) employ at least 80 percent of the business's employees in this state; or

(2) pay 80 percent of the business's payroll to employees in this state.

(e) A qualified business must be primarily engaged in:

- (1) manufacturing, processing, or assembling products;
- (2) conducting research and development; or
- (3) providing services.

(f) A qualified business may not be primarily engaged in:

- (1) retail sales;
- (2) real estate development;
- (3) the business of insurance, banking, or lending; or
- (4) the provision of professional services provided by accountants, attorneys, or physicians.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1B.001, eff. April 1, 2009.

Sec. 228.202. RELOCATION OF PRINCIPAL BUSINESS OPERATIONS. If, before the 90th day after the date a certified capital company makes an investment in a qualified business, the qualified business moves the business's principal business operations from this state, the investment may not be considered a qualified investment for purposes of the percentage requirements under this chapter.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1B.001, eff. April 1, 2009.

Sec. 228.203. EVALUATION OF BUSINESS BY COMPTROLLER. (a) A certified capital company may, before making an investment in a business, request a written opinion from the comptroller as to whether the business in which the company proposes to invest is a qualified business, an early stage business, or a strategic investment or low-income community business.

(b) Not later than the 15th business day after the date of the receipt of a request under Subsection (a), the comptroller shall:

- (1) determine whether the business meets the definition of a qualified business, an early stage business, or a strategic investment or low-income community business, as applicable, and notify the certified capital company of the determination and provide an explanation of the determination; or

(2) notify the company that an additional 15 days will be needed to review the request and make the determination.

(c) If the comptroller fails to notify the certified capital company with respect to the proposed investment within the period specified by Subsection (b), the business in which the company proposes to invest is considered to be a qualified business, an early stage business, or a strategic investment or low-income community business, as appropriate.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1B.001, eff. April 1, 2009.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 87 (S.B. 1969), Sec. 14.003(a), eff. September 1, 2009.

Sec. 228.204. CONTINUATION OF CLASSIFICATION AS QUALIFIED BUSINESS; FOLLOW-ON INVESTMENTS AUTHORIZED. (a) A business that is classified as a qualified business at the time of the first investment in the business by a certified capital company:

(1) remains classified as a qualified business; and

(2) may receive follow-on investments from any certified capital company.

(b) Except as provided by Subsection (c), a follow-on investment made under Subsection (a) is a qualified investment even though the business may not meet the definition of a qualified business at the time of the follow-on investment.

(c) A follow-on investment does not qualify as a qualified investment if, at the time of the follow-on investment, the qualified business no longer has the business's principal business operations in this state.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1B.001, eff. April 1, 2009.

SUBCHAPTER F. PREMIUM TAX CREDIT

Sec. 228.251. PREMIUM TAX CREDIT. (a) A certified investor who makes an investment of certified capital shall earn in the year of investment a vested credit against state premium tax liability equal to 100 percent of the certified investor's investment of

certified capital, subject to the limits imposed by this chapter.

(b) With respect to credits earned as a result of investments made under Program One, beginning with the tax report due March 1, 2009, for the 2008 tax year, a certified investor may take up to 25 percent of the vested premium tax credit in any taxable year of the certified investor. The credit may not be applied to estimated payments due in 2008.

(c) With respect to credits earned as a result of investments made under Program Two, beginning with the tax report due March 1, 2013, for the 2012 tax year, a certified investor may take up to 25 percent of the vested premium tax credit in any taxable year of the certified investor. The credit may not be applied to estimated payments due in 2012.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1B.001, eff. April 1, 2009.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 87 (S.B. 1969), Sec. 14.004(a), eff. September 1, 2009.

Sec. 228.252. LIMIT ON PREMIUM TAX CREDIT. (a) The credit to be applied against state premium tax liability of a certified investor in any one year may not exceed the state premium tax liability of the investor for the taxable year.

(b) A certified investor may carry forward any unused credit against state premium tax liability indefinitely until the premium tax credits are used.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1B.001, eff. April 1, 2009.

Sec. 228.253. PREMIUM TAX CREDIT ALLOCATION CLAIM REQUIRED.

(a) A certified investor must prepare and execute a premium tax credit allocation claim on a form provided by the comptroller.

(b) The certified capital company must have filed the claim with the comptroller on the date on which the comptroller accepted premium tax credit allocation claims on behalf of certified investors with respect to Program One or Program Two, as applicable, under the comptroller's rules.

(c) The premium tax credit allocation claim form must include an affidavit of the certified investor under which the certified investor becomes legally bound and irrevocably committed to make an investment of certified capital in a certified capital company in the amount allocated even if the amount allocated is less than the amount of the claim, subject only to the receipt of an allocation under Section 228.255.

(d) A certified investor may not claim a premium tax credit under Section 228.251 for an investment that has not been funded, without regard to whether the certified investor has committed to fund the investment.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1B.001, eff. April 1, 2009.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 87 (S.B. 1969), Sec. 14.005(a), eff. September 1, 2009.

Sec. 228.254. TOTAL LIMIT ON PREMIUM TAX CREDITS. (a) The total amount of certified capital for which premium tax credits may be allowed under this chapter for all years in which premium tax credits are allowed is:

- (1) \$200 million for Program One; and
- (2) \$200 million for Program Two.

(b) The total amount of certified capital for which premium tax credits may be allowed for all certified investors under this chapter may not exceed the amount that would entitle all certified investors in certified capital companies to take total credits of \$50 million in a year with respect to Program One and \$50 million in a year with respect to Program Two.

(c) A certified capital company and the company's affiliates may not file premium tax credit allocation claims with respect to Program One or Program Two, as applicable, in excess of the maximum amount of certified capital for which premium tax credits may be allowed for that program as provided by this section.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1B.001, eff. April 1, 2009.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 87 (S.B. 1969), Sec. 14.006(a),

eff. September 1, 2009.

Sec. 228.255. ALLOCATION OF PREMIUM TAX CREDIT. (a) If the total premium tax credits claimed by all certified investors with respect to Program One or Program Two, as applicable, exceeds the total limits on premium tax credits established for that program by Section 228.254(a), the comptroller shall allocate the total amount of premium tax credits allowed under this chapter to certified investors in certified capital companies on a pro rata basis in accordance with this section.

(b) The pro rata allocation for each certified investor shall be the product of:

(1) a fraction, the numerator of which is the amount of the premium tax credit allocation claim filed on behalf of the investor with respect to Program One or Program Two, as applicable, and the denominator of which is the total amount of all premium tax credit allocation claims filed on behalf of all certified investors with respect to that program; and

(2) the total amount of certified capital for which premium tax credits may be allowed with respect to that program under this chapter.

(c) The maximum amount of certified capital for which premium tax credit allocation may be allowed on behalf of a single certified investor and the investor's affiliates with respect to Program One or Program Two, as applicable, whether by one or more certified capital companies, may not exceed the greater of:

(1) \$10 million; or

(2) 15 percent of the maximum aggregate amount available with respect to that program under Section 228.254(a).

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1B.001, eff. April 1, 2009.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 87 (S.B. 1969), Sec. 14.007(a), eff. September 1, 2009.

Sec. 228.256. TREATMENT OF CREDITS AND CAPITAL. In any case under this code or another insurance law of this state in which the

assets of a certified investor are examined or considered, the certified capital may be treated as an admitted asset, subject to the applicable statutory valuation procedures.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1B.001, eff. April 1, 2009.

Sec. 228.257. TRANSFERABILITY OF CREDIT. (a) A certified investor may transfer or assign premium tax credits only in compliance with the rules adopted under Section 228.052.

(b) The transfer or assignment of a premium tax credit does not affect the schedule for taking the premium tax credit under this chapter.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1B.001, eff. April 1, 2009.

Sec. 228.258. IMPACT OF PREMIUM TAX CREDIT ON INSURANCE RATEMAKING. A certified investor is not required to reduce the amount of premium tax included by the investor in connection with ratemaking for an insurance contract written in this state because of a reduction in the investor's Texas premium tax derived from premium tax credits granted under this chapter.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1B.001, eff. April 1, 2009.

Sec. 228.259. RETALIATORY TAX. A certified investor claiming a credit against state premium tax liability earned through an investment in a company is not required to pay any additional retaliatory tax levied under Chapter 281 as a result of claiming that credit.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1B.001, eff. April 1, 2009.

SUBCHAPTER G. ENFORCEMENT

Sec. 228.301. ANNUAL REVIEW BY COMPTROLLER. (a) The comptroller shall conduct an annual review of each certified capital company to:

- (1) ensure that the company:
 - (A) continues to satisfy the requirements of this chapter; and
 - (B) has not made any investment in violation of this chapter; and
- (2) determine the eligibility status of the company's qualified investments.

(b) Each certified capital company shall pay the cost of the annual review according to a reasonable fee schedule adopted by the comptroller.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 1B.001, eff. April 1, 2009.

Sec. 228.302. DECERTIFICATION OF CERTIFIED CAPITAL COMPANY.

(a) A material violation of Section 228.105, 228.106, 228.107, 228.151, 228.152, 228.153, 228.154, 228.155, 228.156, 228.202, or 228.204 is grounds for decertification of a certified capital company.

(b) If the comptroller determines that a certified capital company is not in compliance with a law listed in Subsection (a), the comptroller shall notify the company's officers in writing that the company may be subject to decertification after the 120th day after the date the notice is mailed unless the company:

- (1) corrects the deficiencies; and
- (2) returns to compliance with the law.

(c) The comptroller may decertify a certified capital company, after opportunity for hearing, if the comptroller finds that the company is not in compliance with a law listed in Subsection (a) at the end of the period established by Subsection (b).

(c-1) Notwithstanding any other provision of this section, the comptroller may decertify a certified capital company if the comptroller receives a request in writing from the certified capital company stating that the certified capital company has made qualified investments in an amount cumulatively equal to 100 percent of the company's certified capital.

(d) Decertification under this section is effective on receipt of notice of decertification by the certified capital company.

(e) The comptroller shall notify any appropriate state agency of a decertification of a certified capital company.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1B.001, eff. April 1, 2009.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 53 (H.B. 3031), Sec. 1, eff. May 21, 2015.

Sec. 228.303. ADMINISTRATIVE PENALTY. (a) The comptroller may impose an administrative penalty on a certified capital company that violates this chapter.

(b) The amount of the penalty may not exceed \$25,000. Each day a violation continues or occurs is a separate violation for the purpose of imposing the penalty. The amount of the penalty shall be based on:

- (1) the seriousness of the violation, including the nature, circumstances, extent, and gravity of the violation;
- (2) the economic harm 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; and
- (6) any other matter that justice may require.

(c) A certified capital company assessed a penalty under this chapter may request a redetermination as provided by Chapter 111, Tax Code.

(d) The attorney general may sue to collect the penalty.

(e) A proceeding to impose the penalty is a contested case under Chapter 2001, Government Code.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1B.001, eff. April 1, 2009.

SUBCHAPTER H. RECAPTURE AND FORFEITURE OF PREMIUM TAX CREDITS

Sec. 228.351. RECAPTURE AND FORFEITURE OF PREMIUM TAX CREDIT FOLLOWING DECERTIFICATION. (a) Decertification of a certified capital company may, in accordance with this section, cause:

(1) the recapture of premium tax credits previously claimed by the company's certified investors; and

(2) the forfeiture of future premium tax credits to be claimed by the investors.

(b) Decertification of a certified capital company on or before the third anniversary of the company's allocation date causes the recapture of any premium tax credits previously claimed and the forfeiture of any future premium tax credits to be claimed by a certified investor with respect to the company.

(c) For a certified capital company that meets the requirements for continued certification under Section 228.151(a) and subsequently fails to meet the requirements for continued certification under Subsection (b) of that section:

(1) any premium tax credit that has been or will be taken by a certified investor on or before the third anniversary of the allocation date is not subject to recapture or forfeiture; and

(2) any premium tax credit that has been or will be taken by a certified investor after the third anniversary of the company's allocation date is subject to recapture or forfeiture.

(d) For a certified capital company that has met the requirements for continued certification under Section 228.151 and is subsequently decertified:

(1) any premium tax credit that has been or will be taken by a certified investor on or before the fifth anniversary of the allocation date is not subject to recapture or forfeiture; and

(2) any premium tax credit to be taken after the fifth anniversary of the allocation date is subject to forfeiture only if the company is decertified on or before the fifth anniversary of the company's allocation date.

(e) For a certified capital company that has invested an amount cumulatively equal to 100 percent of the company's certified capital in qualified investments, any premium tax credit claimed or to be claimed by a certified investor is not subject to recapture or forfeiture under this section.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 1B.001, eff. April 1, 2009.

Sec. 228.352. NOTICE OF RECAPTURE AND FORFEITURE OF PREMIUM TAX

CREDIT. The comptroller shall send written notice to the address of each certified investor whose premium tax credit is subject to recapture or forfeiture, using the address shown on the investor's last premium tax filing.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1B.001, eff. April 1, 2009.

Sec. 228.353. INDEMNITY AGREEMENTS AND INSURANCE AUTHORIZED.

(a) A certified capital company may agree to indemnify, or purchase insurance for the benefit of, a certified investor for losses resulting from the recapture or forfeiture of premium tax credits under Section 228.351.

(b) Any guaranty, indemnity, bond, insurance policy, or other payment undertaking made under this section may not be provided by more than one certified investor of the certified capital company or affiliate of the certified investor.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1B.001, eff. April 1, 2009.

CHAPTER 229. COOPERATIVE AGREEMENTS WITH OTHER STATES

Sec. 229.001. DEFINITIONS. In this chapter:

(1) "Agent" includes:

(A) a surplus lines agent, as defined by Section 981.002;

(B) a person licensed as a surplus lines agent by another state; and

(C) any other person who performs the acts of an agent, whether through an oral, written, electronic, or other form of communication, by soliciting, negotiating, procuring, or collecting a premium on an insurance contract.

(2) "Insurer" has the meaning assigned by Section 101.002 and includes:

(A) an insurer that does not hold a certificate of authority in this state;

(B) an eligible surplus lines insurer; and

(C) an insurer that holds a certificate of authority in this state but performs acts outside the scope of its authority under

the certificate.

(3) "Premium" includes:

- (A) any consideration for insurance, including:
 - (i) a premium;
 - (ii) a membership fee;
 - (iii) an assessment; and
 - (iv) dues; or

(B) any other meaning of the term adopted in a cooperative agreement.

(4) "Processing entity" means a processing center or clearinghouse established under a cooperative agreement.

(5) "Stamping office" means the Surplus Lines Stamping Office of Texas or similar stamping offices in other states.

Added by Acts 2007, 80th Leg., R.S., Ch. 932 (H.B. 3315), Sec. 11, eff. June 15, 2007.

Renumbered from Insurance Code, Section 228.001 by Acts 2009, 81st Leg., R.S., Ch. 87 (S.B. 1969), Sec. 27.001(60), eff. September 1, 2009.

Sec. 229.002. COOPERATIVE AGREEMENTS WITH OTHER STATES. (a) The comptroller may enter into a cooperative agreement, reciprocal agreement, or compact with another state for the collection of insurance premium taxes imposed by Chapters 225 and 226 on a multistate basis. An agreement or amendment of an agreement takes effect according to its terms, except that an agreement or amendment may not take effect until the proposed agreement or amendment is published in the Texas Register.

(b) An agreement may provide for:

(1) determining a base state and multistate allocation of insurance premiums;

(2) tax reporting requirements;

(3) audit and refund claim procedures;

(4) exchange of information;

(5) requirements for reporting on a multistate basis;

(6) insurance and tax related terms and definitions;

(7) penalties, fees, administrative costs, and interest rates;

(8) audit assessment and refund claim limitation periods;

(9) procedures for collecting amounts due from agents, insurers, or other persons and for collecting and forwarding the amounts due to the jurisdiction to which the amount is owed;

(10) procedures for verifying refund claims by agents, insurers, or other persons and for collecting those amounts from the jurisdiction owing the refund amount;

(11) the temporary remittal of funds equal to the amounts due to another jurisdiction, subject to appropriation of funds for that purpose; and

(12) other provisions to facilitate the administration of the agreement.

(c) The comptroller may, as required by the terms of an agreement, provide to an officer of another state any information that relates to the solicitation, negotiation, procurement, placement, issuance, receipt, or collection of premiums by an agent, insurer, or other person for an insurance contract or policy that may be subject to the premium taxes imposed by Chapter 225 or 226.

(d) An agreement may provide for each state to audit the records of an agent, insurer, or other person based in this state to determine if insurance premium taxes due each state that is a party to the agreement are properly reported and paid. An agreement may provide for each state to forward the findings of an audit performed on an agent, insurer, or other person based in this state to each other state in which the person has an allocation of taxable premiums.

(e) For an agent, insurer, or other person who has an allocation of taxable premiums in this state, the comptroller may use an audit performed by another state that is a party to an agreement with this state to make an assessment of insurance premium taxes against the agent, insurer, or other person. An assessment made by the comptroller under this subsection is prima facie evidence that the amount shown as due is correct.

(f) An agreement entered into under this section does not affect the comptroller's authority to audit any person under any other law.

(g) An agreement entered into under this section prevails over an inconsistent rule of the comptroller. Except as otherwise provided by this section, a statute of this state prevails over an inconsistent provision of an agreement entered into under this section.

(h) The comptroller may segregate in a separate fund or account the amount estimated to be due to other jurisdictions, amounts subject to refund during the fiscal year, fees, and other costs collected under the agreement. On a determination of an amount held that is due to be remitted to another jurisdiction, the comptroller may issue a warrant or make an electronic transfer of the amount as necessary to carry out the purposes of the agreement. An auditing cost, membership fee, or other cost associated with the agreement may be paid from interest earned on funds segregated under this subsection. Any interest earnings in excess of the costs associated with the agreement shall be credited to general revenue.

(i) The legislature finds that it is in the public interest to enter into insurance tax and regulatory agreements with other jurisdictions that may provide for the temporary remittal of amounts due other jurisdictions that exceed the amounts collected and for cooperation with other jurisdictions for the collection of taxes imposed by this state under Chapters 225 and 226 and similar taxes imposed under statutes of other jurisdictions on insurance premiums. The comptroller shall ensure that reasonable measures are developed to recover insurance taxes and other amounts due this state during each biennium.

(j) The comptroller may enter into a cooperative agreement, reciprocal agreement, or compact with another state to provide for the collection of taxes imposed by this state and the other states on insurances taxes that may be due the states and this state based on a standardized premium allocation adopted by the states under the agreement. The comptroller may also enter into other cooperative agreements with surplus lines stamping offices located in this state and other states in the reporting and capturing of related tax information. In addition, the comptroller may enter into cooperative agreements with processing entities located in this state or other states related to the capturing and processing of insurance premium and tax data.

(k) The comptroller may adopt rules as necessary to implement this chapter. In adopting rules under this chapter, the comptroller may not adopt a rule that does not specifically implement this section.

Added by Acts 2007, 80th Leg., R.S., Ch. 932 (H.B. [3315](#)), Sec. 11, eff. June 15, 2007.

Renumbered from Insurance Code, Section 228.002 by Acts 2009, 81st Leg., R.S., Ch. 87 (S.B. 1969), Sec. 27.001(60), eff. September 1, 2009.

CHAPTER 233. CREDIT AGAINST CERTAIN TAXES FOR CERTAIN HOUSING DEVELOPMENTS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 233.0001. DEFINITIONS. In this chapter:

- (1) "Allocation certificate," "credit," and "qualified development" have the meanings assigned by Section 171.551, Tax Code.
- (2) "State premium tax liability" means any tax liability incurred by an entity under Chapter 221, 222, 223, or 224.

Added by Acts 2023, 88th Leg., R.S., Ch. 811 (H.B. 1058), Sec. 2, eff. January 1, 2024.

SUBCHAPTER B. CREDIT

Sec. 233.0051. CREDIT. (a) An entity is eligible for a credit against the entity's state premium tax liability in the amount and under the limitations provided by this chapter if the entity owns a direct or indirect interest in a qualified development.

(b) An entity that claims a credit under this chapter is not required to pay any additional retaliatory tax under Chapter 281 as a result of claiming the credit.

Added by Acts 2023, 88th Leg., R.S., Ch. 811 (H.B. 1058), Sec. 2, eff. January 1, 2024.

Sec. 233.0052. LENGTH OF CREDIT; LIMITATIONS. (a) The entity shall claim the credit in the manner provided by Section 171.556, Tax Code.

(b) The total credit claimed under this chapter for a report, including any carry forward or backward described by Subsection (c), may not exceed the amount of the entity's state premium tax liability due for the report after any other applicable credit.

(c) The entity may carry a surplus credit forward or backward as provided by Section 171.557, Tax Code.

Added by Acts 2023, 88th Leg., R.S., Ch. 811 (H.B. 1058), Sec. 2, eff. January 1, 2024.

Sec. 233.0053. APPLICATION FOR CREDIT. (a) An entity must apply for a credit under this chapter on or with the tax report for the tax year for which the credit is claimed and submit with the application a copy of the allocation certificate issued in connection with the qualified development and any other information required by Subchapter K, Chapter 171, Tax Code.

(b) The comptroller shall adopt a form for the application for the credit. An entity must use this form in applying for the credit.

Added by Acts 2023, 88th Leg., R.S., Ch. 811 (H.B. 1058), Sec. 2, eff. January 1, 2024.

Sec. 233.0054. RULES; PROCEDURES. The comptroller and the Texas Department of Housing and Community Affairs, in consultation with each other, shall adopt rules and procedures to implement, administer, and enforce this chapter.

Added by Acts 2023, 88th Leg., R.S., Ch. 811 (H.B. 1058), Sec. 2, eff. January 1, 2024.

Sec. 233.0055. APPLICABLE PROVISIONS. The provisions of Subchapter K, Chapter 171, Tax Code, relating to recapture, allocation of credit, apportionment of credit, length of credit, filing requirements after allocation, and compliance monitoring apply to the credit authorized by this chapter.

Added by Acts 2023, 88th Leg., R.S., Ch. 811 (H.B. 1058), Sec. 2, eff. January 1, 2024.

SUBCHAPTER C. EXPIRATION OF AUTHORITY TO ALLOCATE CREDITS

Sec. 233.0101. EXPIRATION OF ALLOCATION AUTHORITY; USE OF ALLOCATED CREDITS. (a) The authority of the Texas Department of Housing and Community Affairs to reserve credit amounts and issue allocation certificates for purposes of Subchapter K, Chapter 171,

Tax Code, and this chapter expires as provided by Section 171.565(a), Tax Code.

(b) An entity may claim a credit under this chapter on a tax report as provided by Section 171.565(b), Tax Code.

Added by Acts 2023, 88th Leg., R.S., Ch. 811 (H.B. 1058), Sec. 2, eff. January 1, 2024.

SUBTITLE C. INSURANCE MAINTENANCE TAXES

CHAPTER 251. GENERAL PROVISIONS

Sec. 251.001. DETERMINING RATE OF ASSESSMENT. (a) The commissioner shall annually determine the rate of assessment of each maintenance tax imposed under this subtitle.

(b) In determining the rate of assessment, the commissioner shall consider the requirement to reimburse the appropriate portion of the general revenue fund under Section 201.052.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 251.002. DUTY TO ADVISE COMPTROLLER OF RATE. The commissioner shall advise the comptroller of the applicable rate of assessment of a maintenance tax not later than the 45th day before the due date of the tax report for the period for which that tax is due.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 251.003. EFFECT OF LATE ADVISEMENT OF RATE. (a) Except as provided by Subsection (b), if the commissioner does not advise the comptroller of the applicable rate of assessment of a maintenance tax by the date required by Section 251.002, the rate of assessment is the rate applied in the previous tax period.

(b) If the commissioner advises the comptroller of the applicable rate of assessment of a maintenance tax after the tax has been assessed, the comptroller shall:

(1) advise each taxpayer in writing of the amount of any additional taxes due; or

(2) refund any excess taxes paid.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 251.004. DEPOSIT OF MAINTENANCE TAXES. (a) Except as provided by Subsection (b), maintenance taxes collected under this subtitle shall be deposited in the general revenue fund and reallocated to the Texas Department of Insurance operating account.

(b) Each state fiscal year, the comptroller shall reallocate to the floodplain management account established under Section 16.453, Water Code, the first \$3.05 million of the maintenance taxes collected under Chapter 252 and deposited in the general revenue fund.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 1323 (S.B. 1436), Sec. 1, eff. September 1, 2007.

Acts 2019, 86th Leg., R.S., Ch. 947 (S.B. 7), Sec. 3.02, eff. June 13, 2019.

CHAPTER 252. FIRE AND ALLIED LINES INSURANCE

Sec. 252.001. MAINTENANCE TAX IMPOSED. A maintenance tax is imposed on each authorized insurer with gross premiums subject to taxation under Section 252.003. The tax required by this chapter is in addition to other taxes imposed that are not in conflict with this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 252.002. MAXIMUM RATE; ANNUAL ADJUSTMENT. (a) The rate of assessment set by the commissioner may not exceed 1.25 percent of the gross premiums subject to taxation under Section 252.003.

(b) The commissioner shall annually adjust the rate of assessment of the maintenance tax so that the tax imposed that year, together with any unexpended funds produced by the tax, produces the amount the commissioner determines is necessary to pay the expenses during the succeeding year of regulating all classes of insurance specified under:

- (1) Chapters 1807, 2001-2006, 2171, 6001, 6002, and 6003;

- (2) Subchapter C, Chapter 5;
- (3) Subchapter H, Chapter 544;
- (4) Subchapter D, Chapter 1806;
- (5) Section 403.002;
- (6) Sections 417.007, 417.008, and 417.009, Government Code; and
- (7) Chapter 2154, Occupations Code.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 2C.001, eff. April 1, 2009.

Sec. 252.003. PREMIUMS SUBJECT TO TAXATION. An insurer shall pay maintenance taxes under this chapter on the correctly reported gross premiums from writing insurance in this state against loss or damage by:

- (1) bombardment;
- (2) civil war or commotion;
- (3) cyclone;
- (4) earthquake;
- (5) excess or deficiency of moisture;
- (6) explosion as defined by Section 2002.006(b);
- (7) fire;
- (8) flood;
- (9) frost and freeze;
- (10) hail, including loss by hail on farm crops;
- (11) insurrection;
- (12) invasion;
- (13) lightning;
- (14) military or usurped power;
- (15) an order of a civil authority made to prevent the spread of a conflagration, epidemic, or catastrophe;
- (16) rain;
- (17) riot;
- (18) the rising of the waters of the ocean or its tributaries;
- (19) smoke or smudge;
- (20) strike or lockout;

- (21) tornado;
- (22) vandalism or malicious mischief;
- (23) volcanic eruption;
- (24) water or other fluid or substance resulting from the breakage or leakage of sprinklers, pumps, or other apparatus erected for extinguishing fires, water pipes, or other conduits or containers;
- (25) weather or climatic conditions;
- (26) windstorm;
- (27) an event covered under a home warranty insurance policy; or
- (28) an event covered under an inland marine insurance policy.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 2C.002, eff. April 1, 2009.

Acts 2007, 80th Leg., R.S., Ch. 932 (H.B. [3315](#)), Sec. 12, eff. June 15, 2007.

Reenacted by Acts 2009, 81st Leg., R.S., Ch. 87 (S.B. [1969](#)), Sec. 14.009, eff. September 1, 2009.

Sec. 252.004. MAINTENANCE TAX DUE DATES. (a) The insurer shall pay the maintenance tax annually or semiannually, as determined by the comptroller.

(b) The comptroller may require semiannual or other periodic payment only from an insurer whose maintenance tax liability under this chapter for the previous tax year was at least \$2,000.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 252.005. EXCEPTION. This chapter does not apply to:

(1) a farm mutual insurance company operating under Chapter 911, unless the company is acting as a fronting insurer as defined by Section 221.001(c); or

(2) a mutual insurance company engaged in business under Chapter 12, Title 78, Revised Statutes, before that chapter's repeal by Section 18, Chapter 40, Acts of the 41st Legislature, 1st Called

Session, 1929, as amended by Section 1, Chapter 60, General Laws, Acts of the 41st Legislature, 2nd Called Session, 1929, that retains the rights and privileges under the repealed law to the extent provided by those sections.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 13, eff. April 1, 2007.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 1083 (H.B. 3496), Sec. 2, eff. September 1, 2017.

CHAPTER 253. CASUALTY INSURANCE AND FIDELITY, GUARANTY, AND SURETY BOND INSURANCE

Sec. 253.001. MAINTENANCE TAX IMPOSED. A maintenance tax is imposed on each authorized insurer with gross premiums subject to taxation under Section 253.003. The tax required by this chapter is in addition to other taxes imposed that are not in conflict with this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 253.002. MAXIMUM RATE; ANNUAL ADJUSTMENT. (a) The rate of assessment set by the commissioner may not exceed 0.4 percent of the gross premiums subject to taxation under Section 253.003.

(b) The commissioner shall annually adjust the rate of assessment of the maintenance tax so that the tax imposed that year, together with any unexpended funds produced by the tax, produces the amount the commissioner determines is necessary to pay the expenses during the succeeding year of regulating all classes of insurance specified under Section 253.003.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2C.003, eff. April 1, 2009.

Sec. 253.003. PREMIUMS SUBJECT TO TAXATION. An insurer shall pay maintenance taxes under this chapter on the correctly reported

gross premiums from writing a class of insurance specified under:

- (1) Chapters 2008, 2251, and 2252;
- (2) Subchapter B, Chapter 5;
- (3) Subchapter C, Chapter 1806;
- (4) Subchapter A, Chapter 2301; and
- (5) Subtitle B, Title 10.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2C.004, eff. April 1, 2009.

Sec. 253.004. MAINTENANCE TAX DUE DATES. (a) The insurer shall pay the maintenance tax annually or semiannually, as determined by the comptroller.

(b) The comptroller may require semiannual payment only from an insurer whose maintenance tax liability under this chapter for the previous tax year was at least \$2,000.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

CHAPTER 254. MOTOR VEHICLE INSURANCE

Sec. 254.001. MAINTENANCE TAX IMPOSED. A maintenance tax is imposed on each authorized insurer with gross premiums subject to taxation under Section 254.003. The tax required by this chapter is in addition to other taxes imposed that are not in conflict with this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 254.002. MAXIMUM RATE; ANNUAL ADJUSTMENT. (a) The rate of assessment set by the commissioner may not exceed 0.2 percent of the gross premiums subject to taxation under Section 254.003.

(b) The commissioner shall annually adjust the rate of assessment of the maintenance tax so that the tax imposed that year, together with any unexpended funds produced by the tax, produces the amount the commissioner determines is necessary to pay the expenses during the succeeding year of regulating motor vehicle insurance.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 254.003. PREMIUMS SUBJECT TO TAXATION. An insurer shall pay maintenance taxes under this chapter on the correctly reported gross premiums from writing motor vehicle insurance in this state, including personal and commercial automobile insurance.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 932 (H.B. 3315), Sec. 13, eff. June 15, 2007.

Sec. 254.004. MAINTENANCE TAX DUE DATES. (a) The insurer shall pay the maintenance tax annually or semiannually, as determined by the comptroller.

(b) The comptroller may require semiannual or other periodic payment only from an insurer whose maintenance tax liability under this chapter for the previous tax year was at least \$2,000.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

CHAPTER 255. WORKERS' COMPENSATION INSURANCE

Sec. 255.001. MAINTENANCE TAX IMPOSED. (a) A maintenance tax is imposed on each authorized insurer with gross premiums subject to taxation under Section 255.003, including a:

- (1) stock insurance company;
- (2) mutual insurance company;
- (3) reciprocal or interinsurance exchange; and
- (4) Lloyd's plan.

(b) The tax required by this chapter is in addition to other taxes imposed that are not in conflict with this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 255.002. MAXIMUM RATE; ANNUAL ADJUSTMENT. (a) The rate of assessment set by the commissioner may not exceed 0.6 percent of the gross premiums subject to taxation under Section 255.003.

(b) The commissioner shall annually adjust the rate of assessment of the maintenance tax so that the tax imposed that year, together with any unexpended funds produced by the tax, produces the amount the commissioner determines is necessary to pay the expenses during the succeeding year of regulating workers' compensation insurance.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 255.003. PREMIUMS SUBJECT TO TAXATION. (a) An insurer shall pay maintenance taxes under this chapter on the correctly reported gross workers' compensation insurance premiums from writing workers' compensation insurance in this state, including the modified annual premium of a policyholder that purchases an optional deductible plan under Subchapter E, Chapter 2053.

(b) The rate of assessment shall be applied to the modified annual premium before application of a deductible premium credit.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2C.005, eff. April 1, 2009.

Sec. 255.004. MAINTENANCE TAX DUE DATES. (a) The insurer shall pay the maintenance tax annually or semiannually.

(b) The comptroller may require semiannual payment only from an insurer whose maintenance tax liability under this chapter for the previous tax year was at least \$2,000.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

CHAPTER 256. AIRCRAFT INSURANCE

Sec. 256.001. MAINTENANCE TAX IMPOSED. A maintenance tax is imposed on each authorized insurer with gross premiums subject to taxation under Section 256.003. The tax required by this chapter is in addition to other taxes imposed that are not in conflict with this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 256.002. MAXIMUM RATE; ANNUAL ADJUSTMENT. (a) The rate of assessment set by the commissioner may not exceed 0.4 percent of the gross premiums subject to taxation under Section 256.003.

(b) The commissioner shall annually adjust the rate of assessment of the maintenance tax so that the tax imposed that year, together with any unexpended funds produced by the tax, produces the amount the commissioner determines is necessary to pay the expenses during the succeeding year of regulating all classes of insurance specified under Chapter 2101.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2C.006, eff. April 1, 2009.

Sec. 256.003. PREMIUMS SUBJECT TO TAXATION. An insurer shall pay maintenance taxes under this chapter on the correctly reported gross premiums from writing a class of insurance specified under Chapter 2101.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2C.007, eff. April 1, 2009.

Sec. 256.004. MAINTENANCE TAX DUE DATES. (a) The insurer shall pay the maintenance tax annually or semiannually, as determined by the comptroller.

(b) The comptroller may require semiannual payment only from an insurer whose maintenance tax liability under this chapter for the previous tax year was at least \$2,000.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

CHAPTER 257. LIFE, HEALTH, AND ACCIDENT INSURANCE

Sec. 257.001. MAINTENANCE TAX IMPOSED. (a) A maintenance tax is imposed on each authorized insurer, including a group hospital service corporation, managed care organization, local mutual aid association, statewide mutual assessment company, stipulated premium company, and stock or mutual insurance company, that collects from residents of this state gross premiums or gross considerations subject to taxation under Section 257.003. The tax required by this chapter is in addition to other taxes imposed that are not in conflict with this chapter.

(b) In this section, "managed care organization" means an organization authorized under this code to engage in the business of issuing health benefit plans that is not authorized as a health maintenance organization, preferred provider organization, or insurance company and the taxation of which is not preempted by federal law.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 932 (H.B. 3315), Sec. 14, eff. June 15, 2007.

Sec. 257.002. MAXIMUM RATE; ANNUAL ADJUSTMENT. (a) The rate of assessment set by the commissioner may not exceed 0.04 percent of the gross premiums and gross considerations subject to taxation under Section 257.003.

(b) The commissioner shall annually adjust the rate of assessment of the maintenance tax so that the tax imposed that year, together with any unexpended funds produced by the tax, produces the amount the commissioner determines is necessary to pay the expenses during the succeeding year of regulating life, health, and accident insurers.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 257.003. PREMIUMS AND CONSIDERATIONS SUBJECT TO TAXATION; LIMIT. (a) An insurer shall pay maintenance taxes under this chapter on the correctly reported:

(1) gross premiums collected from writing life, health, and accident insurance in this state, except as provided in Subsection

(b); and

(2) gross considerations collected from writing annuity or endowment contracts in this state.

(b) The gross premiums on which an assessment is based under this chapter may not include:

(1) premiums received from the United States for insurance contracted for by the United States in accordance with or in furtherance of Title XVIII of the Social Security Act (42 U.S.C. Section 1395c et seq.) and its subsequent amendments; or

(2) premiums paid on group health, accident, and life policies in which the group covered by the policy consists of a single nonprofit trust established to provide coverage primarily for employees of:

(A) a municipality, county, or hospital district in this state; or

(B) a county or municipal hospital, without regard to whether the employees are employees of the county or municipality or of an entity operating the hospital on behalf of the county or municipality.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.
Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.006(a), eff. September 1, 2005.

Sec. 257.004. MAINTENANCE TAX DUE DATES. (a) The insurer shall pay the maintenance tax annually, semiannually, or on another periodic basis, as determined by the comptroller.

(b) The comptroller may require semiannual or other periodic payment only from an insurer whose maintenance tax liability under this chapter for the previous year was at least \$2,000.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

CHAPTER 258. HEALTH MAINTENANCE ORGANIZATIONS

Sec. 258.001. APPLICABILITY OF CERTAIN DEFINITIONS. In this chapter, a term defined by Section 843.002 has the meaning assigned by that section.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 258.002. MAINTENANCE TAX IMPOSED. A per capita maintenance tax is imposed on each authorized health maintenance organization with gross revenues subject to taxation under Section 258.004. The tax required by this chapter is in addition to other taxes imposed that are not in conflict with this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 258.003. MAXIMUM RATE; ANNUAL ADJUSTMENT. (a) The rate of assessment set by the commissioner may not exceed \$2 per enrollee.

(b) The commissioner shall annually adjust the rate of assessment of the per capita maintenance tax so that the tax imposed that year, together with any unexpended funds produced by the tax, produces the amount the commissioner determines is necessary to pay the expenses during the succeeding year of regulating health maintenance organizations.

(c) The rate of assessment may differ between basic health care plans, limited health care service plans, and single health care service plans and must equitably reflect any differences in regulatory resources attributable to each type of plan.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 258.004. REVENUES SUBJECT TO TAXATION; LIMIT. (a) A health maintenance organization shall pay per capita maintenance taxes under this chapter on the correctly reported gross revenues collected from issuing health maintenance certificates or contracts in this state.

(b) The amount of maintenance tax assessed may not be computed based on:

(1) enrollees who as individual certificate holders or their dependents are covered by a master group policy paid for by revenues received from the United States for insurance contracted for by the United States in accordance with or in furtherance of Title XVIII of the Social Security Act (42 U.S.C. Section 1395c et seq.) and its subsequent amendments; or

(2) revenues paid on group health, accident, and life certificates or contracts in which the group covered by the certificate or contract consists of a single nonprofit trust established to provide coverage primarily for employees of:

(A) a municipality, county, or hospital district in this state; or

(B) a county or municipal hospital, without regard to whether the employees are employees of the county or municipality or of an entity operating the hospital on behalf of the county or municipality.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.
Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.007(a), eff. September 1, 2005.

Sec. 258.005. MAINTENANCE TAX DUE DATES. (a) The health maintenance organization shall pay the maintenance tax annually or semiannually.

(b) The comptroller may require semiannual or other periodic payment only from a health maintenance organization whose maintenance tax liability under this chapter for the previous year was at least \$2,000.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

CHAPTER 259. THIRD-PARTY ADMINISTRATORS

Sec. 259.001. DEFINITIONS. In this chapter:

(1) "Administrative or service fees" means all consideration, fees, assessments, payments, reimbursements, dues, and other compensation received for services as an administrator during a calendar year. The term does not include sales commissions.

(2) "Administrator" has the meaning assigned by Section 4151.001.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 259.002. MAINTENANCE TAX IMPOSED. A maintenance tax is

imposed on each authorized administrator with administrative or service fees subject to taxation under Section 259.004. The tax required by this chapter is in addition to other taxes imposed that are not in conflict with this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 259.003. MAXIMUM RATE; ANNUAL ADJUSTMENT. (a) The rate of assessment set by the commissioner may not exceed one percent of the administrative or service fees subject to taxation under Section 259.004.

(b) The commissioner shall annually adjust the rate of assessment of the maintenance tax so that the tax imposed that year, together with any unexpended funds produced by the tax, produces the amount the commissioner determines is necessary to pay the expenses of regulating administrators.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 259.004. ADMINISTRATIVE AND SERVICE FEES SUBJECT TO TAXATION. An administrator shall pay maintenance taxes under this chapter on the administrator's correctly reported administrative or service fees.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 259.005. MAINTENANCE TAX DUE DATES. The administrator shall pay the maintenance tax annually, semiannually, or on another periodic basis, as determined by the comptroller.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

CHAPTER 261. TEXAS INSURANCE EXCHANGE

Sec. 261.001. DEFINITION. In this chapter, "exchange" means the Texas Insurance Exchange.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 261.002. MAINTENANCE TAX IMPOSED. A maintenance tax is imposed on the gross premiums paid through the exchange and subject to taxation under Section 261.004.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 261.003. MAXIMUM RATE; ANNUAL ADJUSTMENT. (a) The rate of assessment set by the commissioner may not exceed one percent of the gross premiums subject to taxation under Section 261.004.

(b) The commissioner shall annually adjust the rate of assessment of the maintenance tax so that the tax imposed that year, together with any unexpended funds produced by the tax, produces the amount the commissioner determines is necessary to pay the expenses during the succeeding year of regulating all classes of insurance specified under Chapter 2204.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2C.008, eff. April 1, 2009.

Sec. 261.004. PREMIUMS SUBJECT TO TAXATION. The exchange shall pay maintenance taxes under this chapter on the correctly reported gross premiums paid through the exchange on all classes of insurance specified under Chapter 2204.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2C.009, eff. April 1, 2009.

Sec. 261.005. MAINTENANCE TAX DUE DATES. The exchange shall pay the maintenance tax annually, semiannually, or on another periodic basis, as determined by the comptroller.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

SUBTITLE D. TITLE INSURANCE MAINTENANCE FEES
CHAPTER 271. TITLE INSURANCE MAINTENANCE FEES

Sec. 271.001. APPLICABILITY OF CERTAIN DEFINITIONS. In this chapter, a term defined by Chapter 2501 has the meaning assigned by that chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 271.002. MAINTENANCE FEE IMPOSED. (a) A maintenance fee is imposed on all premiums subject to assessment under Section 271.006.

(b) The maintenance fee is not a tax and shall be reported and paid separately from premium and retaliatory taxes.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 932 (H.B. [3315](#)), Sec. 15, eff. June 15, 2007.

Sec. 271.003. DUPLICATION OF ASSESSMENT PROHIBITED WITH RESPECT TO TITLE INSURANCE AGENTS. The maintenance fee is included in the division of premiums and may not be separately charged to a title insurance agent.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 271.004. DETERMINING RATE OF ASSESSMENT. (a) The commissioner shall annually determine the rate of assessment of the maintenance fee.

(b) In determining the rate of assessment, the commissioner shall consider the requirement to reimburse the appropriate portion of the general revenue fund under Section 201.052.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 271.005. MAXIMUM RATE; ANNUAL ADJUSTMENT. (a) The rate of assessment set by the commissioner may not exceed one percent of the gross premiums subject to assessment under Section 271.006.

(b) The commissioner shall annually adjust the rate of assessment of the maintenance fee so that the fee imposed that year, together with any unexpended funds produced by the fee, produces the amount the commissioner determines is necessary to pay the expenses during the succeeding year of regulating title insurance.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 271.006. PREMIUMS SUBJECT TO ASSESSMENT. An insurer shall pay maintenance fees under this chapter on the correctly reported gross premiums from writing title insurance in this state.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 271.007. COLLECTION OF MAINTENANCE FEE. The comptroller shall collect the maintenance fee.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 271.008. DUTY TO ADVISE COMPTROLLER OF RATE. The commissioner shall advise the comptroller of the applicable rate of assessment of the maintenance fee not later than the 45th day before the due date of the maintenance fee return for the period for which that fee is due.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 271.009. EFFECT OF LATE ADVISEMENT OF RATE. (a) Except as provided by Subsection (b), if the commissioner does not advise the comptroller of the applicable rate of assessment of the maintenance fee by the date required by Section 271.008, the rate of assessment is the rate imposed in the preceding period.

(b) If the commissioner advises the comptroller of the applicable rate of assessment after the fee has been assessed, the

comptroller shall:

- (1) advise each insurer in writing of the amount of any additional fees due; or
- (2) refund any excess fees paid.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 271.010. DEPOSIT OF MAINTENANCE FEES. (a) The comptroller shall deposit maintenance fees collected under this chapter in the general revenue fund to be reallocated to the Texas Department of Insurance operating account.

(b) Amounts in the Texas Department of Insurance operating account may be transferred to the appropriate portion of the general revenue fund in accordance with Section 201.052.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 271.011. MAINTENANCE FEE DUE DATES. (a) The insurer shall pay the maintenance fee on an annual, semiannual, or other periodic basis, as determined by the comptroller.

(b) The comptroller may require semiannual or other periodic payment only from an insurer whose maintenance fee liability under this chapter for the preceding year was at least \$2,000.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 271.012. RULES. The commissioner may adopt reasonable rules to implement payments under this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

SUBTITLE E. OTHER TAXES

CHAPTER 281. RETALIATORY PROVISIONS

SUBCHAPTER A. RETALIATORY TAXES AND OTHER CHARGES

Sec. 281.001. DEFINITIONS. In this subchapter:

- (1) "Domestic insurer" means an insurer organized in this state.

(2) "Foreign insurer" means an insurer organized in another state.

(3) "Tax or other charge" includes:

(A) a tax, including an income, corporate franchise, or maintenance tax;

(B) a fee, including a regulatory fee similar to a maintenance tax;

(C) a license;

(D) a fine;

(E) a penalty;

(F) a deposit requirement; and

(G) any other obligation.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 281.002. TREATMENT OF ALIEN INSURER AS FOREIGN INSURER.

For purposes of this subchapter, an alien insurer is considered to be organized in the state designated by the insurer in which the insurer:

(1) has established its principal office or agency in the United States;

(2) maintains the greatest amount of its assets held in trust or on deposit for the security of its policyholders or policyholders and creditors in the United States; or

(3) was admitted to engage in business in the United States.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 281.003. EXCEPTION. This subchapter does not apply to a person, company, firm, association, group, corporation, or insurance organization of any kind from another state that engages in business in this state if:

(1) at least 15 percent of the voting stock of the person, company, firm, association, group, corporation, or insurance organization is owned by a corporation organized under the laws of and domiciled in this state; and

(2) the person, company, firm, association, group, corporation, or insurance organization met the requirements of

Subdivision (1) before January 30, 1957.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 281.004. RETALIATORY TAXES OR OTHER CHARGES, PROHIBITIONS, AND RESTRICTIONS. (a) The comptroller shall impose and collect a tax or other charge or a prohibition or restriction on a foreign insurer authorized to engage in business in this state if:

(1) the foreign insurer's state of organization by law imposes a tax or other charge or a prohibition or restriction on a similar domestic insurer that is or may be authorized to engage in business in that other state; and

(2) the sum of the taxes or other charges, prohibitions, and restrictions imposed by that other state is more than the sum of the taxes or other charges, prohibitions, and restrictions that this state directly imposes on the foreign insurer.

(b) The comptroller shall impose and collect the tax or other charge, prohibition, or restriction under Subsection (a) in the same manner and for the same purpose as the foreign insurer's state of organization.

(c) The sum of the taxes or other charges that this state imposes on a foreign insurer under this subchapter may not exceed the sum of the taxes or other charges imposed by the foreign insurer's state of organization on a similar domestic insurer that is or may be authorized to engage in business in that other state.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 281.005. EXCLUSION OF CERTAIN TAXES OR CHARGES. In determining an insurer's taxes or other charges under this subchapter, the comptroller may not consider:

(1) an ad valorem tax on property;

(2) a personal income tax;

(3) a sales tax;

(4) a surcharge that an insurer may recover directly from policyholders; or

(5) an assessment for a special purpose, such as an assessment for a guaranty association, high risk health pool, joint underwriting association, or windstorm association, under the law of

this or another state.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 281.006. TREATMENT OF CERTAIN TAX REDUCTIONS AND CREDITS.

(a) Repealed by Acts 2007, 80th Leg., R.S., Ch. 932, Sec. 22(b), eff. June 15, 2007.

(b) For purposes of this subchapter, a tax offset or credit related to an assessment described by Section 281.005 is considered a tax paid in this or another state, as appropriate.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 932 (H.B. 3315), Sec. 22(b), eff. June 15, 2007.

Sec. 281.007. TAX REPORT; ADMINISTRATION AND COLLECTION OF TAX. The comptroller shall prescribe a due date for filing a report and paying a tax imposed under this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 281.008. RECIPROCITY AGREEMENTS. The comptroller by rule may enter into a reciprocity agreement with another state under which the parties agree to mutually set aside retaliatory provisions in situations in which this state and the other state determine that retaliation is not the preferred approach to protect their domestic insurers from excessive taxation or other financial obligations. In adopting rules under this section, the comptroller may not adopt a rule that does not specifically implement this section.

Added by Acts 2007, 80th Leg., R.S., Ch. 932 (H.B. 3315), Sec. 16, eff. June 15, 2007.

SUBCHAPTER B. RETALIATORY PENALTIES OR OTHER OBLIGATIONS

Sec. 281.051. DEFINITIONS. In this subchapter:

(1) "Domestic insurer" and "foreign insurer" have the

meanings assigned by Section 281.001.

(2) "Penalty or other obligation" includes a sanction, fine, financial, deposit, or regulatory requirement, and any other obligation, prohibition, or restriction.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

Sec. 281.052. IMPOSITION OF PENALTY OR OTHER OBLIGATION. (a) The Texas Department of Insurance shall impose a penalty or other obligation on a foreign insurer authorized to engage in the business of insurance in this state if:

(1) the insurance department or an insurance regulatory official of the foreign insurer's state of organization imposes a penalty or other obligation on any domestic insurer authorized to engage in the business of insurance in that state; and

(2) the penalty or other obligation is imposed because the Texas Department of Insurance did not:

(A) obtain or maintain accreditation certification or a similar form of approval, compliance, or acceptance from or as a member of the National Association of Insurance Commissioners or a committee, task force, working group, or advisory committee of the association; or

(B) comply with a model act, regulation, report, or requirement of the National Association of Insurance Commissioners or a committee, task force, working group, or advisory committee of the association, including a market conduct, financial examination, or annual financial statement.

(b) A penalty or other obligation imposed by the Texas Department of Insurance on a foreign insurer under this section must be the same as the penalty or other obligation imposed on the domestic insurer by the insurance department or regulatory official of the foreign insurer's state of organization.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 1, eff. April 1, 2005.

TITLE 4. REGULATION OF SOLVENCY
SUBTITLE A. GENERAL PROVISIONS
CHAPTER 401. AUDITS AND EXAMINATIONS
SUBCHAPTER A. INDEPENDENT AUDIT OF FINANCIAL STATEMENTS

Sec. 401.001. DEFINITIONS. In this subchapter:

(1) "Accountant" means an independent certified public accountant or accounting firm that meets the requirements of Section 401.011.

(2) "Affiliate" has the meaning assigned by Section 823.003.

(3) "Health maintenance organization" means a health maintenance organization authorized to engage in business in this state.

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

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

(B) a fire and marine insurance company;

(C) a general casualty company;

(D) a title insurance company;

(E) a fraternal benefit society;

(F) a mutual life insurance company;

(G) a local mutual aid association;

(H) a statewide mutual assessment company;

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

(J) a farm mutual insurance company;

(K) a county mutual insurance company;

(L) a Lloyd's plan;

(M) a reciprocal or interinsurance exchange;

(N) a group hospital service corporation;

(O) a stipulated premium company; and

(P) a nonprofit legal services corporation.

(5) "Subsidiary" has the meaning assigned by Section 823.003.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 401.002. PURPOSE OF SUBCHAPTER. The purpose of this subchapter is to require an annual audit by an independent certified public accountant of the financial statements reporting the financial condition and the results of operations of each insurer or health maintenance organization.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 401.003. EFFECT OF SUBCHAPTER ON AUTHORITY TO EXAMINE.

This subchapter does not limit the commissioner's authority to order or the department's authority to conduct an examination of an insurer or health maintenance organization under this code or the commissioner's rules.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

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

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

(2) file with the commissioner on or before June 30 an audited financial report for the preceding calendar year.

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

(c) An insurer or health maintenance organization may request an extension of the filing date by submitting the request in writing before the 10th day preceding the filing date. The request must include sufficient detail for the commissioner to make an informed decision on the requested extension. The commissioner may extend the filing date for one or more 30-day periods if the commissioner determines that there is good cause for the extension based on a showing by the insurer or health maintenance organization and the insurer's or health maintenance organization's accountant of the reasons for requesting the extension.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 401.005. ALTERNATIVE FILING FOR CANADIAN OR BRITISH INSURERS OR HEALTH MAINTENANCE ORGANIZATIONS. (a) Instead of the audited financial report required by Section 401.004, an insurer or health maintenance organization domiciled in Canada or the United Kingdom may file the insurer's or health maintenance organization's annual statement of total business on the form filed by the insurer or health maintenance organization with the appropriate regulatory authority in the country of domicile. The statement must be audited by an independent accountant chartered in the country of domicile.

(b) The chartered accountant must be registered with the commissioner under Section 401.014(a). The registration must be accompanied by a statement, signed by the accountant, indicating that the accountant is aware of the requirements of this subchapter and affirming that the accountant will express the accountant's opinion in conformity with those requirements.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

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

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

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

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 401.007. EXEMPTION FOR CERTAIN FOREIGN OR ALIEN INSURERS OR HEALTH MAINTENANCE ORGANIZATIONS. (a) A foreign or alien insurer or health maintenance organization that files an audited financial report in another state in accordance with that state's requirements for audited financial reports may be exempt from filing a report under this subchapter if the commissioner finds that the other state's requirements are substantially similar to the requirements prescribed by this subchapter.

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

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

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

(c) The reports and letter required by Subsection (b)(1) must be filed in accordance with the filing dates prescribed by Sections 401.004 and 401.019. The report required by Subsection (b)(2) must be filed in accordance with the filing date prescribed by Section 401.017.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

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

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

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

section if:

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

(2) the insurer or health maintenance organization:

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

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

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

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

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

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

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

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 401.009. CONTENTS OF AUDITED FINANCIAL REPORT. (a) An audited financial report required under Section 401.004 must:

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

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

(3) include:

(A) the report of an accountant;

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

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

(D) a statement of cash flows;

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

(F) any notes to financial statements;

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

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

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

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

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

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

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

(d) The commissioner shall adopt rules governing the information to be included in the audited financial report under Subsection (a)(3)(H).

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 401.010. REQUIREMENTS FOR FINANCIAL STATEMENTS IN AUDITED FINANCIAL REPORT. (a) An accountant must audit the financial reports provided by an insurer or health maintenance organization for purposes of an audit under this subchapter. The accountant who

audits the reports must conduct the audit in accordance with generally accepted auditing standards or with standards adopted by the Public Company Accounting Oversight Board, as applicable, and must consider the standards specified in the Financial Condition Examiner's Handbook adopted by the National Association of Insurance Commissioners or other analogous nationally recognized standards adopted by commissioner rule.

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

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.001(a), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.001(a), eff. September 1, 2007.

Sec. 401.011. QUALIFICATIONS OF ACCOUNTANT; ACCEPTANCE OF AUDITED FINANCIAL REPORT. (a) Except as provided by Subsections (c) and (d), the commissioner shall accept an audited financial report from an independent certified public accountant or accounting firm that:

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

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

(b) If the insurer or health maintenance organization is

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

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

- (1) the number of partners or individuals the accountant employs, the expertise of the partners or individuals the accountant employs, or the number of the accountant's insurance clients;
- (2) the premium volume of the insurer or health maintenance organization; and
- (3) the number of jurisdictions in which the insurer or health maintenance organization engages in business.

(d) The commissioner may not accept an audited financial report prepared wholly or partly by an individual or firm who the commissioner finds:

- (1) has been convicted of fraud, bribery, a violation of the Racketeer Influenced and Corrupt Organizations Act (18 U.S.C. Section 1961 et seq.), or a state or federal criminal offense involving dishonest conduct;
- (2) has violated the insurance laws of this state with respect to a report filed under this subchapter;
- (3) has demonstrated a pattern or practice of failing to detect or disclose material information in reports filed under this subchapter; or
- (4) has directly or indirectly entered into an agreement of indemnity or release of liability regarding an audit of an

insurer.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.002(a), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.002(a), eff. September 1, 2007.

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

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 401.013. ACCOUNTANT'S LETTER OF QUALIFICATIONS. (a) The audited financial report required under Section 401.004 must be accompanied by a letter provided by the accountant who performed the audit stating:

- (1) the accountant's general background and experience;
- (2) the experience of each individual assigned to prepare the audit in auditing insurers or health maintenance organizations and whether the individual is an independent certified public accountant; and
- (3) that the accountant:
 - (A) is properly licensed by an appropriate state licensing authority, is a member in good standing of the American Institute of Certified Public Accountants, and is otherwise qualified under Section 401.011;
 - (B) is independent from the insurer or health

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

(C) understands that:

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

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

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

(b) Subsection (a)(2) does not prohibit an accountant from using any staff the accountant considers appropriate if use of that staff is consistent with generally accepted auditing standards.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 401.014. REGISTRATION OF ACCOUNTANT. (a) Not later than December 31 of the calendar year to be covered by an audited financial report required by this subchapter, an insurer or health maintenance organization must register in writing with the commissioner the name and address of the accountant retained to prepare the report.

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

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

(2) affirming that the accountant will express the accountant's opinion on the financial statements in terms of the statements' conformity to the statutory accounting practices prescribed or otherwise permitted by the insurance department

described by Subdivision (1) and specifying any exceptions the accountant believes are appropriate.

(c) The commissioner may not accept an audited financial report prepared by an accountant who is not registered under this section.

(d) The commissioner may not accept the registration of a person who does not qualify under Section 401.011 or does not comply with the other requirements of this subchapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 401.015. RESIGNATION OR DISMISSAL OF ACCOUNTANT; STATEMENT CONCERNING DISAGREEMENTS. (a) If an accountant who signed an audited financial report for an insurer or health maintenance organization resigns as accountant for the insurer or health maintenance organization or is dismissed by the insurer or health maintenance organization after the report is filed, the insurer or health maintenance organization shall notify the department not later than the fifth business day after the date of the resignation or dismissal.

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

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

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

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

(c) The statement required by Subsection (b) must include a description of disagreements that were resolved to the accountant's satisfaction and those that were not resolved to the accountant's satisfaction.

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

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

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

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

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

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

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

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

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

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

(4) explanations of consolidating and eliminating entries;
and

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

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

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

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

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

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

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

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

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

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

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

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 401.018. INFORMATION DISCOVERED AFTER DATE OF AUDITED FINANCIAL REPORT. If, after the date of an audited financial report filed under this subchapter, the accountant becomes aware of facts that might have affected the report, the accountant must take action as prescribed in Volume 1, AU Section 561, Professional Standards of the American Institute of Certified Public Accountants.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 401.019. REPORT ON SIGNIFICANT DEFICIENCIES IN INTERNAL CONTROL. (a) In addition to the audited financial report required by this subchapter, each insurer or health maintenance organization shall provide to the commissioner a written report of significant deficiencies required and prepared by an accountant in accordance with the Professional Standards of the American Institute of Certified Public Accountants.

(b) The insurer or health maintenance organization shall annually file with the commissioner the report required by this section not later than the 60th day after the date the audited financial report is filed. The insurer or health maintenance organization shall also provide a description of remedial actions

taken or proposed to be taken to correct significant deficiencies, if the actions are not described in the accountant's report.

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

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 401.020. ACCOUNTANT WORK PAPERS. (a) In this section, "work papers" means the records kept by an accountant of the procedures followed, the tests performed, the information obtained, and the conclusions reached that are pertinent to the accountant's audit of an insurer's or health maintenance organization's financial statements. The term includes work programs, analyses, memoranda, letters of confirmation and representation, abstracts of company documents and schedules, and commentaries prepared or obtained by the accountant in the course of auditing the financial statements that support the accountant's opinion.

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

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

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

(c) The department may copy and retain the copies of pertinent work papers when the department's examiners conduct a review under Subsection (b). The review is considered an investigation, and work papers obtained during that investigation may be made confidential by

the commissioner, unless the work papers are admitted as evidence in a hearing before a governmental agency or in a court.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 401.021. PENALTY FOR FAILURE TO COMPLY. (a) If an insurer or health maintenance organization fails to comply with this subchapter, the commissioner shall order that the insurer's or health maintenance organization's annual audit be performed by a qualified independent certified public accountant.

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

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

(d) Money collected under this section shall be deposited to the credit of the Texas Department of Insurance operating account for use by the commissioner and the department to pay the expenses incurred under this subchapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

SUBCHAPTER B. EXAMINATION OF CARRIERS

Sec. 401.051. DUTY TO EXAMINE CARRIERS. (a) The department or an examiner appointed by the department shall visit at the carrier's principal office:

(1) each carrier that is organized under the laws of this state; and

(2) each other carrier that is authorized to engage in business in this state.

(b) The department or an examiner appointed by the department may visit the carrier for the purpose of investigating the carrier's affairs and condition. The department or an examiner appointed by the department shall examine the carrier's financial condition and ability to meet the carrier's liabilities and compliance with the

laws of this state that affect the conduct of the carrier's business.

(c) The department or an examiner appointed by the department may conduct the visit and examination of a carrier described by Subsection (a)(2) alone or with representatives of the insurance supervising departments of other states.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 401.052. FREQUENCY OF EXAMINATION. (a) Subject to Subsection (b) and except as provided by the rules adopted under that subsection, the department shall visit and examine a carrier as frequently as the department considers necessary. At a minimum, the department shall examine a carrier not less frequently than once every five years.

(b) The commissioner shall adopt rules governing the frequency of examinations of carriers that have been organized or incorporated for less than five years.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 188 (S.B. 1253), Sec. 1, eff. September 1, 2007.

Sec. 401.053. EXAMINATION PERIOD. Unless the department requests that an examination cover a longer period, the examination must cover the period beginning on the last day covered by the most recent examination and ending on December 31 of the year preceding the year in which the examination is being conducted.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 401.054. POWERS RELATED TO EXAMINATION. The department or the examiner appointed by the department:

(1) has free access, and may require the carrier or the carrier's agent to provide free access, to all books and papers of

the carrier or the carrier's agent that relate to the carrier's business and affairs; and

(2) has the authority to summon and examine under oath, if necessary, an officer, agent, or employee of the carrier or any other person in relation to the carrier's affairs and condition.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 401.055. EFFECT OF SUBCHAPTER ON AUTHORITY TO USE INFORMATION. This subchapter does not limit the commissioner's authority to use a final or preliminary examination report, an examiner's or company's work papers or other documents, or any other information discovered or developed during an examination in connection with a legal or regulatory action that the commissioner, in the commissioner's sole discretion, considers appropriate.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 401.056. RULES RELATED TO REPORTS AND HEARINGS. The commissioner by rule shall adopt:

(1) procedures governing the filing and adoption of an examination report;

(2) procedures governing a hearing to be held under this subchapter; and

(3) guidelines governing an order issued under this subchapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 401.057. USE OF AUDIT AND WORK PAPERS. (a) In this section, "work papers" has the meaning assigned by Section 401.020(a).

(b) In conducting an examination under this subchapter, the department shall use audits and work papers that the carrier makes available to the department and that are prepared by an accountant or

accounting firm meeting the qualifications of Section 401.011. The department may conduct a separate audit of the carrier if necessary. Work papers developed in the audit shall be maintained in the manner provided by Sections 401.020(b) and (c).

(c) The carrier shall provide the department with:

(1) the work papers of an accountant or accounting firm or the carrier; and

(2) a record of any communications between the accountant or accounting firm and the carrier that relate to an audit.

(d) The accountant or accounting firm shall deliver the information described by Subsection (c) to the examiner. The examiner shall retain the information during the department's examination of the carrier.

(e) Information obtained under this section is confidential and may not be disclosed to the public except when introduced as evidence in a hearing.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 401.058. CONFIDENTIALITY OF REPORTS AND RELATED INFORMATION. (a) A final or preliminary examination report and any information obtained during an examination are confidential and privileged for all purposes. This information is not subject to:

- (1) disclosure under Chapter 552, Government Code;
- (2) a subpoena, other than a grand jury subpoena; or
- (3) discovery or admissibility in evidence in a civil

action.

(b) Subsection (a) applies if the examined carrier is under supervision or conservatorship. Subsection (a) does not apply to an examination conducted in connection with a liquidation or receivership under this code or another insurance law of this state.

(c) Subsection (a) does not limit the commissioner's authority to use a final or preliminary examination report and any information obtained during an examination in the furtherance of any legal or regulatory action relating to the administration of this code that the commissioner, in the commissioner's sole discretion, considers appropriate.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April

1, 2007.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 164 (H.B. 2437), Sec. 1, eff. May 26, 2017.

Sec. 401.059. DETERMINATION OF VALUE. In determining the value or market value of an investment in or on real estate or an improvement to real estate by a carrier authorized to engage in business in this state, the department, in administering this code, may consider any factor or matter that the department considers proper and material, including:

- (1) an appraisal by a real estate board or other qualified person;
- (2) an affidavit by another person familiar with those values;
- (3) a tax valuation;
- (4) the cost of acquisition after deducting for depreciation and obsolescence;
- (5) the cost of replacement;
- (6) sales of other comparable property;
- (7) enhancement in value from any cause;
- (8) income received or to be received; and
- (9) any improvements made.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 401.060. RIGHT TO INFORMATION RELATING TO DETERMINATION OF VALUE OR MARKET VALUE. (a) If the department determines the value or market value of an insurer's investment in or on real estate or an improvement to real estate, the insurer is entitled to make a written request for a written finding by the commissioner in relation to that determination.

(b) Not later than the 10th day after the date the commissioner receives a request under Subsection (a), the commissioner shall enter a written order or finding that:

- (1) states separately the department's findings on each factor or matter on which the department relied in making the

determination; and

(2) includes the name and address of each person who provided evidence relating to a factor or matter on which the department relied in making the determination.

(c) The commissioner shall provide to the insurer that requested a written finding under this section a copy of the finding or order.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 401.061. DISCIPLINARY ACTION FOR FAILURE TO COMPLY WITH SUBCHAPTER. A carrier is subject to disciplinary action under Chapter 82 if the carrier or the carrier's agent fails or refuses to comply with:

(1) this subchapter or a rule adopted under this subchapter; or

(2) a request by the department or an appointed examiner to be examined or to provide information requested as part of an examination.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 401.062. STAY OF RULE, ORDER, DECISION, OR FINDING. The filing of a petition under Subchapter D, Chapter 36, for judicial review of a rule, order, decision, or finding of the commissioner or department under this subchapter operates as a stay of the rule, order, decision, or finding until the court directs otherwise.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

SUBCHAPTER C. EXAMINERS AND ACTUARIES

Sec. 401.101. USE OF DEPARTMENT EXAMINER OR OTHER QUALIFIED PERSON OR FIRM. The department may use a salaried department examiner or may appoint a qualified person or firm to perform an examination of an insurance organization as provided by law or to

assist in the performance of an examination.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 401.102. LEGISLATIVE INTENT AS TO APPOINTMENT OR EMPLOYMENT OF EXAMINERS AND ACTUARIES. (a) The legislature recognizes that experienced, highly qualified examiners and actuaries are necessary for the department to effectively monitor and regulate the solvency of insurers in this state. It is the intent of the legislature that the department, in appointing or employing an examiner or actuary, select a person who:

(1) has substantial experience in financial matters relating to insurance or other areas of financial activity that are compatible with the business of insurance; and

(2) is recognized for the outstanding quality of the person's work in relation to areas of responsibility typically assigned to an examiner or actuary in the insurance field.

(b) The legislature pledges to provide to the department the necessary funding to implement this section and to support the department in the department's efforts to attract the highly qualified persons necessary to fulfill regulatory responsibilities relating to insurer solvency assigned to those persons under the insurance laws of this state.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 401.103. APPOINTMENT OF EXAMINERS AND ACTUARIES. (a) The department shall appoint:

(1) a chief examiner and the number of assistant examiners the department considers necessary to conduct examinations of insurance companies, corporations, and associations at the expense of the insurance company, corporation, or association as provided by law; and

(2) the number of actuaries the department considers necessary to:

(A) advise the department in connection with the performance of the department's duties; and

(B) otherwise aid and counsel the department in connection with the examinations.

(b) The department may increase or decrease the number of examiners or actuaries as needed for examination duties.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 401.104. APPOINTMENT OF EXAMINERS, ACTUARIES, AND OTHER PERSONS FOR CERTAIN EXAMINATIONS. (a) The department may commission a department actuary, the chief examiner, another department examiner or employee, or any other person to conduct or assist in the examination of a company that is not organized under the laws of this state.

(b) The department may compensate a person described by Subsection (a). If the department compensates the person, the person may not receive any other compensation while the person is assigned to the examination.

(c) Except as provided by this section and Section 401.152, a department actuary or examiner may not continue to serve in that capacity if the person directly or indirectly accepts employment or compensation for a service rendered or to be rendered from any insurance company for any reason.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 401.105. OATH OF EXAMINERS AND ASSISTANTS. Before entering into the duties of appointment as an examiner or assistant examiner, an individual must take and file in the office of the secretary of state an oath to:

- (1) support the constitution of this state;
- (2) faithfully conduct the individual's duties of office;
- (3) make fair and impartial examinations;
- (4) not accept, directly or indirectly, as a gift or emolument any pay for the discharge of the individual's duty, other than the compensation to which the individual is entitled by law; and
- (5) not reveal the condition of a corporation, firm, or person or any information secured while examining a corporation,

firm, or person to anyone other than:

(A) the department or an authorized representative of the department; or

(B) as required when testifying in an administrative hearing under this code or another insurance law of this state or in court.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 401.106. RIGHT OF ACTION ON BOND. If an examiner or assistant examiner knowingly makes a false report or gives any information in violation of law that relates to an examination of a corporation, firm, or person, the corporation, firm, or person has a right of action on a bond authorized under Chapter 653, Government Code, for the entity's injuries in a suit brought in the name of the state at the relation of the entity.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 401.107. REGISTRATION OF CONTRACT EXAMINERS. (a) A person with whom another state contracts to perform any examination initiated by the other state of an insurer domiciled in this state shall register with and provide the following information to the department's chief examiner:

- (1) the person's name;
- (2) if the person is not an individual, the identity of each examiner or other person who will perform any part of the examination;
- (3) the name of the state that contracted with the person;
- (4) the identity of the insurer to be examined;
- (5) a description of each issue that the person has been contracted to examine;
- (6) an estimate of the examination costs to be charged to the insurer to be examined;
- (7) a copy of any contract between the person and the state regulatory body that initiated the examination and a letter authorizing the examination; and

(8) a list of the previous examinations conducted on the same insurer on behalf of any state within the last three years.

(a-1) On accepting a person's registration under Subsection (a), the department shall send written confirmation of the acceptance to:

- (1) the person;
- (2) the insurer to be examined; and
- (3) the state regulatory body that initiated the examination.

(b) It is a violation of this code for a person to accept compensation from multiple states for the same examination, if doing so results in duplicative costs to the insurer being examined. It is not a violation of this code for:

- (1) an examiner to conduct an examination of an insurer for the benefit of multiple states in a coordinated examination; and
- (2) the examiner to accept compensation from the states participating in the coordinated examination to reduce the examination costs to the insurer being examined.

Added by Acts 2009, 81st Leg., R.S., Ch. 1030 (H.B. [4359](#)), Sec. 2, eff. June 19, 2009.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 185 (S.B. [1229](#)), Sec. 1, eff. May 28, 2011.

SUBCHAPTER D. EXAMINATION EXPENSES

Sec. 401.151. EXPENSES OF EXAMINATION OF DOMESTIC INSURER. (a) A domestic insurer examined on behalf of this state by the department or under the department's authority shall pay the expenses of the examination in an amount the commissioner certifies as just and reasonable.

(b) The department shall collect an assessment at the time of the examination to cover all expenses attributable directly to that examination, including:

- (1) the salaries and expenses of department employees; and
- (2) expenses described by Section 803.007.

(c) The department shall also impose an annual assessment on domestic insurers in an amount sufficient to meet all other expenses and disbursements necessary to comply with the laws of this state

relating to the examination of insurers.

(d) In determining the amount of the assessment under Subsection (c), the department:

(1) shall consider:

(A) the insurer's total annual premium receipts or admitted assets, or both, that are not attributable to 90 percent of pension plan contracts as defined by Section 818(a), Internal Revenue Code of 1986; or

(B) the total amount of the insurer's insurance in force; and

(2) may not consider insurance premiums for insurance contracted for by a state or federal governmental entity to provide welfare benefits to designated welfare recipients or contracted for in accordance with or in furtherance of Title 2, Human Resources Code, or the federal Social Security Act (42 U.S.C. Section 301 et seq.).

(e) The amount of all examination and evaluation fees paid to the state by an insurer in each taxable year shall be allowed as a credit on the amount of premium taxes due.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 932 (H.B. 3315), Sec. 17, eff. June 15, 2007.

Acts 2011, 82nd Leg., R.S., Ch. 659 (S.B. 1291), Sec. 2, eff. September 1, 2011.

Acts 2011, 82nd Leg., 1st C.S., Ch. 4 (S.B. 1), Sec. 2.04, eff. September 28, 2011.

Sec. 401.152. EXPENSES OF EXAMINATION OF OTHER INSURERS. (a) An insurer not organized under the laws of this state shall reimburse the department for the salary and expenses of each examiner participating in an examination of the insurer and for other department expenses that are properly allocable to the department's participation in the examination.

(a-1) The department shall also impose an annual assessment on insurers not organized under the laws of this state subject to examination as described by this section in an amount sufficient to

meet all other expenses and disbursements necessary to comply with the laws of this state relating to the examination of insurers. The amount imposed under this subsection must be computed in the same manner as the amount imposed under Section 401.151(c) for domestic insurers.

(b) An insurer shall pay the expenses under this section regardless of whether the examination is made only by the department or jointly with the insurance supervisory authority of another state.

(c) The insurer shall pay the expenses directly to the department on presentation of an itemized written statement from the commissioner.

(d) The commissioner shall determine the salary of an examiner participating in an examination of an insurer's books or records located in another state based on the salary rate recommended by the National Association of Insurance Commissioners or the examiner's regular salary rate.

(e) The limitations provided by Sections 803.007(1) and (2)(B) for a domestic company apply to a foreign insurer.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 1286 (H.B. 2163), Sec. 1, eff. September 1, 2013.

Sec. 401.153. REIMBURSEMENT OF EXPENSES OF CERTAIN PERSONS OR FIRMS. (a) A person or firm appointed by the department to examine an insurer or to assist in the insurer's examination shall be paid for those services at the usual and customary rates charged for those services. The insurer being examined shall pay the fee for those services.

(b) The commissioner may disapprove the payment of a fee under Subsection (a) if the fee is excessive in relation to the services actually performed.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 401.154. TAX CREDIT AUTHORIZED. (a) An insurer is

entitled to a credit on the amount of premium taxes to be paid by the insurer for all examination fees paid under Section 401.153. The insurer may take the credit for the taxable year during which the examination fees are paid and may take the credit to the same extent the insurer may take a credit for examination fees paid when a salaried department examiner conducts the examination.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 932 (H.B. 3315), Sec. 18, eff. June 15, 2007.

Acts 2011, 82nd Leg., 1st C.S., Ch. 4 (S.B. 1), Sec. 2.05, eff. September 28, 2011.

Sec. 401.155. ADDITIONAL ASSESSMENTS. (a) The department shall impose additional assessments against insurers on a pro rata basis as necessary to:

(1) cover all expenses and disbursements required by law; and

(2) comply with this subchapter and Sections 401.103, 401.104, 401.105, and 401.106.

(b) The department shall use any surplus resulting from an assessment under this section to reduce the amount of subsequent assessments.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 401.156. DEPOSIT AND USE OF ASSESSMENT AND FEE. (a) The department shall deposit any assessments or fees collected under this subchapter relating to the examination of insurers and other regulated entities by the financial examinations division or actuarial division, as those terms are defined by Section 401.251, to the credit of an account with the Texas Treasury Safekeeping Trust Company to be used exclusively to pay examination costs, as defined by Section 401.251, to reimburse administrative support costs for the Texas Department of Insurance operating account, and to reimburse premium tax credits for examination costs and examination overhead

assessments.

(b) Money deposited under Subsection (a) accumulates and may be disbursed to the department in a manner consistent with that subsection and Subchapter F.

(c) Revenue that is not related to the examination of insurers or other regulated entities by the financial examinations division or actuarial division shall be deposited to the credit of the Texas Department of Insurance operating account.

(d) To the extent that another provision of law conflicts with this section or a provision of this section, this section or the provision of this section controls.

(e) The department may transfer funds between the account described by Subsection (a) and the Texas Department of Insurance operating account as necessary to ensure that funds are deposited to the correct account and used for the correct purposes. This subsection does not authorize a disbursement or transfer of funds in a manner that is inconsistent with the purposes of Subchapter F and this section.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. [2017](#)), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 659 (S.B. [1291](#)), Sec. 3, eff. September 1, 2011.

Acts 2013, 83rd Leg., R.S., Ch. 489 (S.B. [1665](#)), Sec. 1, eff. June 14, 2013.

Acts 2013, 83rd Leg., R.S., Ch. 1286 (H.B. [2163](#)), Sec. 2, eff. September 1, 2013.

Reenacted and amended by Acts 2015, 84th Leg., R.S., Ch. 1236 (S.B. [1296](#)), Sec. 11.001, eff. September 1, 2015.

SUBCHAPTER E. CONFIDENTIALITY OF CERTAIN INFORMATION

Sec. 401.201. CONFIDENTIALITY OF EARLY WARNING SYSTEM INFORMATION. Information relating to the financial solvency of an organization regulated by the department under this code or another insurance law of this state that is obtained by the department's early warning system is confidential and is not subject to disclosure under Chapter 552, Government Code.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. [2017](#)), Sec. 1, eff. April

1, 2007.

SUBCHAPTER F. SELF-DIRECTED BUDGET FOR CERTAIN DIVISIONS

Sec. 401.251. DEFINITIONS. In this subchapter:

(1) "Actuarial division" means the division within the financial program that conducts actuarial examinations of insurers and other entities regulated by the department and administers state laws relating to the level of reserves required of an insurer.

(2) "Examination cost" means a cost associated with salary, travel, or other personnel expenses associated with the examination of insurers and other entities regulated by the department by the financial examinations division or actuarial division.

(3) "Financial examinations division" means the division within the financial program that conducts financial and market conduct examinations of insurers and other entities regulated by the department.

(4) "Financial program" means the program within the department through which the department regulates the financial and operating conditions of, and issues licenses to, domestic and foreign insurers and other entities regulated by the department.

Added by Acts 2011, 82nd Leg., R.S., Ch. 659 (S.B. [1291](#)), Sec. 1, eff. September 1, 2011.

Sec. 401.252. SELF-DIRECTED BUDGET. (a) The senior associate commissioner of the financial program shall submit to the commissioner an annual budget of examination costs using generally accepted accounting principles. Notwithstanding any other provision of law, the budget may be adopted and approved only by the commissioner. The commissioner shall approve a budget under this subsection not later than August 31 of the year in which the associate commissioner submits the budget to the commissioner.

(b) The financial program may not directly or indirectly cause the Texas Department of Insurance operating account to incur any examination cost.

(c) Subject to any limitations in this code or another insurance law of this state, the department may set the amounts of fees required or permitted by statute or rule as necessary to:

(1) carry out the functions of the financial examinations and actuarial divisions relating to the examination of insurers and other regulated entities; and

(2) fund the budget adopted and approved under this section.

(d) Notwithstanding this section, the financial program may receive funds appropriated from the state to fund costs other than examination costs.

(e) An assessment, fee, charge, or other source of revenue collected by the financial program relating to the examination of insurers and other regulated entities by the financial examinations division or actuarial division shall be deposited to the credit of the account described by Section 401.156(a) for the purposes described by that section.

Added by Acts 2011, 82nd Leg., R.S., Ch. 659 (S.B. [1291](#)), Sec. 1, eff. September 1, 2011.

Sec. 401.253. AUDITS. This subchapter does not affect the duty of the state auditor to audit the financial program.

Added by Acts 2011, 82nd Leg., R.S., Ch. 659 (S.B. [1291](#)), Sec. 1, eff. September 1, 2011.

Sec. 401.254. RECORDS; REPORTING REQUIREMENTS. (a) The financial program shall keep financial and statistical information as necessary to disclose completely and accurately the financial program's receipts and examination costs.

(b) The financial program shall submit to the commissioner and the Legislative Budget Board an annual report that states:

(1) the revenue received by the financial program from assessments and fees collected by the department relating to the examination of insurers and other regulated entities;

(2) the total salary for each financial program employee who performs examinations of insurers and other regulated entities;

(3) the portion of the salary paid to each employee from the self-directed budget approved under Section 401.252;

(4) the portion of the salary paid to each employee from funds appropriated to the financial program by the state;

- (5) the total travel expenses incurred by each employee who performs examinations of insurers and other regulated entities;
- (6) the portion of travel expenses paid for each employee from the self-directed budget approved under Section 401.252;
- (7) the portion of travel expenses paid for each employee from funds appropriated to the financial program by the state; and
- (8) all other examination costs of the financial program.

Added by Acts 2011, 82nd Leg., R.S., Ch. 659 (S.B. [1291](#)), Sec. 1, eff. September 1, 2011.

Sec. 401.255. MEMBERSHIP IN EMPLOYEES RETIREMENT SYSTEM. Employees of the actuarial division and financial examinations division are members of the Employees Retirement System of Texas under Chapter 812, Government Code, and the transition to a self-directed budget as provided by this subchapter has no effect on their membership or any benefits under that system.

Added by Acts 2011, 82nd Leg., R.S., Ch. 659 (S.B. [1291](#)), Sec. 1, eff. September 1, 2011.

CHAPTER 402. DISCLOSURE OF MATERIAL TRANSACTIONS
SUBCHAPTER A. GENERAL PROVISIONS

Sec. 402.001. APPLICABILITY OF CHAPTER. (a) Except as provided by Subsection (b), this chapter applies to:

- (1) each of the following domestic or commercially domiciled insurers:
 - (A) a capital stock insurance company;
 - (B) a mutual insurance company;
 - (C) a title insurance company;
 - (D) a fraternal benefit society;
 - (E) a Lloyd's plan;
 - (F) a reciprocal or interinsurance exchange;
 - (G) a group hospital service corporation or a nonprofit hospital, medical, or dental service corporation;
 - (H) a risk retention group; and
 - (I) a nonprofit legal services corporation; and
- (2) a domestic or commercially domiciled health maintenance organization.

(b) This chapter does not apply to a domestic insurer that engages in the business of insurance only in this state or to a domestic health maintenance organization that engages in the business of a health maintenance organization only in this state until the insurer or health maintenance organization is authorized to engage in the business of insurance or the business of a health maintenance organization, as applicable, in another state.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 402.002. GENERAL REPORTING REQUIREMENTS. (a) An insurer or health maintenance organization shall file with the department a report, including any necessary exhibit or other attachment, that discloses:

- (1) the material acquisition or disposition of assets; or
- (2) the material nonrenewal, cancellation, or revision of a ceded reinsurance agreement.

(b) The insurer or health maintenance organization shall file the report required under Subsection (a) not later than the 15th day after the last day of the calendar month in which any transaction for which a report is required occurs.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 402.003. EXCEPTIONS TO REPORTING REQUIREMENTS. An insurer or health maintenance organization is not required to file a report under Section 402.002 if:

- (1) the acquisition or disposition of assets or the nonrenewal, cancellation, or revision of a ceded reinsurance agreement is not material; or
- (2) the insurer's or health maintenance organization's material acquisition or disposition of assets or material nonrenewal, cancellation, or revision of a ceded reinsurance agreement has been submitted to the commissioner for review, approval, or information under another provision of this code or another law, regulation, or requirement.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 402.004. REPORT MADE ON NONCONSOLIDATED BASIS. (a) An insurer or health maintenance organization shall report each material acquisition or disposition and each material nonrenewal, cancellation, or revision of a ceded reinsurance agreement on a nonconsolidated basis unless the insurer or health maintenance organization:

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

(2) has ceded substantially all of the insurer's or health maintenance organization's direct and assumed business to the pooling arrangement.

(b) For purposes of Subsection (a), an insurer or health maintenance organization is considered to have ceded substantially all of the insurer's or health maintenance organization's direct and assumed business to a pooling arrangement if:

(1) the insurer or health maintenance organization has, during a calendar year, less than \$1 million total direct and assumed written premiums that are not subject to a pooling arrangement; and

(2) the net income of the business that is not subject to the pooling arrangement represents less than five percent of the insurer's or health maintenance organization's capital and surplus.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 402.005. CONFIDENTIALITY OF REPORT. (a) A report obtained by or disclosed to the commissioner under this chapter is confidential and is not subject to a subpoena, other than a grand jury subpoena.

(b) The report may not be disclosed by the commissioner, the National Association of Insurance Commissioners, or any other person without the prior written consent of the affected insurer or health maintenance organization unless the commissioner, after providing

notice and an opportunity for a hearing to the affected insurer or health maintenance organization, determines that the interest of shareholders, holders of policies or evidences of coverage, or the public will be served by publishing the report. If the commissioner makes that determination, the department may:

- (1) disclose the report to the public; and
- (2) publish any part of the report in a manner the commissioner considers appropriate.

(c) The report may be disclosed to the insurance department of another state or another authorized governmental agency without complying with Subsection (b).

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

SUBCHAPTER B. ACQUISITION AND DISPOSITION OF ASSETS

Sec. 402.051. ACQUISITIONS AND DISPOSITIONS CONSIDERED MATERIAL. For purposes of this chapter, an acquisition, or the aggregate of a series of related acquisitions during a 30-day period, or a disposition, or the aggregate of a series of related dispositions during a 30-day period, is material if it:

- (1) is not recurring;
- (2) is not in the ordinary course of business; and
- (3) involves more than five percent of the reporting insurer's or health maintenance organization's total admitted assets as reported in the insurer's or health maintenance organization's most recent statutory statement filed with the department.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 402.052. ACQUISITIONS AND DISPOSITIONS SUBJECT TO CHAPTER.

(a) An asset acquisition subject to this chapter includes a purchase, lease, exchange, merger, consolidation, succession, or other acquisition of assets, except the construction or development of real property by or for the reporting insurer or health maintenance organization or the acquisition of materials for that purpose.

(b) An asset disposition subject to this chapter includes a

sale, lease, exchange, merger, consolidation, mortgage, hypothecation, assignment, whether for the benefit of a creditor or otherwise, abandonment, destruction, or other disposition of assets.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 402.053. CONTENT OF REPORT CONCERNING MATERIAL ACQUISITIONS AND DISPOSITIONS. In a report of a material acquisition or disposition of assets under Section 402.002, an insurer or health maintenance organization shall disclose:

- (1) the date of the transaction;
- (2) the manner of acquisition or disposition;
- (3) a description of the assets involved;
- (4) the nature and amount of the consideration given or received;
- (5) the purpose of the transaction;
- (6) the manner by which the amount of consideration was determined;
- (7) the gain or loss recognized or realized as a result of the transaction; and
- (8) the name of each person from whom the assets were acquired or to whom they were disposed.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

SUBCHAPTER C. NONRENEWAL, CANCELLATION, AND REVISION OF CEDED REINSURANCE AGREEMENTS

Sec. 402.101. NONRENEWALS, CANCELLATIONS, AND REVISIONS CONSIDERED MATERIAL. For purposes of this chapter, a nonrenewal, cancellation, or revision of a ceded reinsurance agreement is material if, on an annual basis, as reported in an insurer's or health maintenance organization's most recent statutory statement filed with the department, the nonrenewal, cancellation, or revision affects:

- (1) for property and casualty business, including accident and health business when written as property and casualty business, more than 50 percent of the insurer's or health maintenance

organization's ceded written premium; or

(2) for life, annuity, and accident and health business, more than 50 percent of the total reserve credit taken for business ceded by the insurer or health maintenance organization.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 402.102. CONDITIONS UNDER WHICH REPORT CONCERNING NONRENEWAL, CANCELLATION, OR REVISION REQUIRED. Except as provided by Section 402.103, an insurer or health maintenance organization shall file a report of a material nonrenewal, cancellation, or revision of ceded reinsurance under Section 402.002, without regard to which party initiated the nonrenewal, cancellation, or revision, if:

(1) the entire cession has been canceled, nonrenewed, or revised, and ceded indemnity and loss adjustment expense reserves after the nonrenewal, cancellation, or revision represent less than 50 percent of the comparable reserves that would have been ceded had the nonrenewal, cancellation, or revision not occurred;

(2) an authorized or accredited reinsurer has been replaced by an unauthorized reinsurer on an existing cession, and the result of the revision affects more than 10 percent of the cession; or

(3) a collateral requirement previously established for an unauthorized reinsurer has been reduced, in that the requirement to collateralize incurred but unreported claim reserves has been waived for at least one unauthorized reinsurer newly participating in an existing cession, and the result of the revision affects more than 10 percent of the cession.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 402.103. CONDITIONS UNDER WHICH REPORT CONCERNING NONRENEWAL, CANCELLATION, OR REVISION NOT REQUIRED. An insurer or health maintenance organization is not required to file a report under Section 402.002 if the insurer's or health maintenance organization's ceded written premium of the total reserve credit taken for business ceded is, on an annual basis, less than an amount

equal to:

- (1) 10 percent of direct and assumed written premiums; or
- (2) 10 percent of the statutory reserve requirement before a cession.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 402.104. CONTENT OF REPORT CONCERNING MATERIAL NONRENEWALS, CANCELLATIONS, AND REVISIONS. In a report of a material nonrenewal, cancellation, or revision of a ceded reinsurance agreement under Section 402.002, an insurer or health maintenance organization shall disclose:

- (1) the effective date of the nonrenewal, cancellation, or revision;
- (2) a description of the transaction that identifies the initiator of the transaction;
- (3) the purpose of the transaction; and
- (4) if applicable, the identity of each replacement reinsurer.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

CHAPTER 403. DIVIDENDS

SUBCHAPTER A. PAYMENT OF DIVIDENDS

Sec. 403.001. LIMITATION ON DIVIDENDS. An insurer organized under the laws of this state, including a life, health, fire, marine, or inland marine insurance company, may not pay a shareholder dividend except from surplus profits arising from the insurer's business.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 463 (S.B. 1006), Sec. 1, eff. June 14, 2013.

Sec. 403.002. DIVIDENDS TO POLICYHOLDERS IN COMMERCIAL LINES.

(a) An insurer may pay to a commercial policyholder or group of commercial policyholders a dividend that covers more than one class or line of commercial business only:

(1) after the insurer establishes on an aggregate basis adequate loss reserves for the classes or lines of commercial insurance included within the dividend; and

(2) if the insurer has sufficient surplus from which to pay the dividend.

(b) Not later than the 15th day before an insurer pays a dividend described by Subsection (a), the insurer shall file with the department notice of the insurer's intent to pay the dividend.

(c) The classes or lines of commercial business for which dividends are authorized under this section include any commercial class or line of commercial business regulated by Title 10 or Chapter 5.

(d) An insurer's limitation of a dividend on one or more classes or lines of commercial business to a group of commercial policyholders is not unfair discrimination if the group:

(1) has clearly identifiable underwriting characteristics;
or

(2) is an association or group of business entities engaged in similar undertakings.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

SUBCHAPTER B. ESTIMATE OF PROFITS

Sec. 403.051. ESTIMATE OF PROFITS. An insurer organized under the laws of this state may not include the following in the estimate of the insurer's profits for the purpose of paying dividends under Section 403.001:

(1) the reserve on all unexpired risks computed in the manner provided by this code;

(2) the amount of all unpaid losses, whether adjusted or unadjusted; and

(3) all other debts due and payable, or to become due and payable, by the insurer.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April

1, 2007.

Sec. 403.052. ESTIMATE OF PROFITS OF CERTAIN INSURERS. A life, health, fire, marine, or inland marine insurance company organized under the laws of this state may not include the following in the estimate of the company's profits for the purpose of paying dividends under Section 403.001:

(1) the reserve on all unexpired risks computed in the manner provided by this code;

(2) the amount of all unpaid losses, whether adjusted or unadjusted;

(3) each amount due the company on bonds, mortgages, stocks, or book-accounts on which no part of the principal or interest has been paid during the year preceding the estimate of profits and for which:

(A) a suit for foreclosure or collection has not been commenced; or

(B) a judgment obtained in a suit for foreclosure or collection has remained unsatisfied for a period of more than two years and no interest has been paid on the judgment; and

(4) if no interest has been paid on a judgment described by Subdivision (3)(B), any interest that is due or accrued on the judgment and remains unpaid.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 403.053. ACQUIRED EARNED SURPLUS. (a) This section applies only to:

(1) a stock domestic insurance company authorized to engage in the business of life, accident, or health insurance in this state;

(2) a stock foreign or alien life, health, or accident insurance company;

(3) a stock insurance company authorized to engage in the business of property, casualty, or fire insurance; and

(4) a domestic Lloyd's plan, reciprocal or interinsurance exchange, or title insurance company.

(b) In determining the amount of "surplus profits arising from

the insurer's business" or "earned surplus" for the purpose of paying dividends to shareholders, the insurer may include the acquired earned surplus of an insurance subsidiary acquired by the insurer to the extent that:

(1) the inclusion is permitted by an order of the commissioner made in accordance with commissioner rules; and

(2) the earned surplus of the acquired subsidiary on the date of acquisition that exists on the date of the commissioner's order is not otherwise reflected in the insurer's earned surplus.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

SUBCHAPTER C. PENALTIES

Sec. 403.101. PENALTIES. (a) The department may revoke the charter of an insurer organized under the laws of this state that pays a dividend in violation of Sections 403.001 and 403.051. If the department revokes an insurer's charter under this subsection, the department shall immediately revoke the insurer's certificate of authority.

(b) Not later than the 10th day before the date on which the department intends to revoke an insurer's certificate of authority under this section, the department shall give the insurer written notice of the department's intent. The notice must include the specific reasons for the revocation.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 403.102. PENALTIES FOR CERTAIN INSURERS. The department may revoke the charter of a life, health, fire, marine, or inland marine insurance company organized under the laws of this state that pays a dividend in violation of Sections 403.001 and 403.052. If the department revokes a company's charter under this section, the department shall immediately revoke the company's certificate of authority.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

CHAPTER 404. FINANCIAL CONDITION**SUBCHAPTER A. HAZARDOUS FINANCIAL CONDITION**

Sec. 404.001. DEFINITION. In this subchapter, "insurer" includes:

- (1) a capital stock insurance company;
- (2) a reciprocal or interinsurance exchange;
- (3) a Lloyd's plan;
- (4) a fraternal benefit society;
- (5) a mutual company, including a mutual assessment company;
- (6) a statewide mutual assessment company;
- (7) a local mutual aid association;
- (8) a burial association;
- (9) a county mutual insurance company;
- (10) a farm mutual insurance company;
- (11) a fidelity, guaranty, or surety company;
- (12) a title insurance company;
- (13) a stipulated premium company;
- (14) a group hospital service corporation;
- (15) a health maintenance organization;
- (16) a risk retention group; and
- (17) any other organization or person engaged in the business of insurance.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 404.002. APPLICABILITY OF SUBCHAPTER. This subchapter applies to a person or organization engaged in the business of insurance without regard to whether the person or organization is listed in Section 404.001, unless another statute specifically cites this subchapter and exempts the person or organization from this subchapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 404.003. ORDER TO REMEDY CONDITION. (a) If the financial condition of an insurer, when reviewed as provided by Subsection (b), indicates a condition that might make the insurer's continued operation hazardous to the insurer's policyholders or creditors or to the public, the commissioner may, after notice and hearing, order the insurer to take action reasonably necessary to remedy the condition.

(b) The insurer's financial condition must be reviewed under Subsection (a) in conjunction with one or more of the following:

- (1) the kinds and nature of risks insured;
- (2) the loss experience and ownership of the insurer;
- (3) the ratio of total annual premium and net investment income to commission expenses, general insurance expenses, policy benefits paid, and required policy reserve increases;
- (4) the insurer's method of operation, affiliations, or investments;
- (5) any contracts that lead or may lead to contingent liability; or
- (6) agreements in respect to guaranty and surety.

(c) In an order issued under Subsection (a), the commissioner may take any action the commissioner considers reasonably necessary to remedy the condition described by Subsection (a), including:

- (1) requiring an insurer to:
 - (A) reduce the total amount of present and potential liability for policy benefits by reinsurance;
 - (B) reduce the volume of new business accepted;
 - (C) suspend or limit writing new business for a period;
 - (D) reduce general insurance and commission expenses by specified methods; or
 - (E) increase the insurer's capital and surplus by contribution; or
- (2) suspending or canceling the insurer's certificate of authority.

(d) The commissioner may use the remedies available under Subsection (c) in conjunction with the provisions of Chapter 83 if the commissioner determines that the financial condition of the insurer is hazardous and can be reasonably expected to cause significant and imminent harm to the insurer's policyholders or the public.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April

1, 2007.

Sec. 404.004. CONSTRUCTION WITH LAW RELATING TO CAPITAL AND SURPLUS. The commissioner's authority under Section 404.003 to require an increase in an insurer's capital and surplus by contribution, and any capital and surplus requirements imposed by the commissioner under that section, prevail over:

(1) the capital and surplus requirements of:

(A) Sections 822.054, 822.201-822.203, 822.205, 822.210-822.212, 841.054, 841.201, 841.204, 841.205, 841.207, 884.206, 884.308, and 884.309; and

(B) Subchapter G, Chapter 841;

(2) any other provision of this code or other law establishing capital and surplus requirements for insurers; and

(3) any rule adopted under a law described by Subdivision (1) or (2).

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 404.005. STANDARDS AND CRITERIA FOR EARLY WARNING. (a) The commissioner by rule may:

(1) establish uniform standards and criteria for early warning that the continued operation of an insurer might be hazardous to the insurer's policyholders or creditors or to the public; and

(2) establish standards for evaluating the financial condition of an insurer.

(b) Standards established by the commissioner under this section must be consistent with the purposes of Section 404.003.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 404.006. AGREEMENT WITH ANOTHER JURISDICTION. The commissioner may enter into an agreement with the insurance regulatory authority of another jurisdiction concerning the management, volume of business, expenses of operation, plans for reinsurance, rehabilitation, or reorganization, and method of

operations of, and type of risks to be insured by, an insurer that is:

- (1) licensed in the other jurisdiction; and
- (2) considered to be in a hazardous financial condition or in need of a specific remedy that may be imposed by the commissioner and the insurance regulatory authority of the other jurisdiction.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

SUBCHAPTER B. IMPAIRMENT OF STOCK OR SURPLUS

Sec. 404.051. IMPAIRMENT PROHIBITED. (a) The impairment of the capital stock of a stock insurance company is prohibited.

(b) Impairment of the following surpluses in excess of that provided by Section 404.053 is prohibited:

- (1) the surplus of a stock insurance company; or
- (2) the minimum required aggregate surplus of a:
 - (A) mutual company;
 - (B) Lloyd's plan; or
 - (C) reciprocal or interinsurance exchange.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 404.052. DETERMINATION OF IMPAIRMENT. (a) When determining under this subchapter whether the surplus or the minimum required aggregate surplus of an insurer is impaired, the commissioner shall charge against the insurer:

- (1) the reinsurance reserve required by the laws of this state; and
- (2) all other debts and claims against the insurer.

(b) This section does not apply to a life insurance company.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 404.053. REMEDY FOR IMPAIRMENT. (a) The commissioner shall order an insurer to remedy an impairment of the insurer's

surplus, aggregate surplus, or aggregate of guaranty fund and surplus, as applicable, by bringing the surplus to an acceptable level specified by the commissioner, or to cease engaging in business in this state, if the commissioner determines that:

(1) the surplus required by Section 822.054, 822.202, 822.203, 822.205, 822.210, 822.211, or 822.212 of a stock insurance company engaged in the kind of insurance business described by the company's certificate of authority:

(A) is impaired by more than 50 percent; or

(B) is less than the minimum level of surplus required by risk-based capital and surplus rules adopted by the commissioner; or

(2) the required aggregate of guaranty fund and surplus of a Lloyd's plan, or the required aggregate surplus of a reciprocal or interinsurance exchange or of a mutual company, other than a life insurance company, engaged in the kind of insurance business described by the insurer's certificate of authority:

(A) is impaired by more than 25 percent; or

(B) is less than the minimum level of surplus required by risk-based capital and surplus rules adopted by the commissioner.

(b) After issuing an order described by Subsection (a), the commissioner shall immediately institute any proceeding necessary to determine what further actions the commissioner will take in relation to the matter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

**CHAPTER 406. SPECIAL DEPOSITS REQUIRED UNDER POTENTIALLY
HAZARDOUS CONDITIONS**

Sec. 406.001. DEFINITION. In this chapter, "insurer" includes:

(1) a capital stock insurance company;

(2) a reciprocal or interinsurance exchange;

(3) a Lloyd's plan;

(4) a fraternal benefit society;

(5) a mutual company, including a mutual assessment company;

(6) a statewide mutual assessment company;

(7) a local mutual aid association;

(8) a burial association;
 (9) a county mutual insurance company;
 (10) a farm mutual insurance company;
 (11) a fidelity, guaranty, or surety company;
 (12) a title insurance company;
 (13) a stipulated premium company;
 (14) a group hospital service corporation;
 (15) a health maintenance organization;
 (16) a risk retention group; and
 (17) any other organization or person engaged in the
 business of insurance.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1C.001,
 eff. April 1, 2009.

Sec. 406.002. APPLICABILITY OF CHAPTER. This chapter applies
 to a person or organization engaged in the business of insurance
 without regard to whether the person or organization is listed in
 Section 406.001, unless another statute specifically cites this
 chapter and exempts the person or organization from this chapter.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1C.001,
 eff. April 1, 2009.

Sec. 406.003. REQUIRED DEPOSIT: STANDARDS AND CRITERIA. The
 commissioner, in the commissioner's sole discretion, may require an
 insurer to make a deposit under this chapter if the commissioner
 determines that one of the following conditions, if not rectified,
 may potentially be hazardous to the insurer's policyholders,
 enrollees, or creditors, or to the public:

(1) the insurer's financial or operating condition,
 reviewed in conjunction with the kinds and nature of risks insured;
 (2) the insurer's method of operation;
 (3) the insurer's relationship with affiliates;
 (4) the nature and amount of the insurer's investments;
 (5) the insurer's contracts that may lead to a contingent
 liability; or
 (6) the insurer's agreements with respect to guaranty and
 surety.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1C.001, eff. April 1, 2009.

Sec. 406.004. REQUIRED DEPOSIT: FORM OF SECURITY. A deposit required under Section 406.003 must be made with the comptroller and approved by the commissioner. The deposit must be made in:

(1) cash;

(2) securities authorized under this code to be a legal investment for the insurer that:

(A) are readily marketable over a national exchange with a maturity date of not more than one year, are listed by the Securities Valuation Office of the National Association of Insurance Commissioners, and qualify as admitted assets; or

(B) are clean, irrevocable, and unconditional letters of credit issued or confirmed by a financial institution organized and licensed under the laws of the United States or a state of the United States; or

(3) another form of security acceptable to the commissioner.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1C.001, eff. April 1, 2009.

Sec. 406.005. DURATION OF DEPOSIT. Subject to Section 406.006, the comptroller shall hold a deposit required under this chapter until the commissioner issues a written order finding that the condition for which the deposit was required no longer exists.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1C.001, eff. April 1, 2009.

Sec. 406.006. SUBSTITUTION OR WITHDRAWAL OF DEPOSIT. (a) An insurer may file a written application with the commissioner requesting:

(1) withdrawal of all or part of the deposit held by the comptroller under this chapter; or

(2) substitution of all or part of the deposited securities held by the comptroller under this chapter.

(b) The application must state the basis for the request to withdraw the deposit or to substitute the deposited security.

(c) An insurer's application for the substitution of a deposited security must provide specific information regarding the security to be deposited as a substitute for the security held by the comptroller.

(d) The commissioner shall issue a letter approving or an order denying an application under this section not later than the 30th day after the date the department receives the application. If the commissioner does not approve or deny the application within that period, the application is denied.

(e) The commissioner may, in the commissioner's sole discretion, approve an application to withdraw a deposit or substitute a deposited security if the commissioner determines that the withdrawal or substitution will not be hazardous to the insurer's policyholders, enrollees, or creditors, or to the public.

(f) The comptroller may not release a deposit made under this chapter, or any part of the deposit, and may not accept a substitute for a deposited security unless the commissioner issues a letter approving the withdrawal or substitution.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1C.001, eff. April 1, 2009.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 553 (S.B. 631), Sec. 1, eff. June 14, 2013.

Sec. 406.007. APPEAL. An insurer may appeal an action of the commissioner under this chapter in accordance with Subchapter D, Chapter 36.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1C.001, eff. April 1, 2009.

Sec. 406.008. CUMULATIVE OF OTHER DEPOSITS. A deposit required to be made under this chapter is in addition to any other deposit that the insurer is required or authorized to make under this code.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1C.001,

eff. April 1, 2009.

SUBTITLE B. RESERVES AND INVESTMENTS

CHAPTER 421. RESERVES IN GENERAL

Sec. 421.001. RESERVES REQUIRED. (a) An insurer shall maintain reserves in an amount estimated in the aggregate to provide for the payment of all losses or claims for which the insurer may be liable and that are:

(1) incurred on or before the date of statement, whether reported or unreported; and

(2) unpaid as of the date of statement.

(b) In addition to the reserves required by Subsection (a), an insurer shall maintain reserves in an amount estimated to provide for the expenses of adjustment or settlement of the losses or claims described by that subsection.

(c) The commissioner shall adopt each current formula recommended by the National Association of Insurance Commissioners for establishing reserves for each line of insurance. Each insurer writing a line of insurance to which a formula adopted under this subsection applies shall establish reserves in compliance with that formula.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 421.002. CERTIFICATES FROM OTHER STATES. In computing the reserve liability of an insurer, the commissioner may accept the certificate of the officer of another state charged with the duty of supervising the insurer if:

(1) the insurer is organized under the laws of the other state; and

(2) the certificate shows that the reserve liability has been computed in accordance with Section 421.001.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

CHAPTER 422. ASSET PROTECTION ACT

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 422.001. SHORT TITLE. This chapter may be cited as the Asset Protection Act.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 422.002. PURPOSES. (a) The purposes of this chapter are to:

(1) require an insurer to maintain unencumbered assets in an amount equal to the insurer's policy reserve liabilities;

(2) provide preferential claims against assets in favor of an owner, beneficiary, assignee, certificate holder, or third-party beneficiary of an insurance policy; and

(3) prevent the pledge or encumbrance of assets in excess of certain amounts without a prior written order of the commissioner.

(b) This chapter and the powers granted and functions authorized by this chapter shall be exercised to accomplish the purposes of this chapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2021, 87th Leg., R.S., Ch. 61 (S.B. 1954), Sec. 1, eff. September 1, 2021.

Sec. 422.003. DEFINITIONS. In this chapter:

(1) "Asset" means any property in which an insurer owns a legal or equitable interest that is reported as an asset in the domestic insurer's statutory financial statements most recently filed with the department.

(2) "Claimant" means an owner, beneficiary, assignee, certificate holder, or third-party beneficiary of an insurance benefit or right arising from the coverage of an insurance policy to which this chapter applies.

(3) "Reserve assets" means the assets of an insurer that are authorized investments for policy reserves under this code.

(4) "Policy reserve liabilities" means the liabilities that an insurer is required under this code to establish for all of the

insurer's outstanding insurance policies.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2021, 87th Leg., R.S., Ch. 61 (S.B. 1954), Sec. 2, eff. September 1, 2021.

Sec. 422.004. APPLICABILITY OF CHAPTER. This chapter applies to:

- (1) the following domestic insurers:
 - (A) a stock life, health, or accident insurance company;
 - (B) a mutual life, health, or accident insurance company;
 - (C) a stock fire or casualty insurance company;
 - (D) a mutual fire or casualty insurance company;
 - (E) a title insurance company;
 - (F) a mutual assessment company;
 - (G) a local mutual aid association;
 - (H) a local mutual burial association;
 - (I) a statewide mutual assessment company;
 - (J) a stipulated premium company;
 - (K) a fraternal benefit society;
 - (L) a group hospital service corporation;
 - (M) a county mutual insurance company;
 - (N) a Lloyd's plan;
 - (O) a reciprocal or interinsurance exchange;
 - (P) a farm mutual insurance company; and
 - (Q) a mortgage guaranty insurer; and
- (2) all kinds of insurance written by an insurer to which this chapter applies.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 422.005. EXEMPTIONS. (a) This chapter does not apply to:

- (1) variable contracts for which separate accounts are required to be maintained;

(2) a reinsurance agreement and any trust account related to the reinsurance agreement if the reinsurance agreement and related trust account meet the requirements of Chapter 493;

(3) an assessment-as-needed company or insurance coverage written by an assessment-as-needed company;

(4) an insurer while:

(A) the insurer is subject to a conservatorship order issued by the commissioner; or

(B) a court-appointed receiver is in charge of the insurer's affairs;

(5) an insurer's reserve assets that are held, deposited, pledged, or otherwise encumbered to secure, offset, protect, or meet the insurer's policy reserve liabilities established in a reinsurance agreement under which the insurer reinsures the insurance policy liabilities of a ceding insurer if:

(A) the ceding insurer and the reinsurer are authorized to engage in business in this state; and

(B) in accordance with a written agreement between the ceding insurer and the reinsurer, reserve assets substantially equal to the policy reserve liabilities the reinsurer must establish on the reinsured business are:

(i) deposited by or withheld from the reinsurer and held in the custody of the ceding insurer, or deposited and held in a trust account with a state or national bank domiciled in this state, as security for the payment of the reinsurer's obligations under the reinsurance agreement;

(ii) held subject to withdrawal by the ceding insurer; and

(iii) held under the separate or joint control of the ceding insurer; or

(6) any pledge, encumbrance, or lien contemplated by or customarily included in the documentation for:

(A) an investment or transaction authorized by:

(i) Section 424.068, Subchapter D, Chapter 424, or Section 425.121 or 425.151; or

(ii) Section 424.068, Subchapter E, Chapter 424, or Section 425.124, 425.125, 425.126, 425.127, 425.128, 425.129, 425.130, 425.131, or 425.132; and

(B) a custodial or trust agreement for an insurer's securities authorized by Section 423.103 that provides for a limited

grant or lien or security interest for payment of fees and expenses due to a service provider or intermediary under the custodial or trust agreement.

(b) Notwithstanding this section, the commissioner may examine any asset, reinsurance agreement, or deposit arrangement described by Subsection (a)(5) at any time, in accordance with the commissioner's authority under this code to examine an insurer.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 594 (S.B. 1070), Sec. 3.02, eff. September 1, 2017.

Acts 2021, 87th Leg., R.S., Ch. 61 (S.B. 1954), Sec. 3, eff. September 1, 2021.

Sec. 422.006. CONFLICT WITH OTHER LAW. If this chapter conflicts with another law relating to the subject matter or application of this chapter, this chapter controls.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 422.007. RULES. The commissioner may adopt rules regarding the provisions of this chapter.

Added by Acts 2021, 87th Leg., R.S., Ch. 61 (S.B. 1954), Sec. 4, eff. September 1, 2021.

SUBCHAPTER B. ENCUMBRANCE OF ASSETS

Sec. 422.051. RESTRICTIONS ON ENCUMBRANCE OF ASSETS. (a) An insurer shall at all times maintain unencumbered assets in an amount equal to the insurer's policy reserve liabilities.

(b) An insurer may not pledge or otherwise encumber:

(1) the insurer's assets in an amount that exceeds the amount of the insurer's capital and surplus; or

(2) more than 10 percent of the insurer's reserve assets.

(b-1) The calculation of the quantitative limits in Subsections

(a) and (b) must be based on the statutory financial statements for the insurer most recently filed with the department as of the date compliance is determined. The date that a pledge or encumbrance is made is the date used to determine compliance with the limits in Subsection (b).

(b-2) Compliance with the quantitative limits in Subsection (b) is achieved when, on the date of determination of compliance, the sum of the value of a proposed pledge or encumbrance, when added to the values of the sum of all previous and still outstanding pledges and encumbrances, does not exceed any quantitative limit in Subsection (b).

(c) Notwithstanding any other provision of this section, on application made to the commissioner, the commissioner may issue a written order approving the pledge or encumbrance of an insurer's asset in any amount if the commissioner determines that the pledge or encumbrance will not adversely affect the insurer's solvency.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2021, 87th Leg., R.S., Ch. 61 (S.B. 1954), Sec. 5, eff. September 1, 2021.

Sec. 422.052. REPORT TO COMMISSIONER. (a) Not later than the 10th day after the date an insurer pledges or otherwise encumbers an asset, the insurer shall report in writing to the commissioner:

(1) the amount and identity of the pledged or encumbered asset; and

(2) the terms of the transaction.

(b) Annually, or more often as required by the commissioner, the insurer shall file with the commissioner a statement sworn to by the insurer's chief executive officer that:

(1) title to assets that equal the amount of the insurer's policy reserve liabilities and that are not pledged or otherwise encumbered is vested in the insurer;

(2) the only assets of the insurer that are pledged or otherwise encumbered are those identified and reported in the sworn statement, and no other assets of the insurer are pledged or otherwise encumbered; and

(3) the terms of the transaction pledging or otherwise encumbering the assets are those reported in the sworn statement.

(c) The insurer is not required to file the report described by Subsection (a) for a pledge or encumbrance permitted in a transaction approved by the commissioner under Section 1152.055.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2021, 87th Leg., R.S., Ch. 61 (S.B. 1954), Sec. 6, eff. September 1, 2021.

Sec. 422.053. CLAIMANT LIEN ON CERTAIN ASSETS. (a) A person, corporation, association, governmental entity, or any other legal entity that accepts as security for an insurer's debt or other obligation a pledge or encumbrance of an asset of the insurer that is not made in accordance with this chapter is considered to have accepted the asset subject to a superior, preferential, and automatically perfected lien in favor of a claimant of the insurer.

(b) Subsection (a) does not apply to:

(1) an asset of an insurer in conservatorship or receivership if the commissioner in the conservatorship proceeding, or the court in which the receivership is pending, approves the pledge or encumbrance of the asset; or

(2) a pledge or encumbrance of an asset permitted in a transaction approved by the commissioner under Section 1152.055.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2021, 87th Leg., R.S., Ch. 61 (S.B. 1954), Sec. 7, eff. September 1, 2021.

Sec. 422.054. PREFERENTIAL CLAIMS ON LIQUIDATION. If an insurer is involuntarily or voluntarily liquidated, a claimant of the insurer has a prior and preferential claim against all assets of the insurer other than the assets that have been pledged or encumbered in accordance with this chapter or the assets that are subject to a pledge or encumbrance of an asset described by Section 422.053(b)(2).

All claimants have equal status, and their prior and preferential claim is superior to any claim or cause of action against the insurer by any other person, corporation, association, or legal entity.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2021, 87th Leg., R.S., Ch. 61 (S.B. 1954), Sec. 8, eff. September 1, 2021.

CHAPTER 423. TRANSACTIONS WITH MONEY AND OTHER ASSETS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 423.001. APPLICABILITY OF CHAPTER. (a) This chapter applies to a domestic insurer regulated under this code, including:

- (1) a stock company;
- (2) a reciprocal or interinsurance exchange;
- (3) a Lloyd's plan;
- (4) a fraternal benefit society;
- (5) a stipulated premium company;
- (6) a mutual insurance company of any kind, including:
 - (A) a statewide mutual assessment company;
 - (B) a local mutual aid association;
 - (C) a burial association;
 - (D) a county mutual insurance company; and
 - (E) a farm mutual insurance company; and
- (7) any other organization or person engaged in the

business of insurance.

(b) A provision of this code limiting the regulation of an insurer under this code does not limit the application of this chapter, except that this chapter does not apply to an insurer that is exempted from its application by another statute that cites this chapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 423.002. AMBIGUITIES AND CONFLICTS WITH OTHER LAW. This chapter controls to the extent of an ambiguity or a conflict between this chapter and another provision of this code.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 423.003. RULES. The commissioner may adopt rules necessary to implement this chapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 423.004. STATUTORY DEPOSITS WITH DEPARTMENT. (a) Except as provided by Subsection (c), notwithstanding any requirement under this code that an insurer deposit with the comptroller money or other assets for the security of an insurer's policyholders or creditors, including a deposit required by another state, an insurer may deposit the required money or other assets with the department in accordance with this section.

(b) A deposit authorized by Subsection (a):

(1) must be approved by the commissioner;

(2) is subject to any requirements applicable to the type of deposit;

(3) must be held under the commissioner's control; and

(4) may not be substituted or withdrawn by the insurer without the commissioner's approval.

(c) This section does not apply to any deposit made under Chapter 406 or a deposit of fees or taxes under this code.

Added by Acts 2015, 84th Leg., R.S., Ch. 263 (S.B. 1427), Sec. 1, eff. September 1, 2015.

SUBCHAPTER B. TRANSACTIONS WITH MONEY

Sec. 423.051. DEPOSIT AND INVESTMENT OF MONEY. A director, member of a committee, officer, or clerk of a domestic insurer who has the duty to handle or invest the insurer's money may not:

(1) invest the money other than in the corporate name of the insurer, except as provided by Section 423.102;

(2) deposit the money unless the deposit is:

(A) in the corporate name of the insurer;

(B) in a pooling account with one or more affiliates,

as described by Section 823.003; or

(C) in accordance with a reinsurance agreement;

(3) borrow the insurer's money;

(4) have any interest in a loan, pledge, security, or property of the insurer, except as a stockholder; or

(5) take or receive for the individual's use a fee, brokerage, commission, gift, or other consideration for, or on account of, a loan made by or on behalf of the insurer.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 423.052. MONEY HELD IN POOLING ACCOUNT. (a) Only a domestic insurer and an affiliate, as described by Section 823.003, may hold money in a pooling account.

(b) The accounting and operating records and books of the insurer and affiliate must be adequately detailed to identify specific insurance policies and policyholders with the money from premiums received by the insurer that issues the policies.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 423.053. AUTHORITY TO DEPOSIT MONEY IN ACCOUNT OF REINSURER. A reinsurance agreement between a domestic insurer and an affiliate, as described by Section 823.003, must specifically authorize the deposit of money from premiums to the account of the affiliate that assumes the reinsurance.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

SUBCHAPTER C. TRANSACTIONS WITH OTHER ASSETS

Sec. 423.101. DEFINITION. In this subchapter, "clearing corporation" means:

(1) a clearing corporation as defined by Section 8.102(a), Business & Commerce Code; or

(2) a clearance system that:

(A) is organized or operating under the laws of at least one foreign country;

(B) provides for book-entry settlement and custody of internationally traded securities; and

(C) has been organized and in operation for not less than 15 consecutive years.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 423.102. DEPOSIT AND HOLDING OF SECURITIES. (a) A domestic insurer that has securities held in or purchased for the insurer's general account or separate accounts may deposit the securities or arrange through an agent, broker, or dealer for deposit of the securities with a clearing corporation or in the Federal Reserve book-entry system.

(b) If securities are deposited directly with a clearing corporation or deposited indirectly through a participating custodian bank, certificates representing securities of the same class of the same issuer may be merged and held in bulk, in the name of a nominee of the clearing corporation, with any other securities deposited with the clearing corporation by any person, regardless of the ownership of the securities.

(c) Certificates under Subsection (b) that represent securities of small denominations may be merged into one or more certificates of larger denominations.

(d) The records of an agent, broker, dealer, or member bank through which an insurer holds securities in the Federal Reserve book-entry system and the records of a custodian bank through which an insurer holds securities with a clearing corporation must show that the securities are held for the insurer and show the accounts for which the securities are held.

(e) A bank must enter into a custodial agreement with an insurer to be eligible to act as a participating custodian bank for the insurer under this section.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 423.103. SECURITIES HELD UNDER CUSTODIAL OR TRUST AGREEMENT. A domestic insurer's securities that are held under a custodial agreement or trust agreement with a bank, Federal Home Loan Bank, or trust company may be issued in the name of a nominee of the bank, Federal Home Loan Bank, or trust company only if the bank, Federal Home Loan Bank, or trust company:

- (1) has corporate trust powers;
- (2) is authorized to act as a custodian or trustee;
- (3) is organized under the laws of the United States or any state of the United States; and
- (4) meets one of the following requirements:
 - (A) is a member of the Federal Reserve System;
 - (B) is a member of or is eligible to receive deposits that are insured by the Federal Deposit Insurance Corporation;
 - (C) maintains an account with a Federal Reserve Bank and is subject to supervision and examination by the Board of Governors of the Federal Reserve System; or
 - (D) is subject to supervision and examination by the Federal Housing Finance Board.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 423.104. PROOF OF OWNERSHIP OF SECURITIES. (a) A domestic insurer may demonstrate ownership of a security through a definitive certificate or in accordance with rules adopted under this section.

(b) The commissioner shall adopt rules under which a domestic insurer may demonstrate ownership of an uncertificated security, as defined by Section 8.102(a), Business & Commerce Code, consistent with common practices of securities exchanges and markets. The rules must establish:

- (1) standards for the types of uncertificated securities the insurer may hold;
- (2) the manner in which the insurer may demonstrate ownership of the security; and
- (3) adequate financial safeguards relating to the ownership of uncertificated securities.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April

1, 2007.

Sec. 423.105. MANDATORY DEPOSIT OF SECURITIES; COMMISSIONER CONTROL. (a) An insurer that is required to deposit securities as a condition of engaging in the business of insurance in this state may deposit the securities with a clearing corporation or in the Federal Reserve book-entry system.

(b) Securities under Subsection (a) are under the commissioner's control and may not be withdrawn by the insurer without the commissioner's approval.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 423.106. REQUIRED EVIDENCE FOR SECURITIES. (a) An insurer that deposits securities under Section 423.105 shall provide evidence to the commissioner to establish that:

(1) the securities are recorded in an account in the name of:

(A) the participating custodian bank or member bank through which the insurer deposits the securities with a clearing corporation or in the Federal Reserve book-entry system; or

(B) the insurer, if the insurer makes the deposit directly with the clearing corporation as a direct participant; and

(2) the records of the participating custodian bank, direct participant, or member bank and of the clearing corporation show that the securities are under the commissioner's control.

(b) Evidence under Subsection (a)(1) must be issued, as applicable, by:

(1) the participating custodian bank;

(2) the member bank; or

(3) the insurer, when the insurer makes the deposit directly with the clearing corporation as a direct participant.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 423.107. ASSETS DEPOSITED WITH CLEARING CORPORATION. A

domestic insurer may deposit assets with a clearing corporation only if:

(1) the insurer is a member of an insurance holding company system that has assets of at least \$5 billion, as shown by annual statements of member insurers for the preceding year;

(2) the insurer uses the clearing corporation only as a depository for investments in internationally traded securities;

(3) the insurer's total investment in internationally traded securities under Subdivision (2) does not exceed the insurer's policyholders' surplus; and

(4) the insurer does not use securities deposited with the clearing corporation as security for reinsurance.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 423.108. LIMITATION ON ASSETS DEPOSITED WITH CLEARING CORPORATION. The commissioner by rule may adopt a reasonable limit on the percentage of a domestic insurer's assets that may be deposited with a clearing corporation. The limit may not exceed five percent of the insurer's total assets, as shown by the insurer's annual statement filed with the department for the year preceding the year for which the limit is adopted.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

CHAPTER 424. INVESTMENTS FOR CERTAIN INSURERS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 424.001. DEFINITIONS. In this chapter:

(1) "Insurer" means any insurer organized under the laws of this state other than an insurer writing life, health, and accident insurance.

(2) "Minimum capital and surplus" means the minimum amount of capital stock and minimum amount of surplus required of an insurer under Section 822.054 or 822.210.

(3) "Securities valuation office" means the Securities Valuation Office of the National Association of Insurance Commissioners.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 424.002. INAPPLICABILITY OF CERTAIN LAW. The definition of "state" assigned by Section 311.005, Government Code, does not apply to this chapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

**SUBCHAPTER B. INVESTMENT OF FUNDS IN EXCESS
OF MINIMUM CAPITAL AND SURPLUS**

Sec. 424.051. GENERAL INVESTMENT AUTHORITY SPECIFIED BY LAW. An insurer may not invest the insurer's funds in excess of minimum capital and surplus, except that an insurer may invest as otherwise authorized by this code.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 424.052. ADDITIONAL GENERAL INVESTMENT AUTHORITY. An insurer may make investments that are not otherwise authorized by this chapter or otherwise authorized by this code for the insurer if:

- (1) the investment is not specifically prohibited by law and does not exceed the limits prescribed by this code;
- (2) the amount of a single investment under this section does not exceed five percent of the insurer's capital and surplus in excess of the insurer's minimum capital and surplus; and
- (3) the aggregate amount of all investments made by the insurer under this section does not exceed five percent of the insurer's assets.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 424.053. LIMITATION AS TO SINGLE ISSUER OR BORROWER. (a) Notwithstanding Sections 424.051, 424.056-424.071, and 424.074, the

aggregate amount of an insurer's investments in all or any type of securities, loans, obligations, or evidences of indebtedness of a single issuer or borrower, other than investments described by Subsection (c), may not exceed five percent of the insurer's total assets.

(b) For purposes of this section, a single issuer or borrower includes:

- (1) the issuer's or borrower's majority-owned subsidiaries;
- (2) the issuer's or borrower's parent; or
- (3) the majority-owned subsidiaries of the issuer's or borrower's parent.

(c) This section does not apply to:

- (1) an authorized investment that:
 - (A) is a direct obligation of or guaranteed by the full faith and credit of the United States, this state, or a political subdivision of this state; or
 - (B) is insured by an agency of the United States or this state; or
- (2) an investment described by Section 424.061 or 424.063.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 424.054. APPLICABILITY OF PERCENTAGE AUTHORIZATIONS AND LIMITATIONS. (a) The percentage authorizations and limitations established by Sections 424.051, 424.053-424.071, and 424.074 apply only at the time an investment is originally acquired or a transaction is entered into and do not apply to the insurer or the investment or transaction after that time.

(b) An investment, once qualified under a law described by Subsection (a), remains qualified notwithstanding any refinancing, restructuring, or modification of the investment, except that an insurer may not refinance, restructure, or modify an investment solely to circumvent the requirements or limitations of a law described by Subsection (a).

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 424.055. WAIVER BY COMMISSIONER OF QUANTITATIVE LIMITATIONS. (a) Notwithstanding Sections 424.051, 424.056-424.071, and 424.074, the commissioner may waive a quantitative limitation on any investment authorized by those laws if:

- (1) the insurer seeks the waiver before making the investment;
- (2) a hearing is held to determine whether the waiver should be granted;
- (3) the applicant seeking the waiver establishes that unreasonable or unnecessary loss or harm will result to the insurer if the commissioner denies the waiver;
- (4) the excess investment will not have a material adverse effect on the insurer; and
- (5) the size of the investment is reasonable in relation to the insurer's assets, capital, surplus, and liabilities.

(b) The commissioner's waiver must be in writing and may treat the resulting excess investment as a nonadmitted asset.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 424.056. WRITTEN INVESTMENT PLAN. (a) Each insurer's board of directors, or, if the insurer does not have a board of directors, the corresponding authority designated by the insurer's charter, bylaws, or plan of operation, shall adopt a written investment plan consistent with the requirements of:

- (1) this chapter;
- (2) Sections 822.204, 822.209, 861.258, and 862.002; and
- (3) other statutes governing investments by the insurer.

(b) The investment plan must:

- (1) specify the diversification of the insurer's investments designed to reduce the risk of large losses, by:
 - (A) broad categories, such as bonds and real property loans;
 - (B) kinds, such as government obligations, obligations of business entities, mortgage-backed securities, and real property loans on office, retail, industrial, or residential properties;
 - (C) quality;
 - (D) maturity;

- (E) type of industry; and
 - (F) geographical areas, as to both domestic and foreign investments;
- (2) balance safety of principal with yield and growth;
 - (3) seek a reasonable relationship of assets and liabilities as to term and nature; and
 - (4) be appropriate considering the capital and surplus and the business conducted by the insurer.

(c) At least annually, the board of directors or corresponding authority shall review the adequacy of the investment plan and the implementation of the plan.

(d) An insurer shall maintain the insurer's investment plan in the insurer's principal office and provide the plan to the commissioner or the commissioner's designee on request. The commissioner or the commissioner's designee shall maintain the plan as a privileged and confidential document. The plan is not subject to public disclosure.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 424.057. INVESTMENT RECORDS. An insurer shall maintain investment records covering each transaction. The insurer must be able to demonstrate at all times to the department that the insurer's investments are within the limitations imposed by the statutes listed in Section 424.056(a).

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 424.058. AUTHORIZED INVESTMENTS: FORM OF MINIMUM CAPITAL AND SURPLUS. An insurer may invest the insurer's funds in excess of minimum capital and surplus in any manner authorized by Section 822.204 for investment of the insurer's minimum capital and surplus.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 424.059. AUTHORIZED INVESTMENTS: GOVERNMENT OBLIGATIONS.

An insurer may invest the insurer's funds in excess of minimum capital and surplus in a bond or other evidence of indebtedness of any state or of Canada or a province of Canada that:

- (1) is issued by the authority of law; and
- (2) at the time of purchase:
 - (A) bears interest; and
 - (B) is not in default as to principal or interest.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 424.060. AUTHORIZED INVESTMENTS: STOCK OF NATIONAL OR STATE BANK. (a) An insurer may invest the insurer's funds in excess of minimum capital and surplus in the stock of:

- (1) a national bank; or
- (2) a state bank of this state whose deposits are insured by the Federal Deposit Insurance Corporation.

(b) Notwithstanding Subsection (a)(2):

- (1) not more than 35 percent of the total outstanding stock of a single state bank may be purchased by a single insurer; and
- (2) if an insurer has invested the insurer's funds in 35 percent of a state bank's stock under this section, no other insurer may invest funds in the bank's remaining stock.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 424.061. AUTHORIZED INVESTMENTS: DEPOSITS IN CERTAIN FINANCIAL INSTITUTIONS. (a) Subject to this section, an insurer may invest in any type of savings deposit, time deposit, certificate of deposit, NOW account, or money market account in a solvent bank, savings and loan association, or credit union that is organized under the laws of the United States or a state, or in a branch of one of those financial institutions.

(b) An investment under this section must be made in accordance with the laws or regulations applicable to the bank, savings and loan association, or credit union.

(c) The amount of an insurer's deposits in a single bank,

savings and loan association, or credit union may not exceed the greater of:

- (1) 20 percent of the insurer's capital and surplus;
- (2) the amount of federal or state deposit insurance coverage that applies to the deposits; or
- (3) 10 percent of the amount of capital, surplus, and undivided profits of the financial institution receiving the deposits.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 424.062. AUTHORIZED INVESTMENTS: CERTAIN OBLIGATIONS OF PARTNERSHIP OR CORPORATION. (a) Except as provided by this section, an insurer may invest the insurer's funds in excess of minimum capital and surplus in a stock, bond, debenture, bill of exchange, evidence of indebtedness, other commercial note or bill, or security of any partnership or dividend-paying corporation that:

- (1) is incorporated under the laws of the United States, this state, another state, Canada, or a province of Canada;
- (2) is solvent at the time of the investment; and
- (3) has not defaulted in the payment of any of the partnership's or corporation's obligations during the five years preceding the date of the investment.

(b) Except as provided by Subsection (d), an insurer may invest the insurer's funds in excess of minimum capital and surplus, and all reserves required by law, in a stock, bond, or debenture of any solvent corporation that is incorporated under the laws of the United States, this state, another state, Canada, or a province of Canada.

(c) Funds invested under Subsection (a) may not be invested in the stock of an oil, manufacturing, or mercantile corporation unless the corporation has, at the time of the investment:

- (1) a net worth of at least \$250,000, if the corporation is organized under the laws of this state; or
- (2) a combined capital, surplus, and undivided profits of at least \$2.5 million, if the corporation is not organized under the laws of this state.

(d) An insurer may not invest the insurer's funds in:

- (1) the insurer's own stock or in any stock on account of

which the holders or owners of the stock may be liable for an assessment other than taxes; or

(2) any stock, bond, or other security issued by a corporation with respect to which a majority of the stock having voting powers is directly or indirectly owned by or for the benefit of an officer or director of the insurer, unless the insurer has been in continuous operation for at least five years.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 424.063. AUTHORIZED INVESTMENTS: MUTUAL FUNDS. An insurer may invest the insurer's funds in excess of minimum capital and surplus in shares of a mutual fund engaged in business under the Investment Company Act of 1940 (15 U.S.C. Section 80a-1 et seq.), as amended, if:

(1) the mutual fund is solvent and has at least \$1 million of net assets as of the date of the mutual fund's latest annual or more recent certified audited financial statement; and

(2) the amount of the insurer's investment in a single mutual fund does not exceed 15 percent of the insurer's capital and surplus.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 424.064. AUTHORIZED INVESTMENTS: REAL PROPERTY. (a) Subject to this section, an insurer may invest the insurer's funds in excess of minimum capital and surplus in real property to the extent authorized by other provisions of this code.

(b) An insurer with admitted assets of more than \$500 million may own investment real property other than real property authorized by another provision of this code, or participations in that other investment real property, if the property is materially enhanced in value by:

(1) the construction of durable, permanent-type buildings and other improvements that cost an amount at least equal to the cost of the real property, excluding buildings and improvements at the time the property is acquired; or

(2) the construction, commenced before the second anniversary of the date the real property is acquired, of buildings and improvements described by Subdivision (1).

(c) The amount invested by an insurer in a single investment real property and improvements, or in any interest in real property and improvements, may not exceed five percent of the insurer's admitted assets in excess of \$500 million. The total amount invested by an insurer in investment real property and improvements may not exceed 15 percent of the insurer's admitted assets in excess of \$500 million.

(d) Except as provided by Section 862.002, an insurer may not own, develop, or hold an equity interest in any residential property or subdivision, single or multiunit family dwelling property, or undeveloped real property to subdivide for or develop residential, single or multiunit family dwellings. This subsection does not apply to an insurer with admitted assets of \$10 billion or more.

(e) The investment authority granted by this section is in addition to and separate from the investment authority granted by Section 862.002, except that an insurer may not invest in any real property that, when added to properties acquired by the insurer under Section 862.002, would exceed the limitations prescribed by that section.

(f) An insurer's admitted assets are determined from the insurer's annual statements that are made as of the December 31 that precedes the date of the determination and are filed with the department as required by law. The value of any investment made under this section is subject to the appraisal requirement of Section 862.002.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 1175 (S.B. 841), Sec. 1, eff. September 1, 2013.

Sec. 424.065. ACTING AS REAL ESTATE BROKER OR SALESPERSON PROHIBITED. An insurer defined in Section 822.001 or 822.201 or another insurer specifically made subject to Sections 424.051, 424.053-424.071, and 424.074 may not engage in the business of a

broker or salesperson as defined by Chapter 1101, Occupations Code, except that the insurer may hold, improve, maintain, manage, rent, lease, sell, exchange, or convey any of the real property interests legally owned as investments under this code.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 424.066. AUTHORIZED INVESTMENTS: OBLIGATIONS SECURED BY REAL PROPERTY LOANS. (a) Subject to this section, an insurer may invest the insurer's funds in excess of minimum capital and surplus in a bond, note, or evidence of indebtedness, or a participation in a bond, note, or evidence of indebtedness, that is secured by a valid first lien on real property or a leasehold estate in real property located in the United States or in any state, commonwealth, territory, or possession of the United States.

(b) The amount of an obligation secured by a first lien on real property or a leasehold estate in real property may exceed 90 percent of the value of the real property or leasehold estate only if:

(1) the amount does not exceed 100 percent of the value of the real property or leasehold estate and the insurer or one or more wholly owned subsidiaries of the insurer owns, in the aggregate, a 10 percent or greater equity interest in the real property or leasehold estate;

(2) the amount does not exceed 95 percent of the value of the real property and:

(A) the property contains only a dwelling designed exclusively for occupancy by not more than four families for residential purposes; and

(B) the portion of the unpaid balance of the obligation that exceeds 90 percent of the value of the real property is guaranteed or insured by a mortgage guaranty insurer authorized to engage in business in this state; or

(3) the amount exceeds 90 percent of the value of the real property only to the extent the obligation is insured or guaranteed by:

(A) this state;

(B) the United States;

(C) the Federal Housing Administration under the

National Housing Act (12 U.S.C. Section 1701 et seq.), as amended; or
 (D) any other agency or instrumentality of the United States.

(c) The term of an obligation secured by a first lien on a leasehold estate in real property and improvements located on the property may not exceed a period equal to four-fifths of the unexpired term of the leasehold estate, and the obligation must fully amortize during that period. The term of the leasehold estate may not expire sooner than the 10th anniversary of the expiration date of the term of the obligation.

(d) An obligation secured by a first lien on a leasehold estate in real property and improvements located on the property must be payable in equal monthly, quarterly, semiannual, or annual payments of principal plus accrued interest to the date of the principal payment.

(e) An insurer's investment in a single obligation under this section may not exceed 10 percent of the insurer's capital and surplus. An insurer's aggregate investments under this section may not exceed 30 percent of the insurer's assets.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 424.067. AUTHORIZED INVESTMENTS: TRANSPORTATION EQUIPMENT. An insurer may invest the insurer's funds in excess of minimum capital and surplus in:

(1) an adequately secured equipment trust obligation, certificate, or other instrument evidencing an interest in transportation equipment wholly or partly located in the United States; and

(2) a right to receive determined portions of rental, purchase, or other fixed obligatory payments for the use or purchase of the equipment.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 424.068. AUTHORIZED INVESTMENTS: INVESTMENT IN FOREIGN JURISDICTION. (a) In addition to the investments in Canada

authorized by Sections 424.051, 424.058-424.071, and 424.074 and subject to this section, an insurer may invest the insurer's funds in excess of minimum capital and surplus in a foreign commonwealth, territory, or possession of the United States or a foreign country other than Canada, or invest in debt obligations and investments within a foreign commonwealth, territory, or possession of the United States or within a foreign country other than Canada if:

(1) the investment is similar to investments the insurer is authorized by Sections 424.051, 424.058-424.071, and 424.074 to make within the United States or Canada; and

(2) the debt obligation or investment is rated one or two by the securities valuation office.

(b) The aggregate amount of an insurer's investments in a single foreign jurisdiction under Sections 424.051, 424.058-424.071, and 424.074 or of an insurer's debt obligations or investments within a single foreign jurisdiction may not exceed:

(1) as to a foreign jurisdiction that is given a sovereign debt rating of one by the securities valuation office, 10 percent of the insurer's admitted assets;

(2) as to a debt obligation or investment within a foreign jurisdiction that is rated one or two by the securities valuation office, 10 percent of the insurer's admitted assets; or

(3) as to any foreign investment other than an investment described by Subdivision (1) or (2), five percent of the insurer's admitted assets.

(c) The amount of investments made under this section may not exceed the sum of:

(1) the amounts authorized by Section 424.073; and

(2) 20 percent of the insurer's assets.

(d) The combined total of the amount of investments made under this section, the amount of similar investments made within the United States and Canada, and any amounts of investments authorized by Section 424.073 may not exceed any limitation prescribed by Sections 424.051, 424.058-424.071, and 424.074.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. [2017](#)), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 1175 (S.B. [841](#)), Sec. 2, eff. September 1, 2013.

Sec. 424.069. AUTHORIZED INVESTMENTS: CERTAIN LOANS. An insurer may invest the insurer's funds in excess of minimum capital and surplus in a loan on the pledge of any mortgage, stock, bond, or other evidence of indebtedness acceptable as an investment under Sections 424.051, 424.053-424.071, and 424.074, if the current value of the mortgage, stock, bond, or other evidence of indebtedness is at least 25 percent more than the amount of the loan.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 424.070. AUTHORIZED INVESTMENTS: OBLIGATIONS OF LOCAL GOVERNMENTAL ENTITIES. (a) Subject to this section, an insurer may invest the insurer's funds in excess of minimum capital and surplus in a bond or other interest-bearing evidence of indebtedness of a:

- (1) county or subdivision of a county;
- (2) municipality;
- (3) road district;
- (4) turnpike district or authority;
- (5) water district;
- (6) school district;
- (7) sanitary or navigation district; or

(8) municipally owned revenue water system, sewer system, or electric utility company with respect to which the municipality has appropriated, pledged, or otherwise provided for special revenues to meet the principal and interest payments of the bond or other evidence of indebtedness.

(b) A bond or other evidence of indebtedness of a navigation district is an authorized investment under this section only if:

- (1) the navigation district is located wholly or partly in a county that has a population of at least 100,000; and
- (2) the interest due on the bond or other evidence of indebtedness has never been in default.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 424.071. AUTHORIZED INVESTMENTS: THE UNIVERSITY OF TEXAS. An insurer may invest the insurer's funds in excess of minimum capital and surplus in an interest-bearing note or bond of The University of Texas issued under the laws of this state.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 424.072. AUTHORIZED INVESTMENTS: BONDS ISSUED, ASSUMED, OR GUARANTEED IN INTERNATIONAL MARKET. An insurer may invest the insurer's funds in excess of minimum capital and surplus in bonds issued, assumed, or guaranteed by any of the following international financial institutions in which the United States is a member:

- (1) the Inter-American Development Bank;
- (2) the International Bank for Reconstruction and Development (the World Bank);
- (3) the African Development Bank;
- (4) the Asian Development Bank; or
- (5) the International Finance Corporation.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 424.073. AUTHORIZED INVESTMENTS: INSURER ENGAGED IN BUSINESS IN FOREIGN COUNTRY. (a) Subject to this section, an insurer authorized by the law of a foreign country to engage in a line of insurance in which the insurer is authorized to engage in this state may invest in foreign securities originating in the foreign country of the same kind as the domestic securities originating in the United States in which the insurer is authorized to invest under Sections 424.051, 424.053-424.071, and 424.074.

(b) The aggregate amount of an insurer's investments made under this section in a single country may not exceed by more than 10 percent at any time the lesser of:

- (1) the amount of funds required by the law of the foreign country to be maintained in securities originating in that country; or
- (2) the amount of total unearned premium reserves, reinsurance reserves, loss reserves, and any other liabilities

required by the law of this state to be carried by the insurer that are directly attributable to the particular insurance policies or contracts on residents or property located in the foreign country.

(c) This section does not authorize an insurer to invest in a foreign security originating in a foreign country with respect to which the president of the United States or other federal authority has refused to exercise the authority to issue guarantees on projects in the country to citizens or corporations of the United States against loss by reason of inconvertibility of currency, expropriation, confiscation, war, revolution, or insurrection because the foreign country has failed to enter into arrangements for the security of American property as required by the president or other federal authority for the issuance of those guarantees.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 424.074. OTHER SPECIFICALLY AUTHORIZED INVESTMENTS. An insurer may invest the insurer's funds in excess of minimum capital and surplus in:

(1) a savings account as authorized by Chapter 65, Finance Code;

(2) a bond or other indebtedness as authorized by Sections 435.045 and 435.046, Government Code;

(3) a bond issued under Subchapter B, Chapter 1505, Government Code;

(4) a bond as authorized by Subchapter B, Chapter 284, Transportation Code;

(5) a municipal bond issued under Sections 51.038 and 51.039, Water Code;

(6) an insured account or evidence of indebtedness as authorized by Section 1, Chapter 160, General Laws, Acts of the 43rd Legislature, Regular Session, 1933 (Article 842a, Vernon's Texas Civil Statutes);

(7) an insured or guaranteed obligation as authorized by Chapter 230, Acts of the 49th Legislature, Regular Session, 1945 (Article 842a-1, Vernon's Texas Civil Statutes);

(8) a bond issued under Section 1, Chapter 1, page 427, General Laws, Acts of the 46th Legislature, Regular Session, 1939

(Article 1269k-1, Vernon's Texas Civil Statutes);

(9) a bond as authorized by Section 24, Chapter 110, Acts of the 51st Legislature, Regular Session, 1949 (Article 8280-133, Vernon's Texas Civil Statutes);

(10) a bond as authorized by Section 19, Chapter 340, Acts of the 51st Legislature, Regular Session, 1949 (Article 8280-137, Vernon's Texas Civil Statutes);

(11) a bond as authorized by Section 10, Chapter 398, Acts of the 51st Legislature, Regular Session, 1949 (Article 8280-138, Vernon's Texas Civil Statutes);

(12) a bond as authorized by Section 18, Chapter 465, Acts of the 51st Legislature, Regular Session, 1949 (Article 8280-139, Vernon's Texas Civil Statutes); or

(13) another investment specifically authorized by law.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. [2017](#)), Sec. 1, eff. April 1, 2007.

Sec. 424.075. AUTHORIZED INVESTMENTS: BOND EXCHANGE-TRADED FUNDS. (a) An insurer may invest the insurer's funds in excess of minimum capital and surplus in shares of a bond exchange-traded fund registered under the Investment Company Act of 1940 (15 U.S.C. Section 80a-1 et seq.), as amended, if:

(1) the exchange-traded fund is solvent and reported at least \$100 million of net assets in the exchange-traded fund's latest annual or more recent certified audited financial statement;

(2) the securities valuation office has designated the exchange-traded fund as meeting the criteria to be placed on the list promulgated by the securities valuation office of exchange-traded funds eligible for reporting as a long-term bond in the Purposes and Procedures Manual of the securities valuation office or a successor publication; and

(3) the amount of the insurer's investment in the exchange-traded fund does not exceed 15 percent of the insurer's capital and surplus.

(b) This section does not authorize an insurer to invest in a bond exchange-traded fund that has:

(1) embedded structural features designed to deliver performance that does not track the full unlevered and positive

return of the underlying index or exposure, including a leveraged or inverse exchange-traded fund; or

(2) an expense ratio in excess of 100 basis points.

(c) An insurer may deposit with the department shares of a bond exchange-traded fund described by Subsection (a) as a statutory deposit if state law requires a statutory deposit from the insurer.

Added by Acts 2019, 86th Leg., R.S., Ch. 1132 (H.B. 2694), Sec. 1, eff. September 1, 2019.

SUBCHAPTER C. INVESTMENT POOLS

Sec. 424.101. DEFINITIONS. In this subchapter:

(1) "Business entity" means an association, corporation, joint stock company, joint venture, limited liability company, mutual fund trust, partnership, or other similar form of business organization, regardless of whether organized for profit.

(2) "Obligation" means:

(A) a bond, note, debenture, trust certificate, including an equipment certificate, or production payment;

(B) a negotiable bank certificate of deposit, bankers' acceptance, credit tenant loan, or other loan secured by financing net leases; or

(C) any other evidence of indebtedness for the payment of money or participation certificates or other evidences of an interest in an obligation otherwise described by this subdivision, whether constituting a general obligation of the issuer or payable only out of certain revenues or certain funds pledged or otherwise dedicated for payment.

(3) "Qualified bank" means a national bank, state bank, or trust company that:

(A) is at all times adequately capitalized as determined by the standards adopted by the United States banking regulators; and

(B) is either a member of the Federal Reserve System or regulated by state banking laws.

(4) "Repurchase transaction," "reverse repurchase transaction," and "securities lending transaction" have the meanings assigned by Section 424.151.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April

1, 2007.

Sec. 424.102. AUTHORITY TO INVEST IN POOL. An insurer may acquire investments and participate in an investment pool that is qualified under Section 424.103(b) and the investments of which are limited to investments authorized for:

- (1) a short-term investment pool under Section 424.104; or
- (2) an authorized investment pool under Section 424.107.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 424.103. INVESTMENT POOL REQUIREMENTS AND QUALIFICATIONS.

(a) An investment pool must be a business entity.

(b) To be qualified, an investment pool must:

(1) have a written pooling agreement and a pool manager that comply with the requirements of this subchapter; and

(2) comply with Subsection (c).

(c) The investment pool may not:

(1) acquire securities issued, assumed, guaranteed, or insured by the investing insurer or an affiliate of the investing insurer;

(2) borrow or incur indebtedness for borrowed money, except for securities lending and reverse repurchase transactions that meet the requirements of this subchapter; or

(3) permit the aggregate value of securities loaned or sold to, purchased from, or invested in a single business entity at the time of the loan, sale, purchase, or investment to exceed 10 percent of the pool's total assets.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 424.104. AUTHORIZED INVESTMENTS FOR SHORT-TERM INVESTMENT POOL. A short-term investment pool may contain only:

- (1) obligations described by Section 424.105;
- (2) money market funds described by Section 424.106; or
- (3) repurchase, reverse repurchase, and securities lending

transactions that meet the requirements of Subchapter D.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 424.105. SHORT-TERM INVESTMENT POOL: CERTAIN SHORT-TERM OBLIGATIONS. (a) Obligations contained in a short-term investment pool must meet the requirements of this section.

(b) The obligations must:

(1) have a rating by the securities valuation office of one or two, or an equivalent rating issued by a nationally recognized statistical rating organization recognized by the securities valuation office; or

(2) be issued by an issuer with outstanding obligations that have a rating described by Subdivision (1).

(c) The obligations must have:

(1) a remaining maturity of 397 days or less or a put that:

(A) entitles the holder to receive the principal amount of the obligation; and

(B) may be exercised through maturity at specified intervals not exceeding 397 days; or

(2) a remaining maturity of three years or less and a floating interest rate that resets at least quarterly on the basis of a current short-term index and is not subject to a maximum limit, if the obligations do not have an interest rate that varies inversely to market interest rate changes.

(d) For purposes of this section, a current short-term index is:

(1) a federal funds rate;

(2) the prime rate;

(3) the rate for treasury bills;

(4) the London InterBank Offered Rate; or

(5) the rate for commercial paper.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 424.106. SHORT-TERM INVESTMENT POOL: CERTAIN MONEY MARKET FUNDS. A short-term investment pool may contain a money market fund

as described by 17 C.F.R. Section 270.2a-7 under the Investment Company Act of 1940 (15 U.S.C. Section 80a-1 et seq.), as amended, that is:

(1) a government money market fund that at all times:

(A) invests only in obligations issued, guaranteed, or insured by the United States or collateralized repurchase agreements composed of those obligations; and

(B) qualifies for investment without a reserve under the Purposes and Procedures Manual of the securities valuation office or a successor publication; or

(2) a class one money market fund that at all times qualifies for investment using the bond class one reserve factor described by the Purposes and Procedures Manual of the securities valuation office.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 424.107. AUTHORIZED INVESTMENTS FOR AUTHORIZED INVESTMENT POOL; LIMITATION. (a) An authorized investment pool may contain only investments that a participating insurer is authorized to acquire by provisions of this code other than this subchapter.

(b) The insurer's total of proportionate ownership interests in a single authorized investment held by an authorized investment pool and the insurer's direct investments in that authorized investment may not exceed the limit prescribed by the applicable authorizing provision.

(c) In addition to the limitation described by Subsection (b), an insurer is subject to the limitations described by Section 424.108.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 424.108. GENERAL INSURER INVESTMENT LIMITATIONS. An insurer may not acquire an investment in an investment pool if, as a result of and after making the investment, the aggregate amount of investments held by the insurer under this subchapter at the time of the investment:

(1) in a single investment pool would exceed 10 percent of the insurer's admitted assets;

(2) in all investment pools investing in investments authorized under Section 424.107 would exceed 25 percent of the insurer's admitted assets; or

(3) in all investment pools would exceed 35 percent of the insurer's admitted assets.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 424.109. DESIGNATION OF POOL MANAGER; QUALIFICATIONS. (a) The pooling agreement for an investment pool must designate a pool manager.

(b) The pool manager must be organized under the laws of the United States or a state and must be:

(1) the investing insurer, an affiliated insurer, or a business entity affiliated with the insurer;

(2) a qualified bank;

(3) a business entity registered under the Investment Advisers Act of 1940 (15 U.S.C. Section 80b-1 et seq.), as amended;

(4) the attorney-in-fact of a reciprocal or interinsurance exchange; or

(5) the United States manager or an affiliate or subsidiary of the United States manager of a United States branch of an alien insurer.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 424.110. POOL MANAGER TO MAINTAIN ASSETS; CUSTODY AGREEMENT. (a) The pool manager shall maintain the assets of the investment pool in one or more accounts, in the name of or on behalf of the pool, under a custody agreement with a qualified bank.

(b) The custody agreement must:

(1) state and recognize the claims and rights of each participant;

(2) acknowledge that the investment pool's underlying assets are held solely for the benefit of each participant in

proportion to the aggregate amount of the participant's investments in the pool; and

(3) contain an agreement that the pool's underlying assets may not be commingled with the general assets of the custodian qualified bank or any other person.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 424.111. POOLING AGREEMENT PROVISIONS. The pooling agreement for an investment pool must provide that:

(1) 100 percent of the ownership interests in the pool must at all times be held by:

(A) an insurer and the insurer's affiliated insurers;

(B) for a pool investing solely in investments authorized under Section 424.104, the insurer and the insurer's subsidiaries and affiliates or any pension or profit-sharing plan of the insurer and the insurer's subsidiaries and affiliates; or

(C) for a United States branch of an alien insurer, subsidiaries or affiliates of the insurer's United States manager;

(2) the pool's underlying assets are held solely for the benefit of each participant and may not be commingled with the general assets of the pool manager or any other person;

(3) each participant owns an undivided interest in the pool's underlying assets in proportion to the aggregate amount of the participant's interest in the pool; and

(4) a pool participant or, if a pool participant is insolvent, bankrupt, or in receivership, the participant's trustee, receiver, conservator, or other successor-in-interest may withdraw all or any portion of the participant's investment from the pool under the terms of the pooling agreement.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 424.112. WITHDRAWALS AND DISTRIBUTIONS. (a) A pool participant must be able to make withdrawals on demand without penalty or other assessment on any business day, and settlement of funds must occur within a reasonable and customary period that does

not exceed five business days after a withdrawal.

(b) The pooling agreement must provide that the pool manager shall make a distribution to a pool participant, at the manager's discretion:

(1) in cash in an amount equal to the fair market value at the time of the distribution of the participant's pro rata share of each of the pool's underlying assets;

(2) in kind in an amount equal to a pro rata share of each underlying asset; or

(3) in a combination of cash and in-kind distributions in an amount equal to a pro rata share of each underlying asset.

(c) A distribution under Subsection (b) must be computed after subtracting all the investment pool's applicable fees and expenses.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 424.113. INVESTMENT POOL RECORDS. The pool manager shall compile and maintain:

(1) detailed accounting records that show:

(A) the cash receipts and disbursements reflecting each pool participant's proportionate investment in the investment pool; and

(B) a complete description of all the pool's underlying assets, including the amount, interest rate, and maturity date, if any, of each of those assets and other appropriate designations; and

(2) other records that, on a daily basis, allow third parties to verify each participant's investment in the pool.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 424.114. INSPECTION OF RECORDS. The pool manager shall make records of the investment pool available for inspection by the commissioner.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 424.115. REPORTS OF TRANSACTIONS BETWEEN POOL AND PARTICIPANT. (a) A transaction between an investment pool and a pool participant is not subject to Subchapter C, Chapter 823, except that before entering into a pool, an insurer subject to Chapter 823 shall give the commissioner the written notice required under Section 823.103.

(b) The investment pool's investment activities and the transactions between the pool and a pool participant must be reported in the registration statement required by Subchapter B, Chapter 823.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

**SUBCHAPTER D. DOLLAR ROLL, REPURCHASE, REVERSE REPURCHASE,
AND SECURITIES LENDING TRANSACTIONS**

Sec. 424.151. DEFINITIONS. In this subchapter:

(1) "Dollar roll transaction" means two simultaneous transactions with settlement dates not more than 96 days apart, in one of which an insurer sells to a business entity, and in the other of which the insurer is obligated to purchase from the same business entity, substantially similar securities that are:

(A) mortgage-backed securities issued, assumed, or guaranteed by the Government National Mortgage Association, the Federal National Mortgage Association, the Federal Home Loan Mortgage Corporation, or a successor to one of those organizations; or

(B) other mortgage-backed securities referred to in 15 U.S.C. Section 77r-1 et seq., as amended.

(2) "Repurchase transaction" means a transaction in which an insurer purchases securities from a business entity that is obligated to repurchase the purchased securities or equivalent securities from the insurer at a specified price, either within a specified period or on demand.

(3) "Reverse repurchase transaction" means a transaction in which an insurer sells securities to a business entity and is obligated to repurchase the sold securities or equivalent securities from the business entity at a specified price, either within a specified period or on demand.

(4) "Securities lending transaction" means a transaction in which an insurer lends securities to a business entity that is

obligated to return the loaned securities or equivalent securities to the insurer, either within a specified period or on demand.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 424.152. TRANSACTIONS AUTHORIZED. An insurer may engage in dollar roll, repurchase, reverse repurchase, and securities lending transactions as provided by this subchapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 424.153. PERIOD OF TRANSACTION. An insurer must enter into a written agreement for each transaction under this subchapter, other than a dollar roll transaction. The agreement must require that the transaction terminate on or before the first anniversary of the transaction's inception.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 424.154. CASH REQUIREMENTS. With respect to cash received in a transaction under this subchapter, an insurer shall:

(1) invest the cash in accordance with this subchapter and in a manner that recognizes the liquidity needs of the transaction; or

(2) use the cash for the insurer's general corporate purposes.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 424.155. COLLATERAL REQUIREMENTS. (a) While a transaction under this subchapter is outstanding, the insurer or the insurer's agent or custodian shall maintain, as to acceptable collateral received in the transaction, either physically or through

the book-entry system of the Federal Reserve, Depository Trust Company, Participants Trust Company, or another securities depository approved by the commissioner:

- (1) possession of the collateral;
- (2) a perfected security interest in the collateral; or
- (3) in the case of a jurisdiction outside of the United States, title to, or the rights of a secured creditor to, the collateral.

(b) The amount of collateral required for repurchase, reverse repurchase, and securities lending transactions is the amount required under the Purposes and Procedures Manual of the securities valuation office or a successor publication.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 424.156. PERCENTAGE LIMITATIONS. (a) An insurer may not enter into a transaction under this subchapter if, as a result of and after making the transaction, the aggregate amount of securities loaned or sold to or purchased from:

- (1) a single business entity counterparty under this subchapter would exceed five percent of the insurer's assets; or
- (2) all business entities under this subchapter would exceed 40 percent of the insurer's assets.

(b) In computing the amount sold to or purchased from a business entity counterparty under a repurchase or reverse repurchase transaction, effect may be given to netting provisions under a master written agreement.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 424.157. RULES. The commissioner may adopt reasonable rules and issue reasonable orders as necessary to implement this subchapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

SUBCHAPTER E. RISK CONTROL TRANSACTIONS

Sec. 424.201. DEFINITIONS. In this subchapter:

(1) "Acceptable collateral" means:

- (A) cash;
- (B) cash equivalents;
- (C) letters of credit and direct obligations; or
- (D) securities that are fully guaranteed as to

principal and interest by the United States.

(2) "Business entity" includes an association, bank, corporation, joint stock company, joint tenancy, joint venture, limited liability company, mutual fund, partnership, sole proprietorship, trust, or other similar form of business organization, regardless of whether organized for profit.

(3) "Cap" means an agreement obligating the seller to make payments to the buyer, with each payment based on the amount by which a reference price or level or the performance or value of one or more underlying interests exceeds a predetermined number that is sometimes called the strike rate or strike price.

(4) "Cash equivalent" means an investment or security that is short-term, highly rated, highly liquid, and readily marketable. The term includes a money market fund described by Section 424.106. For purposes of this subdivision, an investment or security is:

- (A) short-term if it has a remaining term to maturity of one year or less; and
- (B) highly rated if it has:
 - (i) a rating of "P-1" by Moody's Investors Service, Inc.;
 - (ii) a rating of "A-1" by the Standard and Poor's Division of the McGraw Hill Companies, Inc.; or
 - (iii) an equivalent rating by a nationally recognized statistical rating organization recognized by the securities valuation office.

(5) "Collar" means an agreement to receive payments as the buyer of a cap, floor, or option and to make payments as the seller of a different cap, floor, or option.

(6)(A) "Counterparty exposure amount" means:

- (i) for an over-the-counter derivative instrument not entered into under a written master agreement that provides for netting of payments owed by the respective parties, the market value of the over-the-counter derivative instrument, if the liquidation of

the derivative instrument would result in a final cash payment to the insurer, or zero, if the liquidation of the derivative instrument would not result in a final cash payment to the insurer; or

(ii) for an over-the-counter derivative instrument entered into under a written master agreement that provides for netting of payments owed by the respective parties and for which the counterparty's domiciliary jurisdiction is within the United States or a foreign jurisdiction listed in the Purposes and Procedures Manual of the securities valuation office as eligible for netting, the greater of zero or the net sum payable to the insurer in connection with all derivative instruments subject to the written master agreement on the liquidation of the instruments in the event of the counterparty's default under the master agreement, if there is no condition precedent to the counterparty's obligation to make the payment and if there is no setoff of amounts payable under another instrument or agreement.

(B) For purposes of this subdivision, market value or the net sum payable, as applicable, must be determined at the end of the most recent quarter of the insurer's fiscal year and must be reduced by the market value of acceptable collateral held by the insurer or a custodian on the insurer's behalf.

(7) "Derivative instrument":

(A) means an agreement, option, or instrument, or a series or combination of agreements, options, or instruments:

(i) to make or take delivery of, or assume or relinquish, a specified amount of one or more underlying interests, or to make a cash settlement instead of making or taking delivery of, or assuming or relinquishing, a specified amount of an underlying interest; or

(ii) that has a price, performance, value, or cash flow based primarily on the actual or expected price, yield, level, performance, value, or cash flow of one or more underlying interests;

(B) includes an option, a warrant not otherwise permitted to be held by the insurer under this subchapter, a cap, a floor, a collar, a swap, a swaption, a forward, a future, any other substantially similar agreement, option, or instrument, and a series or combination of those agreements, options, or instruments; and

(C) does not include a collateralized mortgage obligation, another asset-backed security, a principal-protected structured security, a floating rate security, an instrument that an

insurer would otherwise be authorized to invest in or receive under a provision of this subchapter other than this subdivision, or a debt obligation of the insurer.

(8) "Derivative transaction" means a transaction involving the use of one or more derivative instruments. The term does not include a dollar roll transaction, repurchase transaction, reverse repurchase transaction, or securities lending transaction.

(9) "Floor" means an agreement obligating the seller to make payments to the buyer, each of which is based on the amount by which a predetermined number that is sometimes called the floor price or floor rate exceeds a reference level, performance, price, or value of one or more underlying interests.

(10) "Forward" means an agreement to make or take delivery in the future of one or more underlying interests, or to effect a cash settlement, based on the actual or expected level, performance, price, or value of those interests. The term does not include a future or a spot transaction effected within a customary settlement period, a when-issued purchase, or another similar cash market transaction.

(11) "Future" means an agreement traded on a futures exchange to make or take delivery of one or more underlying interests, or to effect a cash settlement, based on the actual or expected level, performance, price, or value of those interests.

(12) "Futures exchange" means a foreign or domestic exchange, contract market, or board of trade on which trading in futures is conducted and that, in the United States, is authorized to conduct that trading by the Commodity Futures Trading Commission or a successor to that agency.

(13) "Hedging transaction" means a derivative transaction entered into and maintained to manage, with respect to an asset, liability, or portfolio of assets or liabilities, that an insurer has acquired or incurred or anticipates acquiring or incurring:

(A) the risk of a change in value, yield, price, cash flow, or quantity; or

(B) the currency exchange rate risk.

(14) "Income generation transaction" means a derivative transaction entered into to generate income. The term does not include a hedging transaction or a replication transaction.

(15) "Market value" means the price for a security or derivative instrument obtained from a generally recognized source,

the most recent quotation from a generally recognized source, or if a generally recognized source does not exist, the price determined under the terms of the instrument or in good faith by the insurer, as can be reasonably demonstrated to the commissioner on request, plus the amount of accrued but unpaid income on the security or instrument to the extent that amount is not included in the price as of the date the security or instrument is valued.

(16) "Option" means an agreement giving the buyer the right to buy or receive, referred to as a "call option," to sell or deliver, referred to as a "put option," to enter into, extend, or terminate, or to effect a cash settlement based on the actual or expected level, performance, price, spread, or value of, one or more underlying interests.

(17) "Over-the-counter derivative instrument" means a derivative instrument entered into with a business entity in a manner other than through a securities exchange or futures exchange or cleared through a qualified clearinghouse.

(18) "Potential exposure" means:

(A) as to a futures position, the amount of initial margin required for that position; or

(B) as to a swap, collar, or forward, one-half of one percent multiplied by the notional amount multiplied by the square root of the remaining years to maturity.

(19) "Qualified clearinghouse" means a clearinghouse that:

(A) is subject to the rules of a securities exchange or a futures exchange; and

(B) provides clearing services, including acting as a counterparty to each of the parties to a transaction in a manner that eliminates the parties' credit risk to each other.

(20) "Replication transaction" means a derivative transaction or a combination of derivative transactions effected separately or in conjunction with cash market investments included in the insurer's investment portfolio to replicate the risks and returns of another authorized transaction, investment, or instrument or to operate as a substitute for cash market transactions. The term does not include a hedging transaction.

(21) "Securities exchange" means:

(A) an exchange registered as a national securities exchange or a securities market registered under the Securities Exchange Act of 1934 (15 U.S.C. Section 78a et seq.), as amended;

(B) the Private Offerings, Resales and Trading through Automated Linkages system; or

(C) a designated offshore securities market as defined by 17 C.F.R. Section 230.902, as amended.

(22) "Swap" means an agreement to exchange or to net payments at one or more times based on the actual or expected price, yield, level, performance, or value of one or more underlying interests.

(23) "Swaption" means an option to purchase or sell a swap at a given price and time or at a series of prices and times. The term does not include a swap with an embedded option.

(24) "Underlying interest" means an asset, liability, or other interest underlying a derivative instrument or a combination of those assets, liabilities, or interests. The term includes a security, currency, rate, index, commodity, or derivative instrument.

(25) "Warrant" means an instrument under which the holder has the right to purchase or sell the underlying interest at a given price and time or at a series of prices and times stated in the warrant.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 424.202. RISK CONTROL TRANSACTIONS AUTHORIZED. (a) Except as provided by Subsection (b), an insurer may engage in a risk control transaction authorized by this subchapter to:

- (1) protect the insurer's assets against the risk of changing asset values or interest rates;
- (2) reduce risk; and
- (3) generate income.

(b) An insurer with a statutory net capital and surplus as determined by the insurer's most recent financial statement required to be filed with the department that is less than the minimum amount of capital and surplus required for a new charter and certificate of authority for the same type of insurer may not engage in a transaction authorized under this subchapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 424.203. NOTICE OF INTENT TO ENGAGE IN RISK CONTROL TRANSACTIONS REQUIRED. (a) Before an insurer with a statutory net capital and surplus of less than \$10 million engages in a transaction authorized under this subchapter, the insurer shall file a written notice with the commissioner describing:

- (1) the need to engage in the transaction;
- (2) the lack of acceptable alternatives; and
- (3) the insurer's plan to engage in the transaction.

(b) If the commissioner does not issue an order prohibiting an insurer who files a notice under Subsection (a) from engaging in the transaction on or before the 90th day after the date the commissioner receives the notice, the insurer may engage in the transaction described in the notice.

(c) For purposes of this section, an insurer's net capital and surplus are determined by the insurer's most recent financial statement required to be filed with the department.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 424.204. TRADING REQUIREMENTS FOR DERIVATIVE INSTRUMENTS. Each derivative instrument must be:

- (1) traded on a securities exchange;
- (2) entered into with, or guaranteed by, a business entity;
- (3) issued or written by, or entered into with, the issuer of the underlying interest on which the derivative instrument is based; or

- (4) in the case of futures, traded through a broker who is:
 - (A) registered as a futures commission merchant under the Commodity Exchange Act (7 U.S.C. Section 1 et seq.), as amended; or

- (B) exempt from that registration under 17 C.F.R. Section 30.10, adopted under the Commodity Exchange Act (7 U.S.C. Section 1 et seq.), as amended.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 424.205. DERIVATIVE USE PLAN. (a) Before an insurer

enters into a derivative transaction, the insurer's board of directors must approve a derivative use plan as part of the insurer's investment plan otherwise required by law.

(b) The derivative use plan must:

- (1) describe investment objectives and risk constraints, such as counterparty exposure amounts;
- (2) define permissible transactions, identifying the risks to be hedged and the assets or liabilities being replicated; and
- (3) require compliance with the insurer's internal control procedures established under Section 424.206.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 424.206. INTERNAL CONTROL PROCEDURES. An insurer that enters into a derivative transaction shall establish written internal control procedures that require:

- (1) a quarterly report to the board of directors that reviews:
 - (A) each derivative transaction entered into, outstanding, or closed out;
 - (B) the results and effectiveness of the derivatives program; and
 - (C) the credit risk exposure to each counterparty for over-the-counter derivative transactions based on the counterparty exposure amount;
- (2) a system for determining whether hedging or replication strategies used by the insurer have been effective;
- (3) a system of reports, at least as frequent as monthly, to the insurer's management, that include:
 - (A) a description of each derivative transaction entered into, outstanding, or closed out during the period since the last report;
 - (B) the purpose of each outstanding derivative transaction;
 - (C) a performance review of the derivative instrument program; and
 - (D) the counterparty exposure amount for each over-the-counter derivative transaction;

(4) a written authorization that identifies the responsibilities and limitations of authority of each person authorized to effect and maintain derivative transactions; and

(5) appropriate documentation for each transaction, including:

(A) the purpose of the transaction;

(B) the assets or liabilities to which the transaction relates;

(C) the specific derivative instrument used in the transaction;

(D) for an over-the-counter derivative transaction, the name of the counterparty and the counterparty exposure amount; and

(E) for an exchange-traded derivative instrument, the name of the exchange and the name of the firm that handled the transaction.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 424.207. ABILITY TO DEMONSTRATE HEDGING CHARACTERISTICS AND EFFECTIVENESS. An insurer must be able to demonstrate to the commissioner on request the intended hedging characteristics and continuing effectiveness of a derivative transaction or combination of transactions through:

(1) cash flow testing;

(2) duration analysis; or

(3) other appropriate analysis.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 424.208. OFFSETTING TRANSACTIONS. (a) Subject to this section, an insurer may purchase or sell one or more derivative instruments to wholly or partly offset a derivative instrument previously purchased or sold, without regard to the quantitative limitations of this subchapter.

(b) An offsetting transaction under this section must use the same type of derivative instrument as the derivative instrument being offset.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 424.209. INCLUSION OF COUNTERPARTY EXPOSURE AMOUNTS. The insurer shall include all counterparty exposure amounts in determining compliance with the limitations of this subchapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 424.210. OVERSIGHT BY COMMISSIONER. (a) Not later than the 10th day before the date an insurer is scheduled to enter into an initial hedging transaction, the insurer shall notify the commissioner in writing that:

- (1) the insurer's board of directors has adopted an investment plan that authorizes hedging transactions; and
- (2) each hedging transaction will comply with this subchapter.

(b) If a hedging transaction does not comply with this subchapter or if continuing the transaction may create a hazardous financial condition for the insurer that affects the insurer's policyholders or creditors or the public, the commissioner may, after notice and an opportunity for a hearing, order the insurer to take action that the commissioner determines is reasonably necessary to:

- (1) remedy a hazardous financial condition; or
- (2) prevent an impending hazardous financial condition from occurring.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 424.211. AUTHORITY TO ENTER INTO HEDGING TRANSACTION. After providing notice under Section 424.210, an insurer may enter into a hedging transaction under this subchapter if as a result of and after making the transaction:

- (1) the aggregate statement value of all outstanding caps, floors, options, swaptions, and warrants not attached to another financial instrument purchased by the insurer under this subchapter,

other than a collar, does not exceed 7.5 percent of the insurer's assets;

(2) the aggregate statement value of all outstanding caps, floors, options, swaptions, and warrants written by the insurer under this subchapter, other than a collar, does not exceed three percent of the insurer's assets; and

(3) the aggregate potential exposure of all outstanding collars, forwards, futures, and swaps entered into or acquired by the insurer under this subchapter does not exceed 6.5 percent of the insurer's assets.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 424.212. AUTHORITY TO ENTER INTO INCOME GENERATION TRANSACTION. An insurer may enter into an income generation transaction only if:

(1) as a result of and after making the transaction, the sum of the following amounts does not exceed 10 percent of the insurer's assets:

(A) the aggregate statement value of admitted assets that at the time of the transaction are subject to call or that generate the cash flows for payments the insurer is required to make under caps and floors sold by the insurer and that at the time of the transaction are outstanding under this subchapter;

(B) the statement value of admitted assets underlying derivative instruments that at the time of the transaction are subject to calls sold by the insurer and outstanding under this subchapter; and

(C) the purchase price of assets subject to puts that at the time of the transaction are outstanding under this subchapter; and

(2) the transaction is a sale of:

(A) a call option on assets that meets the requirements of Section 424.213;

(B) a put option on assets that meets the requirements of Section 424.214;

(C) a call option on a derivative instrument, including a swaption, that meets the requirements of Section 424.215; or

(D) a cap or floor that meets the requirements of Section 424.216.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 424.213. LIMITATION ON SALE OF CALL OPTION ON ASSETS. If an income generation transaction is a sale of a call option on assets, the insurer must, during the entire period the option is outstanding, hold, or have a currently exercisable right to acquire, the underlying assets.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 424.214. LIMITATION ON SALE OF PUT OPTION ON ASSETS. (a) If an income generation transaction is a sale of a put option on assets, the insurer must:

(1) during the entire period the option is outstanding, hold sufficient cash, cash equivalents, or interests in a short-term investment pool to purchase the underlying assets on exercise of the option; and

(2) have the ability to hold the underlying assets in the insurer's portfolio.

(b) If during the entire period the put option is outstanding the total market value of all put options sold by the insurer exceeds two percent of the insurer's assets, the insurer shall set aside, under a custodial or escrow agreement, cash or cash equivalents that have a market value equal to the amount of the insurer's put option obligations in excess of two percent of the insurer's assets.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 424.215. LIMITATION ON SALE OF CALL OPTION ON DERIVATIVE INSTRUMENT. If an income generation transaction is a sale of a call option on a derivative instrument, including a swaption, the insurer must:

(1) during the entire period the call option is outstanding, hold, or have a currently exercisable right to acquire, assets generating the cash flow necessary to make any payment for which the insurer is liable under the underlying derivative instrument; and

(2) have the ability to enter into the underlying derivative transaction for the insurer's portfolio.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 424.216. LIMITATION ON SALE OF CAP OR FLOOR. If an income generation transaction is a sale of a cap or a floor, the insurer must, during the entire period the cap or floor is outstanding, hold, or have a currently exercisable right to acquire, assets generating the cash flow necessary to make any payment for which the insurer is liable under the cap or floor.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 424.217. AUTHORITY TO ENTER REPLICATION TRANSACTION. (a) An insurer may enter into a replication transaction only with the prior written approval of the commissioner.

(b) To be eligible for approval by the commissioner:

(1) the insurer must be otherwise authorized to invest the insurer's funds under this chapter in the asset being replicated; and

(2) the asset being replicated must be subject to all the provisions of this subchapter relating to the making of the transaction by the insurer with respect to that kind of asset as if the transaction constituted a direct investment by the insurer in the replicated asset.

(c) The commissioner may adopt rules regarding replication transactions as necessary to implement this section.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 424.218. RULES. The commissioner may adopt rules consistent with this subchapter that prescribe reasonable limits, standards, and guidelines for:

- (1) the risk control transactions authorized under this subchapter; and
- (2) plans related to those transactions.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

**CHAPTER 425. RESERVES AND INVESTMENTS FOR LIFE INSURANCE
COMPANIES AND RELATED ENTITIES
SUBCHAPTER A. GENERAL PROVISIONS**

Sec. 425.001. SECURITIES IN AMOUNT OF RESERVES REQUIRED. The commissioner, after determining the amount of the reserves required on all of a life insurance company's policies in force, shall ensure that the company has at least that amount in securities of the class and character required by the law of this state, after all debts and claims against the company and the minimum capital required by Chapter 841 or 982, as applicable, have been provided for.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.002. CERTAIN INSURERS: DEPOSIT OF SECURITIES, MONEY, OR PROPERTY IN AMOUNT OF LEGAL RESERVES. (a) Except as provided by Subsection (b), a life insurance company incorporated under the laws of this state may deposit with the department, for the common benefit of all the holders of the company's policies and annuity contracts and in an amount equal to the legal reserve on all the company's outstanding policies and contracts in force, securities of the character in which the law of this state permits the company to invest, or against which the law of this state permits the company to loan, the company's capital, surplus, or reserves.

(b) A life insurance company may not make a new deposit of securities after August 28, 1961, except to the extent expressly required by Section 425.003.

(c) For purposes of this section, securities may be physically delivered to the department without being accompanied by a written

transfer of a lien securing the securities. A life insurance company may deposit registered or unregistered United States government securities under this section.

(d) A life insurance company may deposit lawful money of the United States instead of all or part of the securities described by Subsection (a). A company may, for the purposes of the deposit described by Subsection (a), convey to the department in trust the real property in which any part of the company's reserve is lawfully invested. If the company conveys the property, the department shall hold the title to the property in trust until the company deposits with the department securities to take the place of the property, at which time the department shall reconvey the property to the company.

(e) The department may have any securities or real property appraised and valued before the securities or real property may be deposited with or conveyed to the department under this section. The life insurance company shall pay the reasonable expense of the appraisal or valuation.

(f) For purposes of state, county, and municipal taxation, the situs of the deposited securities is the municipality and county in which the life insurance company's charter requires the principal business office of the company making the deposit to be located.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.003. CERTAIN INSURERS: REQUIRED DEPOSITS OF SECURITIES; ADDITIONAL DEPOSITS AND WITHDRAWALS. (a) A life insurance company that, before August 28, 1961, issued or assumed the obligations of policies or annuity contracts that were registered as provided by Article 3.18, as that article existed before August 28, 1961, shall have on deposit with the department securities of the character described by Section 425.002 in an amount equal to or greater than the aggregate net value of the company's outstanding registered policies and annuity contracts in force.

(b) To comply with Subsection (a), a life insurance company shall periodically make additional deposits of securities in amounts of not less than \$5,000. A company whose deposits exceed the aggregate net value of the company's outstanding registered policies and annuity contracts in force may periodically withdraw the excess

in amounts of not less than \$5,000. A company may at any time withdraw any of the company's deposited securities by depositing in their place securities of equal value to the securities replaced and of a character authorized by this chapter.

(c) A life insurance company may at any time collect the interest, rents, and other income from the company's securities on deposit.

(d) The net value of each policy or annuity contract subject to this section is the policy's or contract's value according to the standard prescribed by state law when the first premium on the policy or contract is paid, minus the amount of any liens the life insurance company has against the policy or contract not to exceed the policy's or contract's value.

(e) The department shall hold a life insurance company's securities on deposit with the department under this section in trust for the benefit of all holders of the company's outstanding policies and annuity contracts that were registered as provided by Article 3.18, as that article existed before August 28, 1961.

(f) A life insurance company that has outstanding registered policies or annuity contracts in force may not reinsure all or any part of that outstanding business, other than in a company authorized to engage in business in this state.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.004. RECORDS OF SECURITIES DEPOSITED WITH DEPARTMENT; REPORT OF VALUE. Each life insurance company that is required by Section 425.003 to have securities on deposit with the department shall:

- (1) keep records of:
 - (A) all of the company's outstanding registered policies and annuity contracts in force; and
 - (B) the net value of those policies and contracts; and
- (2) not later than the 15th day after the last day of each calendar month, file with the department a report stating whether the value of the company's securities on deposit is equal to or greater than the aggregate net value of the company's registered policies and annuity contracts outstanding and in force at the end of the

preceding calendar month.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.005. DEPARTMENT DUTIES REGARDING DEPOSITED SECURITIES; INSURANCE COMPANY ACCESS. (a) The department shall keep securities deposited by a life insurance company under Sections 425.002 and 425.003 in a secure safe-deposit, fireproof box or vault in the municipality of, or a municipality near the location of, the company's home office.

(b) The life insurance company's officers may, in accordance with reasonable rules adopted by the commissioner, have access to the securities to detach interest coupons, credit payment, and exchange securities as provided by Section 425.003.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.006. ADDITIONAL RESERVES REQUIRED: SUBSTANDARD OR EXTRA HAZARDOUS POLICIES. (a) If a life insurance company engaged in business under the laws of this state has written or assumed risks that are substandard or extra hazardous and has charged more for the policies under which those risks are written or assumed than the company's published premium rates, the commissioner shall, in valuing those policies, compute and charge extra reserves on the policies as necessary because of the extra hazard assumed and the extra premium charged.

(b) If the commissioner determines, after notice and hearing, that a particular risk or class of risks is substandard or extra hazardous, a life insurance company may not, after the determination is made, write or assume the particular risk or class of risks unless the company charges an extra premium as necessary because of the extra hazard assumed.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.007. SUBSCRIPTION TO OR UNDERWRITING PURCHASE OR SALE OF SECURITIES OR PROPERTY PROHIBITED; CONTROL OF DISPOSITION OF PROPERTY. (a) A life insurance company organized under the laws of this state may not:

- (1) subscribe to, or participate in, any underwriting of the purchase or sale of securities or property;
- (2) enter into a transaction described by Subdivision (1) for a purpose described by Subdivision (1);
- (3) sell on account of the company jointly with any other person, firm, or corporation; or
- (4) enter into any agreement to withhold from sale any of the company's property.

(b) The disposition of the life insurance company's property must be at all times within the control of the company's board of directors.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.008. AUTHORIZED INVESTMENTS FOR FOREIGN COMPANIES. A foreign company shall invest the company's assets in:

- (1) securities or property of the same classes in which the law of this state permits a domestic insurance company to invest; or
- (2) securities permitted by other law of this state and approved by the commissioner as being of substantially the same grade as securities or property in which a domestic insurance company is permitted to invest.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.009. STUDENT LOANS. A foreign or domestic life insurance company may make loans to a student enrolled in an institution of higher education if the principal amount of the loan is insured by:

- (1) the federal government under the Higher Education Act of 1965 (Pub. L. No. 89-329), as amended; or
- (2) the Texas Guaranteed Student Loan Corporation under Chapter 57, Education Code.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

SUBCHAPTER B. STANDARD VALUATION LAW

Sec. 425.051. SHORT TITLE. This subchapter may be cited as the Standard Valuation Law.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.052. DEFINITIONS. (a) In this subchapter:

(1) "Accident and health insurance" means contracts that incorporate morbidity risk and provide protection against economic loss resulting from accident, sickness, or medical conditions and as may be specified in the valuation manual.

(2) "Appointed actuary" means a qualified actuary who is appointed in accordance with the valuation manual to prepare the actuarial opinion required by Section 425.0545.

(3) "Company" means an entity that:

(A) has written, issued, or reinsured life insurance contracts, accident and health insurance contracts, or deposit-type contracts in this state and has at least one such policy in force or on claim; or

(B) has written, issued, or reinsured life insurance contracts, accident and health insurance contracts, or deposit-type contracts in any state and is required to hold a certificate of authority to write life insurance, accident and health insurance, or deposit-type contracts in this state.

(4) "Deposit-type contract" means a contract that does not incorporate mortality or morbidity risk and as may be specified in the valuation manual.

(5) "Life insurance" means contracts that incorporate mortality risk, including annuity and pure endowment contracts, and as may be specified in the valuation manual.

(6) "Policyholder behavior" means any action a policyholder, a contract holder, or any other person with the right to elect options, such as a certificate holder, may take under a policy or contract subject to this subchapter, including lapse,

withdrawal, transfer, deposit, premium payment, loan, annuitization, or benefit elections prescribed by the policy or contract but excluding events of mortality or morbidity that result in benefits prescribed in their essential aspects by the terms of the policy or contract.

(7) "Principle-based valuation" means the valuation described by Section 425.074.

(8) "Qualified actuary" means an individual who is qualified to sign the applicable statement of actuarial opinion in accordance with the American Academy of Actuaries' qualification standards for actuaries signing such statements and who meets the requirements specified in the valuation manual.

(9) "Reserves" means reserve liabilities.

(10) "Tail risk" means a risk that occurs either where the frequency of low probability events is higher than expected under a normal probability distribution or where there are observed events of very significant size or magnitude.

(11) "Valuation manual" means the manual of valuation instructions adopted by the commissioner by rule.

(b) As used in this subchapter:

(1) an "issue year basis" of valuation means a valuation basis under which the interest rate used to determine the minimum valuation standard for the entire duration of the annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of issue or year of purchase of the annuity or guaranteed interest contract; and

(2) a "change in fund basis" of valuation means a valuation basis under which the interest rate used to determine the minimum valuation standard applicable to each change in the fund held under the annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of the change in the fund.

(c) The definitions under Subsection (a) of "accident and health insurance," "appointed actuary," "company," "deposit-type contract," "life insurance," "policyholder behavior," "principle-based valuation," "qualified actuary," and "tail risk" apply only on and after the operative date of the valuation manual.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. [2017](#)), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 313 (S.B. 1654), Sec. 1, eff. September 1, 2015.

Sec. 425.053. ANNUAL VALUATION OF RESERVES FOR POLICIES AND CONTRACTS ISSUED BEFORE OPERATIVE DATE OF VALUATION MANUAL. (a) The department shall annually value or cause to be valued the reserves for all outstanding life insurance policies and annuity and pure endowment contracts of each life insurance company engaged in business in this state issued before the operative date of the valuation manual.

(b) In computing reserves under Subsection (a), the department may use group methods and approximate averages for fractions of a year or otherwise.

(c) Instead of valuing the reserves as required by Subsection (a) for a foreign or alien company, the department may accept any valuation made by or for the insurance supervisory official of another state or jurisdiction if the valuation complies with the minimum standard provided by this subchapter.

(d) Except as otherwise provided by this subchapter, policies and contracts issued on or after the operative date of the valuation manual are governed by Section 425.0535.

(e) The minimum standards for the valuation of policies and contracts issued before the operative date of the valuation manual are as provided by Sections 425.058 through 425.071 and Section 425.072(b), as applicable. Sections 425.072(a), 425.073, and 425.074 do not apply to a policy or contract described by this subsection.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 313 (S.B. 1654), Sec. 2, eff. September 1, 2015.

Acts 2015, 84th Leg., R.S., Ch. 313 (S.B. 1654), Sec. 3, eff. September 1, 2015.

Sec. 425.0535. ANNUAL VALUATION OF RESERVES FOR POLICIES AND CONTRACTS ISSUED ON OR AFTER OPERATIVE DATE OF VALUATION MANUAL. (a) The commissioner shall annually value, or cause to be valued, the

reserves for all outstanding life insurance contracts, annuity and pure endowment contracts, accident and health contracts, and deposit-type contracts of each company issued on or after the operative date of the valuation manual.

(b) In lieu of the valuation of the reserves required of a foreign or alien company, the commissioner may accept a valuation made, or caused to be made, by the insurance supervisory official of another state if the valuation complies with the minimum standard provided by this subchapter.

(c) Sections 425.072(a), 425.073, and 425.074 apply to all policies and contracts issued on or after the operative date of the valuation manual.

Added by Acts 2015, 84th Leg., R.S., Ch. 313 (S.B. 1654), Sec. 4, eff. September 1, 2015.

Sec. 425.054. ACTUARIAL OPINION OF RESERVES ISSUED BEFORE OPERATIVE DATE OF VALUATION MANUAL. (a) This section applies only to an actuarial opinion of reserves issued before the operative date of the valuation manual.

(a-1) For purposes of this section, "qualified actuary" means:

(1) a qualified actuary, as that term is defined by Section 802.002; or

(2) a person who, before September 1, 1993, satisfied the requirements of the former State Board of Insurance to submit an opinion under former Section 2A(a)(1), Article 3.28.

(b) In conjunction with the annual statement and in addition to other information required by this subchapter, each life insurance company engaged in business in this state shall annually submit to the department the opinion of a qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by commissioner rule:

(1) are computed appropriately;

(2) are based on assumptions that satisfy contractual provisions;

(3) are consistent with prior reported amounts; and

(4) comply with applicable laws of this state.

(c) The commissioner by rule shall specify the requirements of an actuarial opinion under Subsection (b), including any matters

considered necessary to the opinion's scope.

(d) The opinion required by this section must:

(1) apply to all of the life insurance company's business in force, including individual and group health insurance plans; and

(2) be in the form and contain the substance specified by commissioner rule and be acceptable to the commissioner.

(e) The commissioner may accept as an opinion required to be submitted under Subsection (b) by a foreign or alien company the opinion filed by that company with the insurance supervisory official of another state if the commissioner determines that the opinion filed in the other state reasonably meets the requirements applicable to a company domiciled in this state.

(f) Except as exempted by or as otherwise provided by commissioner rule, a life insurance company shall include in the opinion required by Subsection (b) an opinion that states whether the reserves and related actuarial items held in support of the policies and contracts specified by commissioner rule adequately provide for the company's obligations under the policies and contracts, including the benefits under and expenses associated with the policies and contracts.

(g) In making the opinion under Subsection (f), the reserves and related actuarial items are considered in light of the assets held by the life insurance company with respect to the reserves and related actuarial items, including:

(1) the investment earnings on the assets; and

(2) the considerations anticipated to be received and retained under the policies and contracts.

(h) The person who certifies the opinion required by Subsection (b) must make the opinion required by Subsection (f).

(i) Rules adopted under this section may exempt life insurance companies that would be exempt from the requirements of this section under the most recently adopted regulation by the National Association of Insurance Commissioners entitled "Model Actuarial Opinion and Memorandum Regulation," or a successor to that regulation, if the commissioner considers the exemption appropriate.

(j) Except as provided by Subsections (n), (o), and (p), any document or other information in the possession or control of the department that is a memorandum in support of the opinion or other material provided by the company to the commissioner in connection with a memorandum is confidential and privileged and not subject to:

- (1) disclosure under Chapter 552, Government Code;
- (2) subpoena;
- (3) discovery; or
- (4) admissibility as evidence in a private civil action.

(k) The commissioner or any person who receives a document or other information described by Subsection (j) while acting under the authority of the commissioner may not testify and may not be compelled to testify in a private civil action concerning the document or other information.

(1) The commissioner may:

(1) share documents or other information, including the confidential and privileged documents or information described by Subsection (j), with another state, federal, or international regulatory agency, with the National Association of Insurance Commissioners and its affiliates and subsidiaries, and with state, federal, and international law enforcement authorities, provided that the recipient agrees to maintain the confidentiality of the document or information; and

(2) receive documents or other information, including confidential and privileged documents or information, from the National Association of Insurance Commissioners and its affiliates and subsidiaries, and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, provided that the commissioner shall maintain as confidential or privileged any document or information received with notice or understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document or information.

(m) Disclosing information or providing a document to the commissioner under this section, or sharing information as authorized under this section, does not result in a waiver of any applicable privilege or claim of confidentiality that may apply to the document or information.

(n) A memorandum in support of the opinion, and any other material provided by the company to the commissioner in connection with the memorandum, may be subject to subpoena for the purpose of defending an action seeking damages from the actuary submitting the memorandum by reason of an action required by this section or rules adopted under this section.

(o) The memorandum or other material provided by the company to the commissioner in connection with the memorandum may otherwise be

released by the commissioner with the written consent of the company, or to the Actuarial Board for Counseling and Discipline or its successor on receipt of a request stating that the memorandum or other material is required for the purpose of professional disciplinary proceedings and setting forth procedures satisfactory to the commissioner for preserving the confidentiality and privileged status of the memorandum or other material.

(p) The memorandum ceases to be confidential and privileged if:

(1) any portion of the memorandum is cited by the company in its marketing;

(2) the memorandum is cited by the company before a government agency other than a state insurance department; or

(3) the memorandum is released by the company to the news media.

(q) This section does not prohibit the commissioner from using information acquired under this section in the furtherance of a legal or regulatory action relating to the administration of this code.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 313 (S.B. 1654), Sec. 5, eff. September 1, 2015.

Acts 2015, 84th Leg., R.S., Ch. 313 (S.B. 1654), Sec. 6, eff. September 1, 2015.

Sec. 425.0545. ACTUARIAL OPINION OF RESERVES AFTER OPERATIVE DATE OF VALUATION MANUAL. (a) A company that has outstanding life insurance contracts, accident and health insurance contracts, or deposit-type contracts in this state and is subject to regulation by the department shall annually submit the opinion of the appointed actuary as to whether the reserves and related actuarial items held in support of the policies and contracts are computed appropriately, are based on assumptions that satisfy contractual provisions, are consistent with prior reported amounts, and are in compliance with applicable laws of this state. An opinion under this section must comply with provisions of the valuation manual, including in regard to any items necessary to its scope.

(b) Unless exempted by the valuation manual, a company

described by Subsection (a) shall include with the opinion required by that subsection an opinion of the same appointed actuary concerning whether the reserves and related actuarial items held in support of the policies and contracts specified in the valuation manual, when considered in light of the assets held by the company with respect to the reserves and related actuarial items, including investment earnings on the assets and considerations anticipated to be received and retained under the policies and contracts, make adequate provision for the company's obligations under the policies and contracts, including benefits under and expenses associated with the policies and contracts.

(c) Each opinion required by this section must:

(1) be in the form and contain the substance that is specified by the valuation manual and is acceptable to the commissioner;

(2) be submitted with the annual statement reflecting the valuation of reserves for each year ending on or after the operative date of the valuation manual;

(3) apply to all policies and contracts subject to this section, plus other actuarial liabilities specified by the valuation manual; and

(4) be based on standards adopted from time to time by the Actuarial Standards Board or its successor, and on any additional standards prescribed by the valuation manual.

(d) In the case of an opinion required to be submitted by a foreign or alien company, the commissioner may accept the opinion filed by the company with the insurance supervisory official of another state if the commissioner determines that the opinion reasonably meets the requirements applicable to a company domiciled in this state.

Added by Acts 2015, 84th Leg., R.S., Ch. 313 (S.B. 1654), Sec. 7, eff. September 1, 2015.

Sec. 425.055. SUPPORTING MEMORANDUM FOR ACTUARIAL OPINION. (a) A memorandum shall be prepared to support each actuarial opinion required by Section 425.054 or 425.0545. The form and substance of each supporting memorandum must comply with the commissioner's rules for memorandums subject to Section 425.054, or the valuation manual

for memorandums subject to Section 425.0545.

(b) The commissioner may engage an actuary or other financial specialist as defined by commissioner rule if:

(1) a life insurance company does not provide a supporting memorandum at the request of the commissioner in the time specified by rule; or

(2) the company provides a supporting memorandum, but the commissioner determines that the supporting memorandum does not meet the standards prescribed by rule or is otherwise unacceptable to the commissioner.

(c) The actuary or other financial specialist under Subsection (b) shall:

(1) review the actuarial opinion and the basis for the opinion; and

(2) prepare the supporting memorandum.

(d) A life insurance company is responsible for the expense of the actuary or other financial specialist under Subsection (b).

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 313 (S.B. 1654), Sec. 8, eff. September 1, 2015.

Sec. 425.056. LIMITATION ON LIABILITY FOR ACTUARIAL OPINION.

(a) Except in cases of fraud or wilful misconduct or as provided by Subsection (b), a person who certifies an opinion under Section 425.054 or 425.0545 is not liable for damages to a person, other than the life insurance company covered by the opinion, for an act, error, omission, decision, or other conduct with respect to the person's opinion.

(b) Subsection (a) does not apply to an administrative penalty imposed under Chapter 84.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 313 (S.B. 1654), Sec. 9, eff. September 1, 2015.

Sec. 425.057. DISCIPLINARY ACTION: COMPANY OR PERSON CERTIFYING OPINION. A company or person that certifies an opinion under Section 425.054 or 425.0545 and that violates Section 425.054, 425.0545, or 425.055 or rules adopted under those sections is subject to disciplinary action under Chapter 82.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 313 (S.B. 1654), Sec. 10, eff. September 1, 2015.

Sec. 425.058. COMPUTATION OF MINIMUM STANDARD: GENERAL RULE.

(a) Except as otherwise provided by Section 425.059, 425.060, 425.061, 425.062, or 425.063, the minimum standard for the valuation of an outstanding life insurance policy or annuity or pure endowment contract issued by a life insurance company on or after the date on which Chapter 1105 applies to policies issued by the company, as determined under Section 1105.002(a) or (b), is the commissioners reserve valuation method described by Sections 425.064, 425.065, and 425.068, computed using the table prescribed by this section and with interest at 3-1/2 percent or at the following rate, if applicable:

(1) in the case of a policy or contract issued on or after June 14, 1973, and before August 29, 1977, other than an annuity or pure endowment contract, four percent;

(2) in the case of a single premium life insurance policy issued on or after August 29, 1977, 5-1/2 percent; or

(3) in the case of a life insurance policy issued on or after August 29, 1977, other than a single premium life insurance policy, 4-1/2 percent.

(b) Except as provided by Subsection (c), for an ordinary life insurance policy issued on the standard basis, excluding any disability or accidental death benefits in the policy, the applicable table is the Commissioners 1941 Standard Ordinary Mortality Table, if the policy was issued before the date on which Section 1105.152 would apply to the policy, as determined under Section 1105.152(a) or (b), or the Commissioners 1958 Standard Ordinary Mortality Table, if Section 1105.152 applies to the policy. For a policy that is issued to insure a female risk:

(1) a modified net premium or present value for a policy issued before August 29, 1977, may be computed according to an age not more than three years younger than the insured's actual age; and

(2) a modified net premium or present value for a policy issued on or after August 29, 1977, may be computed according to an age not more than six years younger than the insured's actual age.

(c) For an ordinary life insurance policy issued on the standard basis, excluding any disability or accidental death benefits in the policy, and to which Subchapter B, Chapter 1105, applies, the applicable table is:

(1) the Commissioners 1980 Standard Ordinary Mortality Table;

(2) at the insurer's option for one or more specified life insurance plans, the Commissioners 1980 Standard Ordinary Mortality Table with Ten-Year Select Mortality Factors; or

(3) any ordinary mortality table adopted after 1980 by the National Association of Insurance Commissioners that is approved by commissioner rule for use in determining the minimum standard valuation for a policy to which this subdivision applies.

(d) For an industrial life insurance policy issued on the standard basis, excluding any disability or accidental death benefits in the policy, the applicable table is:

(1) the 1941 Standard Industrial Mortality Table, if the policy was issued before the date on which Section 1105.153 would apply to the policy as determined under Section 1105.153(a) or (b); or

(2) if Section 1105.153 applies to the policy:

(A) the Commissioners 1961 Standard Industrial Mortality Table; or

(B) any industrial mortality table adopted after 1980 by the National Association of Insurance Commissioners that is approved by commissioner rule for use in determining the minimum standard of valuation for a policy to which this subdivision applies.

(e) For an individual annuity or pure endowment contract, excluding any disability or accidental death benefits in the policy, the applicable table is the 1937 Standard Annuity Mortality Table, or at the insurer's option, the Annuity Mortality Table for 1949, Ultimate, or a modification of either table that is approved by the commissioner.

(f) For a group annuity or pure endowment contract, excluding

any disability or accidental death benefits in the policy, the applicable table is:

(1) the Group Annuity Mortality Table for 1951;

(2) a modification of that table approved by the commissioner; or

(3) at the insurance company's option, a table or a modification of a table prescribed for an individual annuity or pure endowment contract by Subsection (e).

(g) For total and permanent disability benefits in or supplementary to an ordinary policy or contract, the applicable tables are:

(1) for a policy or contract issued on or after January 1, 1966:

(A) the tables of Period 2 disablement rates and the 1930 to 1950 termination rates of the 1952 Disability Study of the Society of Actuaries, with due regard to the type of benefit; or

(B) any table of disablement rates and termination rates adopted after 1980 by the National Association of Insurance Commissioners that are approved by commissioner rule for use in determining the minimum standard of valuation for a policy to which this subdivision applies;

(2) for a policy or contract issued on or after January 1, 1961, and before January 1, 1966:

(A) a table described by Subdivision (1); or

(B) at the insurance company's option, the Class (3) Disability Table (1926); or

(3) for a policy issued before January 1, 1961, the Class (3) Disability Table (1926).

(h) A table described by Subsection (g) must, for an active life, be combined with a mortality table permitted for computing the reserves for a life insurance policy.

(i) For accidental death benefits in or supplementary to a policy, the applicable table is:

(1) for a policy issued on or after January 1, 1966:

(A) the 1959 Accidental Death Benefits Table; or

(B) any accidental death benefits table adopted after 1980 by the National Association of Insurance Commissioners that is approved by commissioner rule for use in determining the minimum standard of valuation for a policy to which this subdivision applies;

(2) for a policy issued on or after January 1, 1961, and

before January 1, 1966:

(A) a table described by Subdivision (1); or

(B) at the insurance company's option, the Inter-Company Double Indemnity Mortality Table; or

(3) for a policy issued before January 1, 1961, the Inter-Company Double Indemnity Mortality Table.

(j) A table described by Subsection (i) must be combined with a mortality table permitted for computing the reserves for a life insurance policy.

(k) For group life insurance, life insurance issued on the substandard basis and other special benefits, the applicable table is a table approved by the commissioner.

(1)(1) Notwithstanding any other law, the minimum reserve requirements applicable to a credit life policy issued under Chapter 1153 before January 1, 2009, are met if, in the aggregate, the reserves are maintained at 100 percent of the 1980 Commissioner's Standard Ordinary Mortality Table, with interest that does not exceed 5.5 percent.

(2) For credit life policy reserves on contracts issued to be effective on or after January 1, 2009, the reserve requirements shall be based on minimum reserve standards established by the commissioner by rule. The commissioner shall adopt the rules based on either:

(A) the 2001 CSO Male Composite Ultimate Mortality Table for male and female insureds; or

(B) another CSO Mortality Table approved by the National Association of Insurance Commissioners on or after January 1, 2009, for use on credit life policy reserves.

(3) For a single premium credit accident and health contract issued on or after January 1, 2009, the reserve requirements shall be based on minimum reserve standards established by the commissioner by rule. The commissioner shall adopt the rules based on either:

(A) the 1985 Commissioners Individual Disability Table A (85CIDA); or

(B) another Commissioner's Disability Table approved by the National Association of Insurance Commissioners on or after January 1, 2009, for use on credit accident and health policy reserves.

(4) For all credit insurance contracts, if the net premium

refund liability exceeds the aggregate recorded contract reserve, the insurer shall establish an additional reserve liability that is equal to the excess of the net refund liability over the contract reserve recorded. The net refund liability may include consideration of commission, premium tax, and other expenses recoverable.

(5) In addition to the rules required to be adopted under this subsection, the commissioner may adopt other rules to implement this subsection.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 399 (H.B. 1761), Sec. 1, eff. June 19, 2009.

Acts 2015, 84th Leg., R.S., Ch. 313 (S.B. 1654), Sec. 11, eff. September 1, 2015.

Sec. 425.059. COMPUTATION OF MINIMUM STANDARD FOR CERTAIN ANNUITIES AND PURE ENDOWMENT CONTRACTS. (a) This section applies to an individual annuity or pure endowment contract issued on or after January 1, 1979, and an annuity or pure endowment purchased on or after January 1, 1979, under a group annuity or pure endowment contract. This section also applies to an annuity or pure endowment contract issued by an insurer after the date specified in a written notice:

(1) that was filed with the State Board of Insurance after June 14, 1973, but before January 1, 1979; and

(2) under which the insurance company filing the notice elected to comply before January 1, 1979, with former Section 4, Article 3.28, with respect to individual or group annuities and pure endowment contracts as specified by the company in the notice.

(b) Except as provided by Section 425.060, 425.061, 425.062, or 425.063, the minimum standard for the valuation of an individual or group annuity or pure endowment contract, excluding any disability or accidental death benefits in the contract, is the commissioner's reserve valuation method described by Sections 425.064 and 425.065, computed using the table prescribed by this section and with interest at the following interest rate, as applicable:

(1) for an individual annuity or pure endowment contract

issued before August 29, 1977, other than an individual single premium immediate annuity contract, four percent;

(2) for an individual single premium immediate annuity contract issued before August 29, 1977, six percent;

(3) for an individual annuity or pure endowment contract issued on or after August 29, 1977, other than an individual single premium immediate annuity contract or an individual single premium deferred annuity or pure endowment contract, 4-1/2 percent;

(4) for an individual single premium immediate annuity contract issued on or after August 29, 1977, 7-1/2 percent;

(5) for an individual single premium deferred annuity or pure endowment contract issued on or after August 29, 1977, 5-1/2 percent;

(6) for an annuity or pure endowment purchased before August 29, 1977, under a group annuity or pure endowment contract, six percent; or

(7) for an annuity or pure endowment purchased on or after August 29, 1977, under a group annuity or pure endowment contract, 7-1/2 percent.

(c) For an individual annuity or pure endowment contract issued before August 29, 1977, the applicable table is:

(1) the 1971 Individual Annuity Mortality Table; or

(2) a modification of that table approved by the commissioner.

(d) For an individual annuity or pure endowment contract issued on or after August 29, 1977, including an individual single premium immediate annuity contract, the applicable table is:

(1) the 1971 Individual Annuity Mortality Table;

(2) an individual annuity mortality table adopted after 1980 by the National Association of Insurance Commissioners that is approved by the commissioner by rule for use in determining the minimum standard of valuation for a specified type of contract to which this subsection applies; or

(3) a modification of one of those tables approved by the commissioner.

(e) For an annuity or pure endowment purchased before August 29, 1977, under a group annuity or pure endowment contract, the applicable table is:

(1) the 1971 Group Annuity Mortality Table; or

(2) a modification of that table approved by the

commissioner.

(f) For an annuity or pure endowment purchased on or after August 29, 1977, under a group annuity or pure endowment contract, the applicable table is:

(1) the 1971 Group Annuity Mortality Table;

(2) a group annuity mortality table adopted after 1980 by the National Association of Insurance Commissioners that is approved by the commissioner by rule for use in determining the minimum standard of valuation for an annuity or pure endowment to which this subsection applies; or

(3) a modification of one of those tables approved by the commissioner.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 313 (S.B. 1654), Sec. 12, eff. September 1, 2015.

Sec. 425.060. APPLICABILITY OF CALENDAR YEAR STATUTORY VALUATION INTEREST RATES. The calendar year statutory valuation interest rates as defined by Sections 425.061, 425.062, and 425.063 are the interest rates used in determining the minimum standard for the valuation of:

(1) a life insurance policy to which Subchapter B, Chapter 1105, applies;

(2) an individual annuity or pure endowment contract issued on or after January 1, 1982;

(3) an annuity or pure endowment purchased on or after January 1, 1982, under a group annuity or pure endowment contract; or

(4) the net increase, if any, in a calendar year after January 1, 1982, in amounts held under a guaranteed interest contract.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.061. COMPUTATION OF CALENDAR YEAR STATUTORY VALUATION INTEREST RATE: GENERAL RULE. (a) For purposes of Subsection (b):

- (1) R1 is the lesser of R or .09;
- (2) R2 is the greater of R or .09;
- (3) R is the reference interest rate determined under Section 425.063; and
- (4) W is the weighting factor determined under Section 425.062.

(b) The calendar year statutory valuation interest rate ("I") is determined as provided by this section, with the results rounded to the nearest one-quarter of one percent:

- (1) for life insurance:

$$I = .03 + W(R1 - .03) + (W/2)(R2 - .09); \text{ and}$$

(2) for a single premium immediate annuity or annuity benefits involving life contingencies arising from another annuity with a cash settlement option or from a guaranteed interest contract with a cash settlement option, or for an annuity or guaranteed interest contract without a cash settlement option, or for an annuity or guaranteed interest contract with a cash settlement option that is valued on a change in fund basis:

$$I = .03 + W(R - .03).$$

(c) For an annuity or guaranteed interest contract with a cash settlement option that is valued on an issue year basis, other than an annuity or contract described by Subsection (b)(2):

- (1) the formula prescribed by Subsection (b)(1) applies to an annuity or guaranteed interest contract with a guarantee duration determined under Section 425.062(f) greater than 10 years; and
- (2) the formula prescribed by Subsection (b)(2) applies to an annuity or guaranteed interest contract with a guarantee duration determined under Section 425.062(f) of 10 years or less.

(d) Notwithstanding Subsections (b) and (c), if the calendar year statutory valuation interest rate for a life insurance policy issued in a calendar year as determined under Subsection (b) or (c), as applicable, would differ from the corresponding actual rate for similar policies issued in the preceding calendar year by less than one-half of one percent, the calendar year statutory valuation interest rate for the policy is the corresponding actual rate for the preceding calendar year. For purposes of this subsection, the calendar year statutory valuation interest rate for a life insurance policy issued in a calendar year is determined for 1980 using the reference interest rate defined for 1979, and is determined for each subsequent calendar year regardless of whether Subchapter B, Chapter

1105, applies to the policy.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.062. WEIGHTING FACTORS. (a) This section prescribes the weighting factors referred to in the formulas prescribed by Section 425.061.

(b) The weighting factor for a life insurance policy is determined by the following table:

Guarantee Duration (Years)	Weighting Factor
10 or less	.50
More than 10, but not more than 20	.45
More than 20	.35

(c) For purposes of Subsection (b), the guarantee duration is the maximum number of years the life insurance can remain in force on a basis guaranteed in the policy or under options to convert to life insurance plans with premium rates or nonforfeiture values, or both, that are guaranteed in the original policy.

(d) The weighting factor for a single premium immediate annuity or for annuity benefits involving life contingencies arising from another annuity with a cash settlement option or from a guaranteed interest contract with a cash settlement option is .80.

(e) The weighting factor for an annuity or a guaranteed interest contract, other than an annuity or contract to which Subsection (d) applies, is determined by the following tables:

(1) For an annuity or guaranteed interest contract that is valued on an issue year basis:

Guarantee Duration (Years)	Weighting Factor for Plan Type		
	A	B	C
5 or less:	.80	.60	.50
More than 5, but not more than 10:	.75	.60	.50
More than 10, but not more than 20:	.65	.50	.45
More than 20:	.45	.35	.35

(2) For an annuity or guaranteed interest contract that is valued on a change in fund basis, the factors prescribed by Subdivision (1) increased by:

Plan Type		
A	B	C
.15	.25	.05

(3) For an annuity or guaranteed interest contract that is valued on an issue year basis that does not guarantee interest on considerations received more than one year after issue or purchase, other than an annuity or contract that does not have a cash settlement option, or an annuity or guaranteed interest contract that is valued on a change in fund basis that does not guarantee interest rates on considerations received more than 12 months after the valuation date, the factors prescribed by Subdivision (1) or determined under Subdivision (2), as appropriate, increased by:

Plan Type		
A	B	C
.05	.05	.05

(f) For purposes of Subsection (e):

(1) for an annuity or guaranteed interest contract with a cash settlement option, the guarantee duration is the number of years for which the contract guarantees interest rates greater than the calendar year statutory valuation interest rate for life insurance policies with guarantee duration greater than 20 years; and

(2) for an annuity or guaranteed interest contract without a cash settlement option, the guarantee duration is the number of years from the issue or purchase date to the date annuity benefits are scheduled to begin.

(g) For purposes of Subsection (e):

(1) a policy is a "Plan Type A" policy if:

(A) the policyholder may withdraw funds at any time, but only:

(i) with an adjustment to reflect changes in interest rates or asset values after the insurance company receives the funds;

(ii) without an adjustment described by Subparagraph (i), provided that the withdrawal is in installments over five years or more; or

(iii) as an immediate life annuity; or

(B) the policyholder is not permitted to withdraw funds

at any time;

(2) a policy is a "Plan Type B" policy if:

(A) before the expiration of the interest rate guarantee:

(i) the policyholder may withdraw funds, but only:

(a) with an adjustment to reflect changes in interest rates or asset values after the insurance company receives the funds; or

(b) without an adjustment described by Subsubparagraph (a), provided that the withdrawal is in installments over five years or more; or

(ii) the policyholder is not permitted to withdraw funds; and

(B) on the expiration of the interest rate guarantee, the policyholder may withdraw funds in a single sum or in installments over less than five years, without an adjustment described by Paragraph (A)(i); and

(3) a policy is a "Plan Type C" policy if the policyholder may withdraw funds before the expiration of the interest rate guarantee in a single sum or in installments over less than five years:

(A) without an adjustment to reflect changes in interest rates or asset values after the insurance company receives the funds; or

(B) subject only to a fixed surrender charge that is a percentage of the fund stipulated in the contract.

(h) An insurance company may elect to value an annuity or guaranteed interest contract with a cash settlement option on an issue year basis or on a change in fund basis. A company must value an annuity or guaranteed interest contract without a cash settlement option on an issue year basis.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.063. REFERENCE INTEREST RATE. (a) In this section, "Moody's Corporate Bond Yield Average" means the Moody's Corporate Bond Yield Average--Monthly Average Corporates, as published by Moody's Investors Service, Inc.

(b) Except as provided by Subsection (g), the reference interest rate for purposes of Section 425.061 is determined as provided by Subsections (c)-(f).

(c) The reference interest rate for a life insurance policy is the lesser of the average over a period of 36 months or the average over a period of 12 months, ending on June 30 of the calendar year preceding the year of issue, of the Moody's Corporate Bond Yield Average.

(d) The reference interest rate is the average over a period of 12 months, ending on June 30 of the calendar year of issue or year of purchase, of the Moody's Corporate Bond Yield Average for:

(1) a single premium immediate annuity or annuity benefits involving life contingencies arising from another annuity with a cash settlement option or from a guaranteed interest contract with a cash settlement option;

(2) an annuity or guaranteed interest contract with a cash settlement option, other than an annuity or contract described by Subdivision (1), that is valued on an issue year basis and has a guarantee duration as determined under Section 425.062(f) of 10 years or less; or

(3) an annuity or guaranteed interest contract without a cash settlement option.

(e) The reference interest rate is the lesser of the average over a period of 36 months or the average over a period of 12 months, ending on June 30 of the calendar year of issue or purchase, of the Moody's Corporate Bond Yield Average for an annuity or guaranteed interest contract with a cash settlement option, other than an annuity or contract described by Subsection (d)(1), that is valued on an issue year basis and has a guarantee duration as determined under Section 425.062(f) greater than 10 years.

(f) The reference interest rate is the average over a period of 12 months, ending on June 30 of the calendar year of the change in the fund, of the Moody's Corporate Bond Yield Average, for an annuity or guaranteed interest contract with a cash settlement option, other than an annuity or contract described by Subsection (d)(1), that is valued on a change in fund basis.

(g) At least annually, the commissioner shall:

(1) determine whether the reference interest rates prescribed by Subsections (c), (d), (e), and (f) continue to be a reasonably accurate approximation of the average yield achieved from

purchases in the United States in publicly quoted markets of investment grade fixed term and fixed interest corporate obligations for the periods referenced in Subsection (c), (d), (e), or (f), as applicable; and

(2) if the commissioner determines that a reference interest rate prescribed by Subsection (c), (d), (e), or (f) is not a reasonably accurate approximation of the average yield described by Subdivision (1), adopt rules in the manner prescribed by Chapters 2001 and 2002, Government Code, to prescribe an alternative method of determining a reference interest rate, as appropriate, that is a reasonably accurate approximation of that average yield.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.064. COMMISSIONERS RESERVE VALUATION METHOD FOR LIFE INSURANCE AND ENDOWMENT BENEFITS. (a) Except as otherwise provided by Sections 425.065 and 425.068 and subject to Subsection (b), for the life insurance and endowment benefits of a policy that provides for a uniform amount of insurance and that requires the payment of uniform premiums, the reserve according to the commissioners reserve valuation method is the difference, if greater than zero, of the present value on the date of valuation of those future guaranteed benefits, minus the present value on that date of any future modified net premiums for a policy described by this subsection. The modified net premiums for a policy described by this subsection are a uniform percentage of the respective contract premiums for those benefits, so that the present value on the policy's issue date of all the modified net premiums is equal to the sum of:

- (1) the present value on that date of those benefits; and
- (2) the difference, if greater than zero, between:

(A) a net level annual premium equal to the present value on the policy's issue date of the benefits provided for after the first policy year, divided by the present value on the policy's issue date of an annuity of one per year, payable on the first policy anniversary and on each subsequent policy anniversary on which a premium becomes due; and

(B) a net one-year term premium for the benefits provided for in the first policy year.

(b) A net level annual premium under Subsection (a)(2)(A) may not exceed the net level annual premium on the 19-year premium whole life plan for insurance of the same amount at an age that is one year older than the age on the policy's issue date.

(c) This subsection applies only to a life insurance policy issued on or after January 1, 1985, for which the contract premium for the first policy year exceeds the contract premium for the second year, for which a comparable additional benefit is not provided in the first year for the excess premium, and that provides an endowment benefit, a cash surrender value, or a combination of an endowment benefit and cash surrender value, in an amount greater than the excess premium. For purposes of this subsection, the "assumed ending date" is the first policy anniversary on which the sum of any endowment benefit and any cash surrender value available on that date is greater than the excess premium. The reserve according to the commissioners reserve valuation method for a policy to which this subsection applies as of any policy anniversary occurring on or before the assumed ending date is, except as otherwise provided by Section 425.068, the greater of:

(1) the reserve as of the policy anniversary computed as prescribed by Subsection (a); or

(2) the reserve as of the policy anniversary computed as prescribed by Subsection (a) but with:

(A) the value prescribed by Subsection (a)(2)(A) reduced by 15 percent of the amount of the excess first-year premium;

(B) each present value of a benefit or premium determined without reference to a premium or benefit provided under the policy after the assumed ending date;

(C) the policy assumed to mature on the assumed ending date as an endowment; and

(D) the cash surrender value provided on the assumed ending date considered to be an endowment benefit.

(d) In making the comparison required by Subsection (c), the mortality tables and interest bases described by Sections 425.058, 425.061, 425.062, and 425.063 must be used.

(e) Reserves according to the commissioners reserve valuation method for the following policies, contracts, and benefits must be computed by a method consistent with the principles of this section:

(1) a life insurance policy that provides for a varying amount of insurance or that requires the payment of varying premiums;

(2) a group annuity or pure endowment contract purchased under a retirement or deferred compensation plan established or maintained by an employer, including a partnership or sole proprietorship, by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under Section 408, Internal Revenue Code of 1986, and that section's subsequent amendments;

(3) disability or accidental death benefits in a policy or contract; and

(4) all other benefits, other than life insurance and endowment benefits in a life insurance policy or benefits provided by any other annuity or pure endowment contract.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 313 (S.B. 1654), Sec. 13, eff. September 1, 2015.

Sec. 425.065. COMMISSIONERS ANNUITY RESERVE VALUATION METHOD FOR ANNUITY AND PURE ENDOWMENT BENEFITS. (a) This section applies to an annuity or pure endowment contract other than a group annuity or pure endowment contract purchased under a retirement or deferred compensation plan established or maintained by an employer, including a partnership or sole proprietorship, by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under Section 408, Internal Revenue Code of 1986, and that section's subsequent amendments.

(b) Reserves according to the commissioners annuity reserve method for benefits under an annuity or pure endowment contract, excluding any disability or accidental death benefits in the contract, are the greatest of the respective excesses of the present values on the valuation date of the future guaranteed benefits under the contract at the end of each respective contract year, including guaranteed nonforfeiture benefits, minus the present value on the valuation date of any future valuation considerations derived from future gross considerations that are required by the contract terms and that become payable before the end of the respective contract year. The future guaranteed benefits must be determined by using the

mortality table, if any, and the interest rate or rates specified in the contract for determining guaranteed benefits. The valuation considerations are the portions of the respective gross considerations applied under the contract terms to determine nonforfeiture values.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 313 (S.B. 1654), Sec. 14, eff. September 1, 2015.

Sec. 425.066. MINIMUM AGGREGATE RESERVES. (a) An insurance company's aggregate reserves for all life insurance policies, excluding disability or accidental death benefits, issued by the company on or after the date on which Chapter 1105 applies to policies issued by the company, as determined under Section 1105.002(a) or (b), may not be less than the aggregate reserves computed in accordance with the methods prescribed by Sections 425.064, 425.065, 425.068, and 425.069 and the mortality table or tables and interest rate or rates used in computing nonforfeiture benefits for those policies.

(b) The aggregate reserves of an insurance company to which this section applies for all policies, contracts, and benefits may not be less than the aggregate reserves determined to be necessary to issue a favorable opinion under Section 425.054.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.067. OPTIONAL RESERVE COMPUTATIONS. (a) Reserves for a policy or contract issued by a life insurance company before the date on which Chapter 1105 would apply to the policy or contract, as determined under Section 1105.002(a) or (b), may be computed, at the company's option, according to any standard that produces greater aggregate reserves for all those policies and contracts than the minimum reserves required by the laws applicable to those policies and contracts immediately before that date.

(b) Reserves for any category, as established by the

commissioner, of policies, contracts, or benefits issued by a life insurance company on or after the date on which Chapter 1105 applies to policies, contracts, or benefits issued by the company, as determined under Section 1105.002(a) or (b), may be computed, at the company's option, according to any standard that produces greater aggregate reserves for the category than the minimum aggregate reserves computed according to the standard provided by this subchapter, but the interest rate or rates used for those policies and contracts, other than annuity and pure endowment contracts, may not be higher than the corresponding interest rate or rates used in computing any nonforfeiture benefits provided in those policies or contracts.

(c) An insurance company that has adopted a standard of valuation that produces greater minimum aggregate reserves than the aggregate reserves computed according to the standard provided by this subchapter may, with the commissioner's approval, adopt any lower standard of valuation that produces aggregate reserves at least equal to the minimum aggregate reserves computed according to the standard provided by this subchapter.

(d) For purposes of this section, the holding of additional reserves previously determined to be necessary to issue a favorable opinion under Section 425.054 may not be considered to be the adoption of a higher standard of valuation.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.068. RESERVE COMPUTATION: GROSS PREMIUM CHARGED LESS THAN VALUATION NET PREMIUM. (a) If in a contract year the gross premium charged by a life insurance company on a policy or contract is less than the valuation net premium for the policy or contract computed by the method used in computing the reserve on the policy or contract but using the minimum valuation mortality standards and interest rate, the minimum reserve required for the policy or contract is the greater of:

(1) the reserve computed according to the mortality table, interest rate, and method actually used for the policy or contract;
or

(2) the reserve computed by the method actually used for

the policy or contract but using the minimum valuation mortality standards and interest rate and replacing the valuation net premium with the actual gross premium in each contract year for which the valuation net premium exceeds the actual gross premium.

(b) The minimum valuation mortality standards and interest rate under Subsection (a) are the standards and rate provided by Sections 425.058, 425.061, 425.062, and 425.063.

(c) This subsection applies only to a life insurance policy issued on or after January 1, 1985, for which the gross premium for the first policy year exceeds the gross premium for the second policy year, for which a comparable additional benefit is not provided in the first year for the excess premium, and that provides an endowment benefit, a cash surrender value, or a combination of an endowment benefit and cash surrender value, in an amount greater than the excess premium. For a policy to which this subsection applies, Subsections (a) and (b) shall be applied as if the method actually used in computing the reserve for the policy were the method described in Section 425.064, ignoring Section 425.064(c). The minimum reserve at each policy anniversary is the greater of:

- (1) the minimum reserve computed in accordance with Section 425.064, including Section 425.064(c); or
- (2) the minimum reserve computed in accordance with this section.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.069. RESERVE COMPUTATION: INDETERMINATE PREMIUM PLANS AND CERTAIN OTHER PLANS. (a) For a life insurance plan that provides for future premium determination, the amounts of which are to be determined by the insurance company based on estimates of future experience, or a life insurance plan or annuity for which the minimum reserves cannot be determined by the methods described by Sections 425.064, 425.065, and 425.068, the reserves held must:

- (1) be appropriate in relation to the benefits and the pattern of premiums for the plan; and
- (2) be computed by a method that is consistent with the principles of this subchapter, as determined by commissioner rule.

(b) Notwithstanding any other provision of state law, the

commissioner must affirmatively approve a policy, contract, or certificate that provides life insurance under a plan described by Subsection (a) before the policy, contract, or certificate may be marketed, issued, delivered, or used in this state.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.070. COMPUTATION OF RESERVE FOR CERTAIN POLICIES BY CALENDAR YEAR OF ISSUE. (a) The reserve for a policy or contract issued by a life insurance company before the date on which Chapter 1105 would apply to the policy or contract, as determined under Section 1105.002(a) or (b), must be computed in accordance with the terms of the policy or contract and this section.

(b) For a policy issued before January 1, 1910, the computation must be based on the American Experience Table of Mortality and 4-1/2 percent annual interest.

(c) For a policy issued on or after January 1, 1910, and before January 1, 1948, the computation must be based on:

(1) the Actuaries or Combined Experience Table of Mortality and four percent annual interest, if the interest rate guaranteed in the policy is four percent annually or higher; or

(2) the American Experience Table of Mortality and the lower rate specified in the policy, if the policy was issued on a reserve basis of an interest rate lower than four percent annually.

(d) For a policy issued on or after January 1, 1948, the computation must be based on the mortality table and interest rate specified in the policy, provided that:

(1) the specified interest rate may not exceed 3-1/2 percent annually;

(2) the specified table for a policy, other than an industrial life insurance policy, is the American Experience Table of Mortality, the American Men Ultimate Table of Mortality, the Commissioners 1941 Standard Ordinary Mortality Table, or, for a policy issued after December 31, 1959, the Commissioners 1958 Standard Ordinary Mortality Table; and

(3) the specified table for an industrial life insurance policy is the American Experience Table of Mortality, the Standard Industrial Mortality Table, the Sub-Standard Industrial Mortality

Table, the 1941 Standard Industrial Mortality Table, or the 1941 Sub-Standard Industrial Mortality Table, or, for a policy issued after December 31, 1963, the Commissioners 1961 Standard Industrial Mortality Table.

(e) For a policy, other than an industrial life insurance policy, issued after December 31, 1959, to insure a female risk, the computation must be based on any mortality table and interest rate permitted under Subsection (d) and specified in the policy but may, at the insurance company's option, be based on an age not more than three years younger than the insured's actual age.

(f) Except as otherwise provided by Section 425.059 for coverage purchased under a group annuity or pure endowment contract to which that section applies, for a policy issued on a substandard risk, an annuity contract, or a contract or policy for disability benefits or accidental death benefits, the computation must be based on the standards and methods adopted by the insurance company and approved by the commissioner.

(g) For a group insurance policy issued before May 15, 1947, the computation must be based on the American Men Ultimate Table of Mortality with interest at the rate of three percent or 3-1/2 percent annually as provided by the policy. The reserve value of a group insurance policy issued on or after May 15, 1947, and before January 1, 1961, must be computed on the basis of either the American Men Ultimate Table of Mortality or the Commissioners 1941 Standard Ordinary Mortality Table with interest at a rate not to exceed 3-1/2 percent annually as provided by the policy. For a group insurance policy issued on or after January 1, 1961, the computation must be based on an interest rate not to exceed 3-1/2 percent annually and the mortality table adopted by the insurance company with the commissioner's approval.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.071. LAPSE RATES IN MINIMUM STANDARD OF VALUATION. (a) The minimum standard of valuation under this subchapter may include lapse rates in the calculation of reserves for a secondary guarantee in universal life contracts issued after December 31, 2006.

(b) For purposes of this section, a secondary guarantee refers

to specified conditions in a universal life contract that, if satisfied, provide for death benefits to remain in effect regardless of the accumulation value in the contract.

(c) Lapse rates authorized by this section may not exceed two percent per year.

(d) The commissioner is authorized to adopt rules to implement this section.

Added by Acts 2007, 80th Leg., R.S., Ch. 681 (H.B. 1590), Sec. 1, eff. June 15, 2007.

Sec. 425.072. MINIMUM STANDARD FOR ACCIDENT AND HEALTH INSURANCE CONTRACTS. (a) The standard prescribed by the valuation manual for accident and health insurance contracts issued on or after the operative date of the valuation manual is the minimum standard of valuation required under Section 425.0535.

(b) For disability, accident and sickness, and accident and health insurance contracts issued before the operative date of the valuation manual, the minimum standard of valuation is the standard in existence before the operative date of the valuation manual in addition to any requirements established by the commissioner and adopted by rule.

Added by Acts 2015, 84th Leg., R.S., Ch. 313 (S.B. 1654), Sec. 15, eff. September 1, 2015.

Sec. 425.073. VALUATION MANUAL FOR POLICIES ISSUED ON OR AFTER THE OPERATIVE DATE OF THE VALUATION MANUAL. (a) Except as otherwise provided by this section, for policies issued on or after the operative date of the valuation manual, the standard prescribed by the valuation manual is the minimum standard of valuation required under Section 425.0535.

(b) The commissioner by rule shall adopt a valuation manual and determine the operative date of the valuation manual. A valuation manual adopted by the commissioner under this section must be substantially similar to the valuation manual approved by the National Association of Insurance Commissioners. The operative date must be January 1 of the first calendar year immediately following a year in which, on or before July 1, the commissioner determines that:

(1) the valuation manual has been adopted by the National Association of Insurance Commissioners by an affirmative vote of at least 42 members, or three-fourths of the members voting, whichever is greater;

(2) the National Association of Insurance Commissioners Standard Model Valuation Law, as amended by the National Association of Insurance Commissioners in 2009, or legislation including substantially similar terms and provisions, has been enacted by states representing greater than 75 percent of the direct premiums written as reported in the following annual statements submitted for 2008:

(A) life insurance and accident and health annual statements;

(B) health annual statements; or

(C) fraternal annual statements; and

(3) the National Association of Insurance Commissioners Standard Model Valuation Law, as amended by the National Association of Insurance Commissioners in 2009, or legislation including substantially similar terms and provisions, has been enacted by at least 42 of the following 55 jurisdictions:

(A) the 50 United States;

(B) American Samoa;

(C) the United States Virgin Islands;

(D) the District of Columbia;

(E) Guam; and

(F) Puerto Rico.

(c) After a valuation manual has been adopted by the commissioner by rule, any changes to the valuation manual must be adopted by rule and must be substantially similar to changes adopted by the National Association of Insurance Commissioners. Unless a change in the valuation specifies a later effective date, the effective date for changes to the valuation manual may not be earlier than January 1 of the year immediately following the date on which the commissioner determines that the changes to the valuation manual have been adopted by the National Association of Insurance Commissioners by an affirmative vote representing:

(1) at least three-fourths of the members of the National Association of Insurance Commissioners voting, but not less than a majority of the total membership; and

(2) members of the National Association of Insurance

Commissioners representing jurisdictions totaling greater than 75 percent of the direct premiums written as reported in the most recently available annual statements as provided by Subsections (b)(2)(A)-(C).

(d) The valuation manual must specify:

(1) the minimum valuation standards for and definitions of the policies or contracts subject to Section 425.0535, including:

(A) the commissioner's reserve valuation method for life insurance contracts subject to Section 425.0535;

(B) the commissioner's annuity reserve valuation method for annuity contracts subject to Section 425.0535; and

(C) the minimum reserves for all other policies or contracts subject to Section 425.0535;

(2) the policies or contracts that are subject to the requirements of a principle-based valuation under Section 425.074 and the minimum valuation standards consistent with those requirements, including:

(A) the requirements for the format of reports to the commissioner under Section 425.074(b)(3), which must include the information necessary to determine if a valuation is appropriate and in compliance with this subchapter;

(B) the assumptions prescribed for risks over which the company does not have significant control or influence; and

(C) the procedures for corporate governance and oversight of the actuarial function, and a process for appropriate waiver or modification of the procedures;

(3) the policies that are not subject to a principle-based valuation under Section 425.074;

(4) the data and form of data required under Section 425.075, to whom the data must be submitted, and other desired requirements, including requirements concerning data analyses and reporting of analyses;

(5) other requirements, including requirements relating to reserve methods, models for measuring risk, generation of economic scenarios, assumptions, margins, use of company experience, disclosure, certification, reports, actuarial opinions and memorandums, transition rules, and internal controls; and

(6) an exemption that allows certain companies to value reserves based on an exception from certain requirements of this section and Section 425.074.

(e) Repealed by Acts 2023, 88th Leg., R.S., Ch. 611 (H.B. 3673), Sec. 2, eff. September 1, 2023.

(f) With respect to policies that are not subject to a principle-based valuation under Section 425.074 as described by Subsection (d)(3), the minimum valuation standard specified in the valuation manual must:

(1) be consistent with the minimum valuation standard before the operative date of the valuation manual; or

(2) develop reserves that quantify the benefits and guarantees, and the funding, associated with the contracts and their risks at a level of conservatism that reflects conditions that include unfavorable events that have a reasonable probability of occurring.

(g) In the absence of a specific valuation requirement or if a specific valuation requirement in the valuation manual does not in the commissioner's opinion comply with this subchapter, the company shall, with respect to the requirement, comply with minimum valuation standards prescribed by the commissioner by rule.

(h) The commissioner may employ or contract with a qualified actuary, at the expense of the company, to perform an actuarial examination of the company and provide an opinion concerning the appropriateness of any reserve assumption or method used by the company, or to review and provide an opinion on a company's compliance with any requirement of this subchapter. The commissioner may rely on the opinion, regarding provisions contained within this subchapter, of a qualified actuary engaged by the insurance supervisory official of another state.

(i) The commissioner may require a company to change an assumption or method as necessary in the commissioner's opinion to comply with a requirement of the valuation manual or this subchapter.

(j) The commissioner may take other disciplinary action as permitted under Chapter 82.

Added by Acts 2015, 84th Leg., R.S., Ch. 313 (S.B. 1654), Sec. 15, eff. September 1, 2015.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 611 (H.B. 3673), Sec. 1, eff. September 1, 2023.

Acts 2023, 88th Leg., R.S., Ch. 611 (H.B. 3673), Sec. 2, eff. September 1, 2023.

Sec. 425.074. REQUIREMENTS OF A PRINCIPLE-BASED VALUATION. (a) A company shall establish reserves using a principle-based valuation that meets the conditions for policies or contracts provided by the valuation manual. At a minimum, the valuation shall:

(1) quantify the benefits and guarantees, and the funding, associated with the contracts and their risks at a level of conservatism that reflects conditions that include unfavorable events that have a reasonable probability of occurring during the terms of the contracts;

(2) with respect to policies and contracts with significant tail risk, reflect conditions appropriately adverse to quantify the tail risk;

(3) incorporate assumptions, risk analysis methods, and financial models and management techniques that are consistent with those used in the company's overall risk assessment process, while recognizing potential differences in financial reporting structures and any prescribed assumptions or methods;

(4) incorporate assumptions:

(A) prescribed by the valuation manual; or

(B) established:

(i) using the company's available experience, to the extent that data is relevant and statistically credible; or

(ii) to the extent that the company data is not available, relevant, or statistically credible, using other relevant, statistically credible experience; and

(5) provide margins for uncertainty, including adverse deviation and estimation error, such that the greater the uncertainty the larger the margin and resulting reserve.

(b) A company using a principle-based valuation for one or more policies or contracts subject to this section and as specified by the valuation manual shall:

(1) establish procedures for corporate governance and oversight of the actuarial valuation function consistent with procedures specified by the valuation manual;

(2) provide to the commissioner and the company's board of directors an annual certification of the effectiveness of the internal controls with respect to the principle-based valuation; and

(3) develop, and file with the commissioner on request, a

principle-based valuation report that complies with standards prescribed in the valuation manual.

(c) A company's internal controls with respect to the principle-based valuation must be designed to ensure that all material risks inherent in the liabilities and associated assets subject to the valuation are included in the valuation, and that valuations are made in accordance with the valuation manual. The certification described by Subsection (b)(2) must be based on the controls in place as of the end of the preceding calendar year.

(d) A principle-based valuation may include a prescribed formulaic reserve component.

Added by Acts 2015, 84th Leg., R.S., Ch. 313 (S.B. 1654), Sec. 15, eff. September 1, 2015.

Sec. 425.075. EXPERIENCE REPORTING FOR POLICIES IN FORCE ON OR AFTER OPERATIVE DATE OF VALUATION MANUAL. A company shall submit mortality, morbidity, policyholder behavior, or expense experience and other data as prescribed in the valuation manual.

Added by Acts 2015, 84th Leg., R.S., Ch. 313 (S.B. 1654), Sec. 15, eff. September 1, 2015.

Sec. 425.076. CONFIDENTIALITY. (a) In this section, "confidential information" means:

(1) a memorandum in support of an opinion submitted under Section 425.0545 and any other documents, materials, and other information, including, but not limited to, all working papers, and copies thereof, created, produced, or obtained by or disclosed to the commissioner or any other person in connection with such memorandum;

(2) all documents, materials, and other information, including, but not limited to, all working papers, and copies thereof, created, produced, or obtained by or disclosed to the commissioner or any other person in the course of an examination made under Section 425.073(h); provided, however, that if an examination report or other material prepared in connection with an examination made under Subchapter B, Chapter 401, is not held as private and confidential information under Subchapter B, Chapter 401, an examination report or other material prepared in connection with an

examination made under Section 425.073(h) shall not be "confidential information" to the same extent as if such examination report or other material had been prepared under Subchapter B, Chapter 401;

(3) any reports, documents, materials, and other information developed by a company in support of, or in connection with, an annual certification by the company under Section 425.074(b)(2) evaluating the effectiveness of the company's internal controls with respect to a principle-based valuation and any other documents, materials, and other information, including, but not limited to, all working papers, and copies thereof, created, produced, or obtained by or disclosed to the commissioner or any other person in connection with such reports, documents, materials, and other information;

(4) any principle-based valuation report developed under Section 425.074(b)(3) and any other documents, materials, and other information, including, but not limited to, all working papers, and copies thereof, created, produced, or obtained by or disclosed to the commissioner or any other person in connection with such report; and

(5) any documents, materials, data, and other information submitted by a company under Section 425.075 (collectively, "experience data") and any other documents, materials, data, and other information, including, but not limited to, all working papers, and copies thereof, created or produced in connection with such experience data, in each case that include any potentially company-identifying or personally identifiable information, that is provided to or obtained by the commissioner (together with any "experience data," the "experience materials") and any other documents, materials, data, and other information, including, but not limited to, all working papers, and copies thereof, created, produced, or obtained by or disclosed to the commissioner or any other person in connection with such experience materials.

(b) Except as provided in this section, a company's confidential information is confidential by law and privileged, and shall not be subject to Chapter 552, Government Code, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action; provided, however, that the commissioner is authorized to use the confidential information in the furtherance of any regulatory or legal action brought against the company as a part of the commissioner's official duties.

(c) Neither the commissioner nor any person who received confidential information while acting under the authority of the commissioner shall be permitted or required to testify in any private civil action concerning any confidential information.

(d) In order to assist in the performance of the commissioner's duties, the commissioner may share confidential information (1) with other state, federal, and international regulatory agencies and with the National Association of Insurance Commissioners and its affiliates and subsidiaries and (2) in the case of confidential information specified in Subsections (a)(1) and (a)(4) only, with the Actuarial Board for Counseling and Discipline or its successor upon request stating that the confidential information is required for the purpose of professional disciplinary proceedings and with state, federal, and international law enforcement officials; in the case of (1) and (2), provided that such recipient agrees, and has the legal authority to agree, to maintain the confidentiality and privileged status of such documents, materials, data, and other information in the same manner and to the same extent as required for the commissioner.

(e) The commissioner may receive documents, materials, data, and other information, including otherwise confidential or privileged documents, materials, data, or information, from the National Association of Insurance Commissioners and its affiliates and subsidiaries, from regulatory or law enforcement officials of other foreign or domestic jurisdictions and from the Actuarial Board for Counseling and Discipline or its successor and shall maintain as confidential or privileged any document, material, data, or other information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, data, or other information.

(f) The commissioner may enter into agreements governing sharing and use of information consistent with Subsections (b) through (k).

(g) No waiver of any applicable privilege or claim of confidentiality in the confidential information shall occur as a result of disclosure to the commissioner under this section or as a result of sharing as authorized in Subsection (d).

(h) A privilege established under the law of any state or jurisdiction that is substantially similar to the privilege established under Subsections (b) through (k) shall be available and

enforced in any proceeding in, and in any court of, this state.

(i) In this section, a reference to a regulatory agency, law enforcement agency, or the National Association of Insurance Commissioners includes an employee, agent, consultant, or contractor of the agency or association, as applicable.

(j) Notwithstanding this section, any confidential information specified in Subsections (a)(1) and (a)(4) may be:

(1) subject to subpoena for the purpose of defending an action seeking damages from the appointed actuary submitting the related memorandum in support of an opinion submitted under Section 425.0545 or a principle-based valuation report developed under Section 425.074(b)(3) by reason of an action required by this subchapter or by rules adopted under this subchapter; and

(2) released by the commissioner with the written consent of the company.

(k) Once any portion of a memorandum in support of an opinion submitted under Section 425.0545 or a principle-based valuation report developed under Section 425.074(b)(3) is cited by the company in its marketing or is publicly volunteered to or before a governmental agency other than a state insurance department or is released by the company to the news media, all portions of such memorandum or report shall no longer be confidential and privileged.

Added by Acts 2015, 84th Leg., R.S., Ch. 313 (S.B. 1654), Sec. 15, eff. September 1, 2015.

Sec. 425.077. SINGLE STATE EXEMPTION. The commissioner may exempt specific product forms or product lines of a domestic company that is licensed and doing business only in this state from the requirements of Section 425.073 if:

(1) the commissioner has issued an exemption in writing to the company and has not subsequently revoked the exemption in writing; and

(2) the company computes reserves using assumptions and methods used before the operative date of the valuation manual in addition to any requirements established by the commissioner and adopted by rule.

Added by Acts 2015, 84th Leg., R.S., Ch. 313 (S.B. 1654), Sec. 15, eff. September 1, 2015.

SUBCHAPTER C. AUTHORIZED INVESTMENTS AND TRANSACTIONS FOR CAPITAL STOCK LIFE, HEALTH, AND ACCIDENT INSURERS

Sec. 425.101. DEFINITIONS. In this subchapter:

(1) "Assets" means the statutory accounting admitted assets of an insurance company. The term includes lawful money of the United States, whether in the form of cash or demand deposits in solvent banks, savings and loan associations, credit unions, and branches of those entities, organized under the laws of the United States or a state of the United States, if held in accordance with the laws or regulations applicable to those entities. The term does not include the company's separate accounts that are subject to Chapter 1152.

(2) "Securities valuation office" means the Securities Valuation Office of the National Association of Insurance Commissioners.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.102. INAPPLICABILITY OF CERTAIN LAW. The definition of "state" assigned by Section 311.005, Government Code, does not apply to this subchapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.103. APPLICABILITY OF SUBCHAPTER. (a) This subchapter and rules adopted to interpret and implement this subchapter apply to all domestic insurance companies as defined in Section 841.001 and to other insurance companies specifically made subject to this subchapter, including a stipulated premium company that elects under Section 884.311 to be governed by this subchapter.

(b) Subchapter D does not apply to an insurance company to which this subchapter applies.

(c) This subchapter does not limit or restrict investments in or transactions with or within subsidiaries and affiliates made under Chapter 823.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.104. PURPOSE. The purpose of this subchapter is to protect and further the interests of insureds, insurance companies, creditors, and the public by providing standards for development and administration of plans for investment of insurance companies' assets.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.105. WRITTEN INVESTMENT PLAN. (a) Each insurance company's board of directors or, if the company does not have a board of directors, the corresponding authority designated by the company's charter, bylaws, or plan of operation, shall adopt a written investment plan consistent with this subchapter.

(b) The investment plan must:

(1) specify the diversification of the insurance company's investments, so as to reduce the risk of large losses, by:

(A) broad categories, such as bonds and real property loans;

(B) kinds, such as government obligations, obligations of business entities, mortgage-backed securities, and real property loans on office, retail, industrial, or residential properties;

(C) quality;

(D) maturity;

(E) industry; and

(F) geographical areas, as to both domestic and foreign investments;

(2) balance safety of principal with yield and growth;

(3) seek a reasonable relationship of assets and liabilities as to term and nature; and

(4) be appropriate considering the capital and surplus and the business conducted by the company.

(c) At least annually, the board of directors or corresponding authority shall review the adequacy of the investment plan and the implementation of the plan.

(d) An insurance company shall maintain the company's investment plan in the company's principal office and provide the plan to the commissioner or the commissioner's designee on request. The commissioner or the commissioner's designee shall maintain the plan as a privileged and confidential document. The plan is not subject to public disclosure.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.106. INVESTMENT RECORDS; DEMONSTRATION OF COMPLIANCE. An insurance company shall maintain investment records covering each transaction. The company must be able to demonstrate at all times that the company's investments are within the limitations imposed by this subchapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.108. AUTHORIZED INVESTMENTS AND TRANSACTIONS IN GENERAL. (a) Subject to the limitations and restrictions imposed by this subchapter, and, unless otherwise specified, based on the insurance company's capital, surplus, and admitted assets as reported in the company's most recently filed statutory financial statement, the investments and transactions described by this subchapter and Subchapter F, Chapter 823, are authorized investments and transactions for a company subject to this subchapter.

(b) An insurance company may not make an investment or enter into a transaction that is not authorized by this subchapter or Subchapter F, Chapter 823.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.109. AUTHORIZED INVESTMENTS: GOVERNMENT OBLIGATIONS. (a) An insurance company may invest in:

- (1) a bond, evidence of indebtedness, or other obligation of the United States;

(2) a bond, evidence of indebtedness, or other obligation guaranteed as to principal and interest by the full faith and credit of the United States;

(3) a bond, evidence of indebtedness, or other obligation of an agency or instrumentality of the United States government; and

(4) subject to Subsections (b) and (c), a bond, evidence of indebtedness, or other obligation of a governmental unit in the United States, Canada, or any province or municipality of Canada, or of an instrumentality of one of those governmental units.

(b) An insurance company may not invest in a bond, evidence of indebtedness, or other obligation under Subsection (a)(4) if the governmental unit or instrumentality is in default in the payment of principal of or interest on any of the governmental unit's or instrumentality's obligations.

(c) An insurance company's investments in the obligations of a single governmental unit or instrumentality under Subsection (a)(4) may not exceed 20 percent of the company's capital and surplus.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.110. AUTHORIZED INVESTMENTS: OBLIGATIONS OF AND OTHER INVESTMENTS IN BUSINESS ENTITIES. (a) In this section:

(1) "Business entity" includes a sole proprietorship, corporation, association, general or limited partnership, limited liability company, joint-stock company, joint venture, trust, or other form of business organization, regardless of whether organized for profit, that is organized under the laws of the United States, another state, Canada, or any district, province, or territory of Canada.

(2) "Counterparty exposure amount" has the meaning assigned by Section 425.125.

(b) Subject to this section, an insurance company may invest in an obligation, including a bond or evidence of indebtedness, a participation in a bond or evidence of indebtedness, or an asset-backed security, that is issued, assumed, guaranteed, or insured by a business entity.

(c) An insurance company's investments in the obligations or counterparty exposure amounts of a single business entity rated by

the securities valuation office may not exceed 20 percent of the company's statutory capital and surplus.

(d) An insurance company may not invest in an obligation, counterparty exposure amount, or preferred stock of a business entity if, after making the investment:

(1) the aggregate amount of those investments then held by the company that are rated 3, 4, 5, or 6 by the securities valuation office would exceed 20 percent of the company's assets;

(2) the aggregate amount of those investments then held by the company that are rated 4, 5, or 6 by the securities valuation office would exceed 10 percent of the company's assets;

(3) the aggregate amount of those investments then held by the company that are rated 5 or 6 by the securities valuation office would exceed three percent of the company's assets; or

(4) the aggregate amount of those investments then held by the company that are rated 6 by the securities valuation office would exceed one percent of the company's assets.

(e) If an insurance company attains or exceeds the limit of a rating category referred to in Subsection (d), the company is not precluded from acquiring investments in other rating categories subject to the specific and multiple category limits applicable to those investments.

(f) Notwithstanding Subsections (c)-(e), an insurance company may invest in an additional obligation of a business entity in which the company holds one or more obligations if the investment is made to protect an investment previously made in that business entity. Obligations invested in under this subsection may not exceed one-half percent of the company's assets.

(g) This section does not prohibit an insurance company from investing in an obligation as a result of a restructuring of an already held obligation or preferred stock that is rated 3, 4, 5, or 6 by the securities valuation office.

(h) An insurance company shall include all counterparty exposure amounts in determining compliance with the limitations of this section.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. [2017](#)), Sec. 1, eff. April 1, 2007.

Sec. 425.111. AUTHORIZED INVESTMENTS: BONDS ISSUED, ASSUMED, OR GUARANTEED IN INTERNATIONAL MARKET. (a) Subject to this section, an insurance company may invest in bonds issued, assumed, or guaranteed by:

- (1) the Inter-American Development Bank;
- (2) the International Bank for Reconstruction and Development (the World Bank);
- (3) the Asian Development Bank;
- (4) the State of Israel;
- (5) the African Development Bank; and
- (6) the International Finance Corporation.

(b) An insurance company's investments in the bonds of a single entity under this section may not exceed 20 percent of the company's capital and surplus.

(c) The aggregate of all investments made by an insurance company under this section may not exceed 20 percent of the company's assets.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.112. AUTHORIZED INVESTMENTS: POLICY LOANS. An insurance company may invest in loans on the security of the company's own policies in an amount that does not exceed the amount of the reserve values of those policies.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.113. AUTHORIZED INVESTMENTS: DEPOSITS IN CERTAIN FINANCIAL INSTITUTIONS. (a) Subject to this section, an insurance company may invest in any type of savings deposit, time deposit, certificate of deposit, NOW account, or money market account in a solvent bank, savings and loan association, or credit union that is organized under the laws of the United States or a state, or in a branch of one of those financial institutions.

(b) An investment under this section must be made in accordance with the laws or regulations applicable to the bank, savings and loan association, or credit union.

(c) The amount of an insurance company's deposits in a single bank, savings and loan association, or credit union may not exceed the greater of:

- (1) 20 percent of the company's capital and surplus;
- (2) the amount of federal or state deposit insurance coverage that applies to the deposits; or
- (3) 10 percent of the amount of capital, surplus, and undivided profits of the financial institution receiving the deposits.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.114. AUTHORIZED INVESTMENTS: INSURANCE COMPANY INVESTMENT POOLS. (a) In this section, "affiliate" means, with respect to a person, another person that, directly or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with the person.

(b) Subject to Subsections (c)-(g), an insurance company may acquire investments in an investment pool that invests only in:

(1) obligations that have a rating by the securities valuation office of one or two, or an equivalent rating issued by a nationally recognized statistical rating organization recognized by the securities valuation office, or that are issued by an issuer with outstanding obligations that have a securities valuation office one or two rating or an equivalent rating described by this subdivision, and that:

(A) have a remaining maturity of 397 days or less or a put that:

(i) entitles the holder to receive the principal amount of the obligation; and

(ii) may be exercised through maturity at specified intervals not exceeding 397 days; or

(B) have a remaining maturity of three years or less and a floating interest rate that resets at least quarterly on the basis of a current short-term index (federal funds, prime rate, treasury bills, London InterBank Offered Rate, or commercial paper) and is not subject to a maximum limit, if the obligations do not have an interest rate that varies inversely to market interest rate

changes;

(2) securities lending, repurchase, and reverse repurchase transactions that meet the requirements of Section 425.121 and any applicable department rules;

(3) money market funds as authorized by Section 425.123, except that a short-term investment pool may not acquire investments in a single business entity that exceed 10 percent of the total assets of the pool; or

(4) investments that an insurance company may make under this subchapter, if:

(A) the company's proportionate interest in the amount invested in those investments does not exceed the limits of this subchapter; and

(B) the aggregate amount of the company's investments in all investment pools under this subdivision does not exceed 25 percent of the company's assets.

(c) An insurance company may not acquire an investment in an investment pool under Subsection (b) if, after making the investment, the aggregate amount of the company's investments in all investment pools would exceed 35 percent of the company's assets.

(d) For an investment in an investment pool to be qualified under this section, the pool may not:

(1) acquire securities issued, assumed, guaranteed, or insured by an investing insurer or an affiliate of the investing insurance company; or

(2) borrow or incur an indebtedness for borrowed money, except for securities lending and reverse repurchase transactions.

(e) For an investment pool to be qualified under this section:

(1) the pool manager must:

(A) be organized under the laws of the United States or a state and designated as the pool manager in a pooling agreement; or

(B) be:

(i) the investing insurance company, an affiliated insurance company, a business entity affiliated with the investing company, a custodian bank, a business entity registered under the Investment Advisers Act of 1940 (15 U.S.C. Section 80b-1 et seq.), as amended;

(ii) in the case of a reciprocal or interinsurance exchange, the exchange's attorney-in-fact; or

(iii) in the case of a United States branch of an

alien insurance company, the United States manager or an affiliate or subsidiary of the United States manager;

(2) the pool manager or an entity designated by the pool manager of the type described by Subdivision (1)(B) must maintain:

(A) detailed accounting records showing:

(i) the cash receipts and disbursements reflecting each participant's proportionate investment in the pool; and

(ii) a complete description of all the pool's underlying assets, including the amount, interest rate, maturity date, if any, and other appropriate designations; and

(B) other records that, on a daily basis, allow a third party to verify each participant's investments in the pool; and

(3) the assets of the pool must be held in one or more accounts, in the name or on behalf of the pool, at the principal office of the pool manager or under a custody agreement or trust agreement with a custodian bank, provided that the agreement:

(A) states and recognizes the claims and rights of each participant;

(B) acknowledges that the pool's underlying assets are held solely for the benefit of each participant in proportion to the aggregate amount of the participant's investments in the pool; and

(C) contains an agreement that the pool's underlying assets may not be commingled with the general assets of the custodian bank or any other person.

(f) The pooling agreement for each investment pool must be in writing and must provide that:

(1) 100 percent of the interests in the pool must be held at all times by the insurance company, the company's subsidiaries or affiliates, or, in the case of a United States branch of an alien insurance company, the affiliates or subsidiaries of the United States manager, and any unaffiliated insurance company;

(2) the pool's underlying assets may not be commingled with the general assets of the pool manager or any other person;

(3) in proportion to the aggregate amount of each pool participant's interest in the pool:

(A) each participant owns an undivided interest in the pool's underlying assets; and

(B) the pool's underlying assets are held solely for the benefit of each participant;

(4) a participant, or, in the event of the participant's

insolvency, bankruptcy, or receivership, the participant's trustee, receiver, conservator, or other successor in interest, may withdraw all or part of the participant's investment from the pool under the terms of the pooling agreement;

(5) a withdrawal may be made on demand without penalty or other assessment on any business day, and settlement of funds must occur within a reasonable and customary period after the withdrawal, except that:

(A) in the case of publicly traded securities, the settlement period may not exceed five business days; and

(B) in the case of securities and investments other than publicly traded securities, the settlement period may not exceed 10 business days;

(6) the amount of a distribution under Subdivision (5) must be computed after subtracting all the pool's applicable fees and expenses;

(7) the pool manager shall distribute to a participant, at the manager's discretion:

(A) in cash, an amount that represents the fair market value of the participant's pro rata share of each of the pool's underlying assets;

(B) in kind, an amount that represents a pro rata share of each underlying asset; or

(C) in a combination of cash and in-kind distributions, an amount that represents a pro rata share in each underlying asset; and

(8) the pool manager shall make the records of the pool available for inspection by the commissioner.

(g) An investment in an investment pool is not considered to be an affiliate transaction under Subchapter C, Chapter 823, but each pooling agreement is subject to the standards of Section 823.101 and the reporting requirements of Section 823.052.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.115. AUTHORIZED INVESTMENTS: EQUITY INTERESTS. (a) In this section, "business entity" means a real estate investment trust, corporation, limited liability company, association, limited

partnership, joint venture, mutual fund, trust, joint tenancy, or other similar form of business organization, regardless of whether organized for profit.

(b) Subject to this section, an insurance company may invest in an equity interest, including common stock, an equity investment in an investment company other than a money market fund described by Section 425.123, a real estate investment trust, a limited partnership interest, a warrant, another right to acquire an equity interest that is created by the person that owns or would issue the equity in which the interest is acquired, and an equity interest in a business entity that is organized under the laws of the United States, a state of the United States, Canada, or a province or territory of Canada.

(c) If a market value from a generally recognized source is not available for an equity interest, the business entity or other investment in which the interest is acquired must be subject to:

(1) an annual audit by an independent certified public accountant; or

(2) another method of valuation acceptable to the commissioner.

(d) An insurance company may not invest in a partnership as a general partner except through an investment subsidiary.

(e) An insurance company's investments under this section in a single business entity, other than a money market fund described by Section 425.123, may not exceed 15 percent of the company's capital and surplus.

(f) The aggregate amount of an insurance company's investments under this section may not exceed 25 percent of the company's assets.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.116. AUTHORIZED INVESTMENTS: PREFERRED STOCK. (a) Subject to this section, an insurance company may invest in preferred stock of a business entity, as defined by Section 425.110.

(b) An insurance company may invest in preferred stock only if:

(1) the stock is rated by the securities valuation office;

and

(2) the sum of the company's aggregate investment in

preferred stock rated 3, 4, 5, or 6 and the company's investments under Section 425.110(d) does not exceed the limitations specified by Section 425.110(d).

(c) An insurance company's investments in the preferred stock of a single business entity may not exceed 20 percent of the company's capital and surplus.

(d) The aggregate amount of an insurance company's investments in preferred stock as to which there is not a sinking fund for the redemption and retirement of the stock that meets the standards established by the National Association of Insurance Commissioners may not exceed 10 percent of the company's assets.

(e) The aggregate amount of an insurance company's investments under this section may not exceed 40 percent of the company's assets.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.117. AUTHORIZED INVESTMENTS: COLLATERAL LOANS. (a) Subject to this section, an insurance company may invest in a collateral loan secured by:

- (1) a first lien on an asset; or
- (2) a valid and perfected first security interest in an

asset.

(b) The amount of a loan invested in under this section may not exceed 80 percent of the value of the collateral asset at any time during the duration of the loan.

(c) The asset used as collateral for a loan under this section must be an asset, other than real property described by Section 425.119, in which the insurance company is authorized by this subchapter to directly invest.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.118. AUTHORIZED INVESTMENTS: OBLIGATIONS SECURED BY REAL PROPERTY LOANS. (a) Subject to this section, an insurance company may invest in a note, an evidence of indebtedness, or a participation in a note or evidence of indebtedness that is secured by a valid first lien on real property or a leasehold estate in real

property located in the United States.

(b) The amount of an obligation secured by a first lien on real property or a leasehold estate in real property may exceed 90 percent of the value of the real property or leasehold estate only if:

(1) the amount does not exceed 100 percent of the value of the real property or leasehold estate and the insurance company or one or more wholly owned subsidiaries of the company owns, in the aggregate, a 10 percent or greater equity interest in the real property or leasehold estate;

(2) the amount does not exceed 95 percent of the value of the real property or leasehold estate and:

(A) the property contains only a dwelling designed exclusively for occupancy by not more than four families for residential purposes; and

(B) the portion of the unpaid balance of the obligation that exceeds 90 percent of the value of the property or leasehold estate is guaranteed or insured by a mortgage guaranty insurer authorized to engage in business in this state; or

(3) the amount exceeds 90 percent of the value of the real property or leasehold estate only to the extent the obligation is insured or guaranteed by:

(A) the United States;

(B) the Federal Housing Administration under the National Housing Act (12 U.S.C. Section 1701 et seq.), as amended; or

(C) this state.

(c) The term of an obligation secured by a first lien on a leasehold estate in real property may not, as of the date the obligation is acquired, exceed a period equal to four-fifths of the unexpired term of the leasehold estate, including any renewal options exercisable by the lessee, and the obligation must fully amortize during that period. The term of the leasehold estate, including any renewal options exercisable by the lessee, may not expire sooner than the 10th anniversary of the expiration date of the term of the obligation.

(d) An obligation secured by a first lien on a leasehold estate in real property must be payable in one or more installments of an amount or amounts sufficient to ensure that, at any time during the original term of the obligation, the principal balance on the obligation is not greater than the principal balance would have been if the obligation had been amortized over the original term of the

obligation in equal monthly, quarterly, semiannual, or annual payments of principal and interest with payments of interest only for the first five years of the original term of the obligation.

(d-1) Subsection (d) does not apply to an obligation secured by a first lien on a leasehold estate in real property if:

(1) the amount of the obligation does not, as of the date the obligation is acquired, exceed 75 percent of the value of the leasehold estate;

(2) the lease agreement provides that the fee simple estate in the real property transfers automatically to the lessee on or before the expiration of the term of the leasehold estate, including any renewal options exercisable by the lessee; or

(3) the lease agreement provides that the lessee has an option to purchase the fee simple estate in the real property on or before the expiration of the term of the leasehold estate, including any renewal options exercisable by the lessee, for an amount that is less than 10 percent of the appraised value of the real property, and the insurance company has a contractual right if the lessee does not exercise that option to acquire the fee simple estate in the real property for that same amount, by assignment from the lessee or otherwise.

(e) Except as provided by Subsection (e-1), if any part of the value of buildings is to be included in the value of real property or a leasehold estate in real property to secure an obligation under this section:

(1) the buildings must be covered by adequate property insurance, including fire and extended coverage insurance, issued by:

(A) an insurer authorized to engage in business in this state; or

(B) an insurer recognized as acceptable to issue that coverage by the insurance regulatory official of the state in which the real property is located;

(2) the amount of insurance provided by one or more policies may not be less than the lesser of:

(A) the unpaid balance of the obligation; or

(B) the insurable value of the buildings; and

(3) the loss clause under each policy must be payable to the insurance company as the company's interest may appear.

(e-1) The property insurance otherwise required under Subsection (e) is not required if the borrower maintains a net worth

as indicated in the borrower's audited financial statements for the most recent fiscal year of at least the greater of five times the amount of the indebtedness or \$100 million and:

(1) the insurance company has recourse against the borrower or the borrower's guarantor; or

(2) for an obligation secured by a leasehold estate:

(A) the tenant assigned the lease to the insurance company; and

(B) the lease agreement is in writing and provides that if a building on the property is damaged or destroyed, the tenant or the tenant's guarantor is obligated to rebuild or restore the damaged or destroyed building to the building's condition immediately before the damage or destruction occurred or compensate the owner for the loss arising from the damage or destruction.

(f) To the extent that a note, evidence of indebtedness, or participation in a note or evidence of indebtedness under this section represents an equity interest in the underlying real property:

(1) the value of that equity interest must be determined at the time the note, evidence of indebtedness, or participation is executed; and

(2) the portion of the obligation that represents an equity interest in the property must be designated as an investment subject to Section 425.119(c).

(g) An insurance company's investment in a single obligation under this section may not exceed 25 percent of the company's capital and surplus.

(h) An insurance company may purchase a first lien on real property after the origination of the lien if:

(1) the first lien is insured by a mortgagee's title policy issued to the original mortgagee that contains a provision that inures the policy to the use and benefit of the owners of the evidence of indebtedness indicated in the policy and to any subsequent owners of that evidence of indebtedness; and

(2) the company maintains evidence of an assignment or other transfer of the first lien on real property to the company.

(i) For purposes of Subsection (h)(2), an assignment or other transfer to the insurance company that is duly recorded in the county in which the real property is located is presumed to create legal ownership of the first lien by the company.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 1100 (H.B. 3803), Sec. 1, eff. September 1, 2017.

Sec. 425.1185. AUTHORIZED INVESTMENTS: MEZZANINE REAL ESTATE LOANS. (a) In this section, "mezzanine real estate loan" means a loan that is secured by a pledge of direct or indirect equity interests in an entity that owns real estate.

(b) Subject to Subsections (c) and (d), an insurance company with more than \$10 billion in admitted assets may invest in a mezzanine real estate loan if the loan documents:

(1) require that each pledgor abstain from granting an additional security interest in the equity interest pledged;

(2) employ techniques to minimize the likelihood or impact of a bankruptcy filing by the real estate owner or the mezzanine real estate loan borrower; and

(3) require the real estate owner or the mezzanine real estate loan borrower to:

(A) hold no assets other than, in the case of the owner, the real estate, and in the case of the borrower, the equity interests in the entity;

(B) not engage in any business other than, in the case of the owner, the ownership and operation of the real estate, and in the case of the borrower, holding an ownership interest in the owner; and

(C) not incur additional debt, other than limited trade payables, a first mortgage loan, or the mezzanine real estate loan.

(c) Before making an initial investment in a mezzanine real estate loan, an insurance company shall corroborate that the sum of the first mortgage on the real estate and the mezzanine real estate loan does not exceed 100 percent of the value of the current appraised value of the real estate.

(d) An insurance company's cumulative investment under this section may not exceed three percent of the insurance company's admitted assets.

Added by Acts 2015, 84th Leg., R.S., Ch. 310 (S.B. 1008), Sec. 1, eff.

September 1, 2015.

Sec. 425.119. AUTHORIZED INVESTMENTS: REAL PROPERTY. (a) Subject to this section, an insurance company may invest in a real property fee simple or leasehold estate located in the United States.

(b) An insurance company may invest in home and branch office real property or a participation in home or branch office real property. At least 30 percent of the available space in a building used as a home or branch office must be occupied for the business purposes of the company and the company's affiliates. A company's aggregate investment in home and branch office real property may not exceed 20 percent of the company's assets.

(c) An insurance company may invest in real property other than home and branch office real property or participations in home and branch office real property. A company's investment under this subsection in a single piece of property or in an interest in a single piece of property, including improvements, fixtures, and equipment relating to the property, may not exceed five percent of the company's assets.

(d) Investment real property held under Subsection (b) or (c) must be materially enhanced in value by:

(1) the construction of durable, permanent-type buildings and other improvements that cost an amount at least equal to the cost of the real property, excluding buildings and improvements at the time the real property is acquired; or

(2) the construction, commenced before the second anniversary of the date the real property is acquired, of buildings and improvements described by Subdivision (1).

(e) The admissible asset value of each investment in real property under Subsection (b) or (c) is subject to review and approval by the commissioner. The commissioner may, at the time the investment is made or any time the insurance company is being examined, have the investment appraised by an appraiser appointed by the commissioner. The company shall pay the reasonable expense of the appraisal. The expense of the appraisal is considered to be a part of the expense of examination of the company unless the company applies for the appraisal to be made. A company may not increase the valuation of real property described by Subsection (b) or (c) unless:

(1) the company applies for the increase in valuation; and

(2) the commissioner approves the increase.

(f) Except as provided by Subsection (g), an insurance company may not own, develop, or hold an equity interest in any residential property or subdivision, single or multiunit family dwelling property, or undeveloped real property to subdivide for or develop residential or single or multiunit family dwellings. This subsection does not apply to an insurer with admitted assets of \$10 billion or more, as determined from the insurer's annual statements that are made as of the December 31 that precedes the date of the determination and are filed with the department as required by law.

(g) An insurance company may invest in other real property acquired:

(1) in good faith to secure a loan previously contracted for, or for money due;

(2) in satisfaction of a debt previously contracted for in the course of the company's dealings; or

(3) by purchase at a sale under a judgment or decree of a court or under a mortgage or other lien held by the company.

(h) Regardless of the manner in which an insurance company acquires real property under this section, on the sale of the property, the company may retain indefinitely the fee title to the mineral estate or any portion of the mineral estate.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 1175 (S.B. 841), Sec. 3, eff. September 1, 2013.

Sec. 425.120. AUTHORIZED INVESTMENTS: OIL, GAS, AND MINERALS.

(a) In this section:

(1) "Producing" means producing oil, gas, or other minerals in paying quantities. A well that has been shut in is considered to be producing oil, gas, or other minerals in paying quantities if shut-in royalties are being paid.

(2) "Production payment" means a right to oil, gas, or other minerals in place or as produced that entitles the owner of the right to a specified fraction of production until the owner receives a specified amount of money, or a specified number of units of oil,

gas, or other minerals.

(3) "Royalty" or "overriding royalty" means a right to oil, gas, and other minerals in place or as produced that entitles the owner of the right to a specified fraction of production without limitation to a specified amount of money or a specified number of units of oil, gas, or other minerals.

(b) Subject to this section, in addition to and without limitation on the purposes for which real property may be acquired, secured, held, or retained under other provisions of this subchapter, an insurance company may secure, hold, retain, and convey production payments, producing royalties, and producing overriding royalties, or participations in production payments, producing royalties, or producing overriding royalties as an investment for the production of income.

(c) An insurance company may not carry an asset described by Subsection (b) in an amount that exceeds 90 percent of the appraised value of the asset.

(d) A single investment under this section may not exceed 10 percent of the amount of the insurance company's capital and surplus that exceeds the statutory minimum capital and surplus applicable to the company.

(e) The aggregate amount of an insurance company's investments under this section may not exceed 10 percent of the company's assets as of December 31 preceding the date of the investment.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.121. AUTHORIZED INVESTMENTS: SECURITIES LENDING, REPURCHASE, REVERSE REPURCHASE, AND DOLLAR ROLL TRANSACTIONS. (a) In this section:

(1) "Dollar roll transaction" means two simultaneous transactions with settlement dates not more than 96 days apart, in one of which an insurance company sells to a business entity, and in the other of which the company is obligated to purchase from the same business entity, substantially similar securities that are:

(A) mortgage-backed securities issued, assumed, or guaranteed by the Government National Mortgage Association, the Federal National Mortgage Association, the Federal Home Loan Mortgage

Corporation, or a successor to one of those organizations; or

(B) other mortgage-backed securities referred to in 15 U.S.C. Section 77r-1, as amended.

(2) "Repurchase transaction" means a transaction in which an insurance company purchases securities from a business entity that is obligated to repurchase the purchased securities or equivalent securities from the company at a specified price, either within a specified period or on demand.

(3) "Reverse repurchase transaction" means a transaction in which an insurance company sells securities to a business entity and is obligated to repurchase the sold securities or equivalent securities from the business entity at a specified price, either within a specified period or on demand.

(4) "Securities lending transaction" means a transaction in which an insurance company lends securities to a business entity that is obligated to return the loaned securities or equivalent securities to the company, either within a specified period or on demand.

(b) Subject to this section, an insurance company may engage in securities lending, repurchase, reverse repurchase, and dollar roll transactions.

(c) An insurance company must enter into a written agreement for each transaction under this section, other than a dollar roll transaction. The agreement must require that the transaction terminate on or before the first anniversary of the transaction's inception.

(d) With respect to cash received in a transaction under this section, an insurance company shall:

(1) invest the cash in accordance with this subchapter and in a manner that recognizes the liquidity needs of the transaction; or

(2) use the cash for the company's general corporate purposes.

(e) While a transaction under this section is outstanding, the insurance company or the company's agent or custodian shall maintain, as to acceptable collateral received in the transaction, either physically or through the book-entry system of the Federal Reserve, Depository Trust Company, Participants Trust Company, or another securities depository approved by the commissioner:

(1) possession of the collateral;

(2) a perfected security interest in the collateral; or

(3) in the case of a jurisdiction outside of the United States, title to, or rights of a secured creditor to, the collateral.

(f) The limitations of Sections 425.110 and 425.157(b) do not apply to the business entity counterparty exposure created by a transaction under this section. An insurance company may not enter into a transaction under this section if, as a result of and after making the transaction:

(1) the aggregate amount of securities loaned or sold to or purchased from any one business entity counterparty under this section would exceed five percent of the company's assets; or

(2) the aggregate amount of all securities loaned or sold to or purchased from all business entities under this section would exceed 40 percent of the company's assets.

(g) For purposes of Subsection (f)(1), in computing the amount sold to or purchased from a business entity counterparty under a repurchase or reverse repurchase transaction, effect may be given to netting provisions under a master written agreement.

(h) The amount of collateral required for securities lending, repurchase, and reverse repurchase transactions is the amount required under the Purposes and Procedures Manual of the securities valuation office or a successor publication.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.122. AUTHORIZED INVESTMENTS: PREMIUM LOANS. (a) Subject to Subsection (b), an insurance company may make loans to finance the payment of premiums for the company's own insurance policies or annuity contracts.

(b) The amount of a loan under this section may not exceed the sum of:

(1) the available cash value of the insurance policy or annuity contract for which the premium loan is made; and

(2) the amount of any escrowed commissions payable relating to the insurance policy or annuity contract.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.123. AUTHORIZED INVESTMENTS: MONEY MARKET FUNDS. (a) An insurance company may invest in a money market fund as described by 17 C.F.R. Section 270.2a-7 under the Investment Company Act of 1940 (15 U.S.C. Section 80a-1 et seq.), that is:

(1) a government money market fund that:

(A) invests only in obligations issued, guaranteed, or insured by the United States government or collateralized repurchase agreements composed of these obligations; and

(B) qualifies for investment without a reserve under the Purposes and Procedures Manual of the securities valuation office or a successor publication; or

(2) a class one money market fund that qualifies for investment using the bond class one reserve factor described by the Purposes and Procedures Manual of the securities valuation office or a successor publication.

(b) For purposes of complying with Section 425.115, a money market fund that qualifies for listing in the categories prescribed by Subsection (a) must conform to the Purposes and Procedures Manual of the securities valuation office or a successor publication.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.1231. AUTHORIZED INVESTMENTS: BOND EXCHANGE-TRADED FUNDS. (a) An insurance company may invest the insurer's funds in excess of minimum capital and surplus in shares of a bond exchange-traded fund registered under the Investment Company Act of 1940 (15 U.S.C. Section 80a-1 et seq.), as amended, if:

(1) the exchange-traded fund is solvent and reported at least \$100 million of net assets in the exchange-traded fund's latest annual or more recent certified audited financial statement;

(2) the securities valuation office has designated the exchange-traded fund as meeting the criteria to be placed on the list promulgated by the securities valuation office of exchange-traded funds eligible for reporting as a long-term bond in the Purposes and Procedures Manual of the securities valuation office or a successor publication; and

(3) the amount of the insurance company's investment in the exchange-traded fund does not exceed 15 percent of the insurance

company's capital and surplus.

(b) This section does not authorize an insurance company to invest in a bond exchange-traded fund that has:

(1) embedded structural features designed to deliver performance that does not track the full unlevered and positive return of the underlying index or exposure, including a leveraged or inverse exchange-traded fund; or

(2) an expense ratio in excess of 100 basis points.

(c) A bond exchange-traded fund described by Subsection (a) shall be considered a business entity for purposes of Section 425.110.

(d) An insurance company may deposit with the department shares of a bond exchange-traded fund described by Subsection (a) as a statutory deposit if state law requires a statutory deposit from the insurance company.

Added by Acts 2019, 86th Leg., R.S., Ch. 1132 (H.B. 2694), Sec. 2, eff. September 1, 2019.

Sec. 425.124. AUTHORIZED INVESTMENTS: RISK CONTROL TRANSACTIONS. Subject to Sections 425.126-425.132, an insurance company may use derivative instruments, as defined by Section 425.125, to engage in hedging transactions, replication transactions, and income generation transactions, as those terms are defined by Section 425.125.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.125. RISK CONTROL TRANSACTIONS: DEFINITIONS. In Sections 425.124-425.132:

(1) "Acceptable collateral" means cash, cash equivalents, letters of credit, and direct obligations, or securities that are fully guaranteed as to principal and interest by the United States government.

(2) "Business entity" includes a sole proprietorship, corporation, limited liability company, association, partnership, joint stock company, joint venture, mutual fund, bank, trust, joint tenancy, or other similar form of business organization, regardless

of whether organized for profit.

(3) "Cap" means an agreement obligating the seller to make payments to the buyer, with each payment based on the amount by which a reference price or level or the performance or value of one or more underlying interests exceeds a predetermined number that is sometimes called the strike rate or strike price.

(4) "Cash equivalent" means an investment or security that is short-term, highly rated, highly liquid, and readily marketable. The term includes a money market fund described by Section 425.123. For purposes of this subdivision, an investment or security is:

(A) short-term if it has a remaining term to maturity of one year or less; and

(B) highly rated if it has:

(i) a rating of "P-1" by Moody's Investors Service, Inc.;

(ii) a rating of "A-1" by the Standard and Poor's Division of the McGraw Hill Companies, Inc.; or

(iii) an equivalent rating by a nationally recognized statistical rating organization recognized by the securities valuation office.

(5) "Collar" means an agreement to receive payments as the buyer of an option, cap, or floor and to make payments as the seller of a different option, cap, or floor.

(6)(A) "Counterparty exposure amount" means:

(i) for an over-the-counter derivative instrument not entered into under a written master agreement that provides for netting of payments owed by the respective parties, the market value of the over-the-counter derivative instrument, if the liquidation of the derivative instrument would result in a final cash payment to the insurer, or zero, if the liquidation of the derivative instrument would not result in a final cash payment to the insurance company; or

(ii) for an over-the-counter derivative instrument entered into under a written master agreement that provides for netting of payments owed by the respective parties, and for which the counterparty's domiciliary jurisdiction is within the United States or a jurisdiction outside the United States that is listed in the Purposes and Procedures Manual of the securities valuation office as eligible for netting, the greater of zero or the net sum payable to the company in connection with all derivative instruments subject to the written master agreement on the liquidation of the instruments in

the event of the counterparty's default under the master agreement, if there is no condition precedent to the counterparty's obligation to make the payment and if there is no setoff of amounts payable under another instrument or agreement.

(B) For purposes of this subdivision, market value or the net sum payable, as applicable, must be determined at the end of the most recent quarter of the insurance company's fiscal year and must be reduced by the market value of acceptable collateral held by the company or a custodian on the company's behalf.

(7) "Derivative instrument":

(A) means an agreement, option, or instrument, or a series or combinations of agreements, options, or instruments:

(i) to make or take delivery of, or assume or relinquish, a specified amount of one or more underlying interests, or to make a cash settlement instead of making or taking delivery of, or assuming or relinquishing, a specified amount of an underlying instrument; or

(ii) that has a price, performance, value, or cash flow based primarily on the actual or expected price, yield, level, performance, value, or cash flow of one or more underlying interests;

(B) includes an option, a warrant not otherwise permitted to be held by the insurance company under this subchapter, a cap, a floor, a collar, a swap, a swaption, a forward, a future, any other substantially similar agreement, option, or instrument, and a series or combination of those agreements, options, or instruments; and

(C) does not include a collateralized mortgage obligation, another asset-backed security, a principal-protected structured security, a floating rate security, an instrument that a company would otherwise be authorized to invest in or receive under a provision of this subchapter other than Sections 425.124-425.132, or a debt obligation of the company.

(8) "Derivative transaction" means a transaction involving the use of one or more derivative instruments. The term does not include a dollar roll transaction, repurchase transaction, reverse repurchase transaction, or securities lending transaction.

(9) "Floor" means an agreement obligating the seller to make payments to the buyer, each of which is based on the amount by which a predetermined number that is sometimes called the floor rate or floor price exceeds a reference price, level, performance, or

value of one or more underlying interests.

(10) "Forward" means an agreement to make or take delivery in the future of one or more underlying interests, or to effect a cash settlement, based on the actual or expected price, level, performance, or value of those interests. The term does not include a future, a spot transaction effected within a customary settlement period, a when-issued purchase, or another similar cash market transaction.

(11) "Future" means an agreement traded on a futures exchange to make or take delivery of one or more underlying interests, or to effect a cash settlement based on the actual or expected price, level, performance, or value of those interests.

(12) "Futures exchange" means a foreign or domestic exchange, contract market, or board of trade on which trading in futures is conducted and that, in the United States, is authorized to conduct that trading by the Commodity Futures Trading Commission or a successor to that agency.

(13) "Hedging transaction" means a derivative transaction entered into and maintained to manage, with respect to an asset, liability, or portfolio of assets or liabilities, that an insurance company has acquired or incurred or anticipates acquiring or incurring:

(A) the risk of a change in value, yield, price, cash flow, or quantity; or

(B) the currency exchange rate risk.

(14) "Income generation transaction" means a derivative transaction entered into to generate income. The term does not include a hedging transaction or a replication transaction.

(15) "Market value" means the price for a security or derivative instrument obtained from a generally recognized source, the most recent quotation from a generally recognized source, or if a generally recognized source does not exist, the price determined under the terms of the instrument or in good faith by the insurance company, as can be reasonably demonstrated to the commissioner on request, plus the amount of accrued but unpaid income on the security or instrument to the extent that amount is not included in the price as of the date the security or instrument is valued.

(16) "Option" means an agreement giving the buyer the right to buy or receive, referred to as a "call option," to sell or deliver, referred to as a "put option," to enter into, extend, or

terminate, or to effect a cash settlement based on the actual or expected price, spread, level, performance, or value of, one or more underlying interests.

(17) "Over-the-counter derivative instrument" means a derivative instrument entered into with a business entity in a manner other than through a securities exchange or futures exchange or cleared through a qualified clearinghouse.

(18) "Potential exposure" means:

(A) as to a futures position, the amount of initial margin required for that position; or

(B) as to a swap, collar, or forward, one-half of one percent multiplied by the notional amount multiplied by the square root of the remaining years to maturity.

(19) "Qualified clearinghouse" means a clearinghouse that:

(A) is subject to the rules of a securities exchange or a futures exchange; and

(B) provides clearing services, including acting as a counterparty to each of the parties to a transaction in a manner that eliminates the parties' credit risk to each other.

(20) "Replication transaction" means a derivative transaction or a combination of derivative transactions effected separately or in conjunction with cash market investments included in the insurance company's investment portfolio to replicate the risks and returns of another authorized transaction, investment, or instrument, or to operate as a substitute for cash market transactions. The term does not include a hedging transaction.

(21) "Securities exchange" means:

(A) an exchange registered as a national securities exchange or a securities market registered under the Securities Exchange Act of 1934 (15 U.S.C. Section 78a et seq.), as amended;

(B) the Private Offerings, Resales and Trading through Automated Linkages system; or

(C) a designated offshore securities market as defined by 17 C.F.R. Section 230.902, as amended.

(22) "Swap" means an agreement to exchange or to net payments at one or more times based on the actual or expected price, yield, level, performance, or value of one or more underlying interests.

(23) "Swaption" means an option to purchase or sell a swap at a given price and time or at a series of prices and times. The

term does not include a swap with an embedded option.

(24) "Underlying interest" means an asset, liability, or other interest underlying a derivative instrument or a combination of those assets, liabilities, or other interests. The term includes a security, currency, rate, index, commodity, or derivative instrument.

(25) "Warrant" means an instrument that gives the holder the right to purchase or sell the underlying interest at a given price and time or at a series of prices and times outlined in the warrant agreement.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.126. RISK CONTROL TRANSACTIONS: DERIVATIVE USE PLAN.

(a) Before an insurance company enters into a derivative transaction, the company's board of directors must approve a derivative use plan as part of the investment plan required by Section 425.105.

(b) The derivative use plan must:

- (1) describe investment objectives and risk constraints, such as counterparty exposure amounts;
- (2) define permissible transactions identifying the risks to be hedged or the assets or liabilities being replicated; and
- (3) require compliance with internal control procedures.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.127. RISK CONTROL TRANSACTIONS: INTERNAL CONTROL PROCEDURES. An insurance company that enters into a derivative transaction shall establish written internal control procedures that provide for:

- (1) a quarterly report to the board of directors that reviews:
 - (A) each derivative transaction entered into, outstanding, or closed out;
 - (B) the results and effectiveness of the derivatives program; and
 - (C) the credit risk exposure to each counterparty for

over-the-counter derivative transactions based on the counterparty exposure amount;

(2) a system for determining whether hedging or replication strategies used have been effective;

(3) a system of regular reports, at least monthly, to management that include:

(A) a description of each derivative transaction entered into, outstanding, or closed out during the period since the last report;

(B) the purpose of each outstanding derivative transaction;

(C) a performance review of the derivative instrument program; and

(D) the counterparty exposure amount for each over-the-counter derivative transaction;

(4) a written authorization that identifies the responsibilities and limitations of authority of each person authorized to effect and maintain derivative transactions; and

(5) appropriate documentation for each transaction, including:

(A) the purpose of the transaction;

(B) the assets or liabilities to which the transaction relates;

(C) the specific derivative instrument used in the transaction;

(D) for an over-the-counter derivative transaction, the name of the counterparty and the counterparty exposure amount; and

(E) for an exchange-traded derivative instrument, the name of the exchange and the name of the firm that handled the transaction.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.128. RISK CONTROL TRANSACTIONS: OVERSIGHT BY COMMISSIONER. (a) An insurance company must be able to demonstrate to the commissioner on request the intended hedging characteristics and continuing effectiveness of a derivative transaction or combination of transactions through:

- (1) cash flow testing;
- (2) duration analysis; or
- (3) other appropriate analysis.

(b) Ten days before entering into an initial hedging transaction, an insurance company shall notify the commissioner in writing that:

- (1) the company's board of directors has adopted an investment plan that authorizes hedging transactions; and
- (2) each hedging transaction will comply with Sections 425.124-425.132.

(c) After providing the notice under Subsection (b), the insurance company may enter into a hedging transaction under Section 425.124 if as a result of and after making the transaction:

- (1) the aggregate statement value of all outstanding options other than collars, and of all caps, floors, swaptions, and warrants under Sections 425.124-425.132 not attached to another financial instrument purchased by the company does not exceed 7.5 percent of the company's assets;
- (2) the aggregate statement value of all outstanding options other than collars, and of all caps, floors, swaptions, and warrants written by the company under Sections 425.124-425.132 does not exceed three percent of the company's assets; and
- (3) the aggregate potential exposure of all outstanding collars, swaps, forwards, and futures entered into or acquired by the company under Sections 425.124-425.132 does not exceed 6.5 percent of the company's assets.

(d) If the hedging transaction does not comply with Sections 425.124-425.132, or if continuing the transaction may create a hazardous financial condition for the insurance company that affects the company's policyholders or creditors or the public, the commissioner may, after notice and an opportunity for a hearing, order the company to take action reasonably necessary to:

- (1) remedy a hazardous financial condition; or
- (2) prevent an impending hazardous financial condition from occurring.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.129. RISK CONTROL TRANSACTIONS: LIMITATIONS ON INCOME GENERATION TRANSACTIONS. An insurance company may enter into an income generation transaction only if:

(1) as a result of and after making the transaction, the sum of the following amounts does not exceed 10 percent of the company's assets:

(A) the aggregate statement value of admitted assets that at the time of the transaction are subject to call or that generate the cash flows for payments the company is required to make under caps and floors sold by the company and that at the time of the transaction are outstanding under Sections 425.124-425.132;

(B) the statement value of admitted assets underlying derivative instruments that at the time of the transaction are subject to calls sold by the company and outstanding under those sections; and

(C) the purchase price of assets subject to puts that at the time of the transaction are outstanding under those sections; and

(2) the transaction is one of the following types, is covered in the manner specified by this subdivision, and meets the other requirements of this subdivision:

(A) a sale of a call option on assets, if during the entire period the option is outstanding, the company holds, or has a currently exercisable right to acquire, the underlying assets;

(B) a sale of a put option on assets, if:

(i) during the entire period the option is outstanding, the company holds sufficient cash, cash equivalents, or interests in a short-term investment pool to purchase the underlying assets on exercise of the option;

(ii) the company has the ability to hold the underlying assets in the company's portfolio; and

(iii) during the entire period the option is outstanding, when the total market value of all put options sold by the company exceeds two percent of the company's assets, the company sets aside, under a custodial or escrow agreement, cash or cash equivalents that have a market value equal to the amount of the company's put option obligations in excess of two percent of the company's assets;

(C) a sale of a call option on a derivative instrument, including a swaption, if:

(i) during the entire period the call option is outstanding, the company holds, or has a currently exercisable right to acquire, assets generating the cash flow to make any payment for which the company is liable under the underlying derivative instrument; and

(ii) the company has the ability to enter into the underlying derivative transaction for the company's portfolio; and

(D) a sale of a cap or floor, if during the entire period the cap or floor is outstanding, the company holds, or has a currently exercisable right to acquire, assets generating the cash flow to make any payment for which the company is liable under the cap or floor.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.130. RISK CONTROL TRANSACTIONS: LIMITATIONS ON REPLICATION TRANSACTIONS. (a) An insurance company may enter into a replication transaction only with the prior written approval of the commissioner, and only if:

(1) the company would otherwise be authorized to invest the company's funds under this subchapter in the asset being replicated; and

(2) the asset being replicated is subject to all the provisions of this subchapter relating to the making of investments by the company in that type of asset as if the transaction constituted a direct investment by the company in the replicated asset.

(b) The commissioner may adopt fair and reasonable rules regarding replication transactions to implement this section.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.131. RISK CONTROL TRANSACTIONS: TRADING REQUIREMENTS. For purposes of Sections 425.124-425.132, each derivative instrument must be:

(1) traded on a securities exchange;

(2) entered into with, or guaranteed by, a business entity;

(3) issued or written by, or entered into with, the issuer of the underlying interest on which the derivative instrument is based; or

(4) in the case of futures, traded through a broker that is:

(A) registered as a futures commission merchant under the Commodity Exchange Act (7 U.S.C. Section 1 et seq.); or

(B) exempt from that registration under 17 C.F.R. Section 30.10, adopted under the Commodity Exchange Act.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.132. RISK CONTROL TRANSACTIONS: OFFSETTING TRANSACTIONS. (a) Subject to this section, an insurance company may purchase or sell one or more derivative instruments to wholly or partly offset a derivative instrument previously purchased or sold, without regard to the quantitative limitations of Sections 425.124-425.131.

(b) An offsetting transaction under this section must use the same type of derivative instrument as the derivative instrument being offset.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.151. AUTHORIZED INVESTMENTS: FOREIGN COUNTRIES AND UNITED STATES TERRITORIES. (a) In addition to the investments within Canada authorized by this subchapter and subject to this section, an insurance company may make investments within another foreign country or a commonwealth, territory, or possession of the United States.

(b) An investment made under this section must be substantially the same type as an investment authorized to be made within the United States or Canada by this subchapter.

(c) The sum of the amount of investments made under this section and the amount of similar investments made within the United States and Canada may not exceed any limitation imposed by Sections 425.109-425.121, 425.124-425.132, and 425.152.

(d) The aggregate amount of an insurance company's investments under this section may not exceed the sum of:

(1) the amount of the company's reserves attributable to insurance business in force in foreign countries, if any, and any additional investments required by a foreign country as a condition of engaging in business in that country; and

(2) 20 percent of the company's assets.

(e) An insurance company may not invest more than 10 percent of the company's assets in investments denominated in foreign currency that are not hedged under Sections 425.124-425.132.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.152. AUTHORIZED INVESTMENTS: INVESTMENTS NOT OTHERWISE SPECIFIED OR PROHIBITED; INVESTMENTS AUTHORIZED BY OTHER LAW. (a) Subject to this section, an insurance company may make an investment that is not otherwise authorized by this subchapter and that is not specifically prohibited by statute, including any portion of an investment that exceeds the limits imposed by Sections 425.109-425.121, 425.124-425.132, and 425.151.

(b) If any aggregate or individual investment limitation imposed by Sections 425.109-425.121, 425.124-425.132, and 425.151 is exceeded, the excess portion of the investment is considered to be an investment under Subsection (a).

(c) The insurance company has the burden of establishing the value of an investment made under Subsection (a).

(d) The amount of a single investment made by an insurance company under Subsection (a) may not exceed 10 percent of the company's capital and surplus in excess of the statutory minimum capital and surplus applicable to that company.

(e) The aggregate amount of an insurance company's investments under Subsection (a) may not exceed the lesser of:

(1) five percent of the company's assets; or

(2) the amount of the company's capital and surplus that exceeds the amount of statutory minimum capital and surplus applicable to that company.

(f) An insurance company may invest in any investment authorized for an insurance company that is subject to this

subchapter by a provision of this code other than this subchapter or by another law of this state.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.153. AUTHORIZED INVESTMENTS: CERTAIN PREVIOUSLY AUTHORIZED INVESTMENTS. (a) An insurance company may continue to hold an investment held by the company on January 1, 1986, that does not conform to the requirements of the investments authorized by Sections 425.109-425.120, 425.151, and 425.152 if the investment was legally authorized at the time the investment was made or acquired or that the company was authorized to hold immediately before January 1, 1986.

(b) An investment described by Subsection (a) is considered an authorized investment of the insurance company. A company shall dispose of the investment at the investment's maturity date, if any, or within the time prescribed by the law under which the investment was acquired, if any.

(c) This section does not alter the legal or accounting status of an investment described by Subsection (a).

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.154. APPLICABILITY OF PERCENTAGE AUTHORIZATIONS AND LIMITATIONS. The percentage authorizations and limitations established by this subchapter apply only at the time an investment is originally acquired or a transaction is entered into and do not apply to the insurance company or the investment or transaction after that time, except as provided by Section 425.155.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.155. QUALIFICATION OF INVESTMENTS. (a) The qualification or disqualification of an investment under one section of this subchapter does not prevent the investment from qualifying,

wholly or partly, under another section of this subchapter. An investment authorized by more than one section may be held under the authorizing section elected by the insurance company.

(b) An investment or transaction qualified under any section of this subchapter at the time the insurance company acquired the investment or entered into the transaction continues to be qualified under that section.

(c) An insurance company may elect to transfer at any time the qualification of an investment, wholly or partly, to the authority of any section of this subchapter under which the investment qualifies at the time of the transfer, regardless of whether the investment originally qualified under that section.

(d) An investment, once qualified under this subchapter, remains qualified notwithstanding any refinancing, restructuring, or modification of the investment, except that an insurance company may not refinance, restructure, or modify an investment to circumvent the requirements of this subchapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.156. DISTRIBUTIONS, REINSURANCE, AND MERGER. (a) This subchapter does not prohibit an insurance company from acquiring additional obligations, securities, or other assets received as a dividend or as a distribution of assets.

(b) This subchapter does not apply to securities, obligations, or other assets accepted incident to the workout, adjustment, restructuring, or similar realization of any kind of previously authorized investment or transaction if the insurance company's board of directors or a committee appointed by the board of directors determines that acceptance of the securities, obligations, or other assets is in the company's best interests.

(c) This subchapter does not apply to assets acquired under a lawful agreement of bulk reinsurance, merger, or consolidation if the assets were legal and authorized investments for the ceding, merged, or consolidated insurance company.

(d) An obligation, security, or other asset acquired as permitted by this section is not required to be qualified under any other section of this subchapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.157. AGGREGATE DIVERSIFICATION REQUIREMENTS. (a) This section takes precedence over Sections 425.109-425.120, 425.122-425.153, and 425.155(a), (b), and (c).

(b) An insurance company's investments in all or any types of securities, loans, obligations, or evidences of indebtedness of a single issuer or borrower, including the issuer's or borrower's majority-owned subsidiaries or parent and the majority-owned subsidiaries of the issuer's or borrower's parent, may not, in the aggregate, exceed five percent of the company's assets. This subsection does not apply to:

(1) authorized investments that:

(A) are direct obligations of, or are guaranteed by the full faith and credit of, the United States, this state, or a political subdivision of this state; or

(B) are insured by an agency of the United States or this state; or

(2) an investment provided for by Section 425.112 or 425.113.

(c) Except as otherwise provided by this subsection, an insurance company's aggregate investment in real property under Sections 425.119, 425.120, 425.152, and 425.153 may not exceed 33-1/3 percent of the company's assets. If a company acquires real property under Section 425.119(g) and that acquisition causes the company's aggregate real estate investment to exceed the limitation imposed by this subsection, the company shall, on or before the 10th anniversary of the date the real property is acquired, dispose of a sufficient amount of real property to comply with the applicable limitation. A company that does not dispose of excess real property as required by this subsection may not admit as an asset the value of the real property that exceeds the applicable limitation.

(d) If an insurance company's real property acquisitions exceed the limitation imposed by Subsection (c), the company may not acquire additional real property under Section 425.119(b) or (c) or 425.120, 425.152, or 425.153 until the company disposes of the excess real property as specified by Subsection (c).

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.158. WAIVER BY COMMISSIONER OF QUANTITATIVE LIMITATIONS. (a) The commissioner may waive a quantitative limitation on any investment authorized by Sections 425.109-425.132 and 425.151-425.156 if:

- (1) the insurer seeks the waiver before making the investment;
 - (2) a hearing is held to determine whether the waiver should be granted;
 - (3) the applicant seeking the waiver establishes that unreasonable or unnecessary loss or harm will result to the company if the commissioner denies the waiver;
 - (4) the excess investment will not have a material adverse effect on the company; and
 - (5) the size of the investment is reasonable in relation to the company's assets, capital, surplus, and liabilities.
- (b) The commissioner's waiver must be in writing and may treat the resulting excess investment as a nonadmitted asset.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.159. ACCOUNTING PROVISIONS. (a) Each insurance company shall maintain reasonable, adequate, and accurate evidence of the company's ownership of the company's assets and investments.

(b) An insurance company shall evidence the company's ownership of governmental or corporate securities as provided by Sections 423.101, 423.102, 423.104(a), 423.105, 423.106, 423.107, and 423.108.

(c) An insurance company shall hold investments, other than investments made as a participation in a partnership or joint venture, only in the company's own name or as otherwise provided by Chapter 423.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.160. INVESTMENTS OF CEDING INSURERS. (a) Subject to this section, if a domestic insurance company assumes and reinsures the business of and takes over the assets of another domestic insurance company or a foreign company, all assets or investments of the ceding company that were authorized as proper assets or investments for the funds of that company and taken over by the assuming company are considered valid assets or investments of the assuming company under the laws of this state.

(b) The commissioner must approve assets or investments described by Subsection (a) and the terms on which those assets or investments are taken over. The commissioner may require the assuming insurance company to reasonably dispose of any of those assets or investments that do not otherwise meet the requirements of this subchapter within a period that will minimize any financial loss or other hardship caused by disposing of the asset or investment.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.161. ACTING AS REAL ESTATE BROKER OR SALESPERSON PROHIBITED. A domestic insurance company or another insurance company specifically made subject to this subchapter may not engage in the business of a broker or salesperson as defined by Chapter 1101, Occupations Code, except that the company may hold, improve, maintain, manage, rent, lease, sell, exchange, or convey any of the real property interests owned as investments under Sections 425.109-425.132 and 425.151-425.153.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.162. RULES. The commissioner may adopt rules, minimum standards, or limitations that are fair and reasonable as appropriate to supplement and implement this subchapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

SUBCHAPTER D. AUTHORIZED INVESTMENTS AND TRANSACTIONS FOR OTHER LIFE, HEALTH, AND ACCIDENT INSURERS

Sec. 425.201. DEFINITION. In this subchapter, "contingency funds" means an insurer's contingency funds over and above the amount of the insurer's policy reserves.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.202. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to an insurer organized under Chapter 881, 884, 885, 886, 887, or 2551, except as specifically provided by those chapters.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.203. LIMITATION ON FUNDS AND OTHER ASSETS. (a) An insurer may not use the insurer's funds to make an investment or loan that is not authorized by this subchapter.

(b) An insurer may not secure, hold, or convey real property except as authorized by this subchapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.204. APPROVAL OF INVESTMENTS AND LOANS REQUIRED. (a) An insurer may not make an investment unless the investment has been authorized by the insurer's board of directors or by a committee responsible for supervising investments.

(b) An insurer may not make a loan other than a policy loan unless the loan has been authorized by the insurer's board of directors or by a committee responsible for supervising loans.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.205. AUTHORIZED INVESTMENTS FOR ALL FUNDS: GOVERNMENT

BONDS. (a) Subject to this section, an insurer may invest any of the insurer's funds and accumulations in:

(1) a bond, treasury bill, note, or certificate of indebtedness of the United States or any other obligation or security fully guaranteed as to principal and interest by the full faith and credit of the United States;

(2) a bond of Canada or a province or municipality of Canada;

(3) a bond of a state, county, or municipality of the United States;

(4) a bond or interest-bearing warrant issued by a county, municipality, school district, or other subdivision that is:

(A) organized under the laws of a state of the United States; and

(B) authorized to issue the bond or warrant under the constitution and laws of that state;

(5) a bond or interest-bearing warrant issued by an educational institution that is:

(A) organized under the laws of a state of the United States; and

(B) authorized to issue the bond or warrant under the constitution and laws of that state;

(6) a bond or warrant, including a revenue or special obligation, of an educational institution located in a state of the United States;

(7) a bond or warrant payable from designated revenues of a municipality, county, drainage district, road district, or other civil administration, agency, authority, instrumentality, or subdivision that is:

(A) organized under the laws of a state of the United States; and

(B) authorized to issue the bond or warrant under the constitution and laws of that state;

(8) a paving certificate or other certificate or evidence of indebtedness issued by a municipality in a state of the United States and secured by a first lien on real estate; and

(9) a bond issued under the Farm Credit Act of 1971 (12 U.S.C. Section 2001 et seq.) that is issued against and secured by promissory notes or obligations, the payment of which is secured by mortgage, deed of trust, or other valid lien on unencumbered real

property located in this state.

(b) An insurer may invest in a bond or warrant described by Subsection (a)(4) or (5) only if the issuer of the bond or warrant has made legal provision to impose a tax to meet the obligation.

(c) An insurer may invest in a bond or warrant described by Subsection (a)(6) only if the special revenue or income to meet the principal and interest payments as they accrue on the obligation has been appropriated, pledged, or otherwise provided by the educational institution.

(d) An insurer may invest in a bond or warrant described by Subsection (a)(7) only if special revenue or income to meet the principal and interest payments as they accrue on the obligation has been appropriated, pledged, or otherwise provided by the municipality or other entity.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.206. AUTHORIZED INVESTMENTS FOR ALL FUNDS: CORPORATE BONDS, NOTES, AND DEBENTURES. (a) Subject to Subsection (e), an insurer may invest any of the insurer's funds and accumulations in a first mortgage bond or first lien note on real or personal property of:

(1) a solvent corporation that has not defaulted in the payment of any debt during the five years preceding the investment;

(2) a solvent corporation that has not been in existence for five consecutive years but whose first mortgage bonds or first lien notes on real or personal property are fully guaranteed by a solvent corporation that has not defaulted in the payment of any debt during the five years preceding the investment;

(3) a solvent corporation that has not been in existence for five consecutive years but whose first mortgage bonds or first lien notes on real or personal property are secured by leases or other contracts executed by a solvent corporation that has not defaulted in the payment of any debt during the five years preceding the investment, if the required rentals or other required payments under the leases or other contracts are sufficient in all circumstances to pay interest and principal when due on the bonds or notes; or

(4) a solvent corporation that has not been in existence for five consecutive years preceding the investment, if:

(A) the corporation has succeeded to the business and assets and has assumed the liabilities of another corporation; and

(B) neither the successor corporation or the corporation succeeded has defaulted in the payment of any debt during the five years preceding the investment.

(b) Subject to Subsection (e), an insurer may invest any of the insurer's funds and accumulations in a note or debenture of a corporation with a net worth of at least \$5 million if:

(1) a prior lien in excess of 10 percent of the net worth of the corporation does not exist against the real or personal property of the corporation at the time the note or debenture is issued; and

(2) under the provisions of the indenture providing for the issuance of the note or debenture, a prior lien that exceeds 10 percent of the net worth of the corporation cannot be created against the real or personal property of the corporation at the time the note or debenture is issued.

(c) Subject to Subsection (e), an insurer may invest any of the insurer's funds and accumulations in a note or debenture of a solvent corporation that has not been in existence for five consecutive years if:

(1) a prior lien does not exist against the real or personal property of the corporation at the time the note or debenture is issued;

(2) under the provisions of the indenture providing for the issuance of the note or debenture, a prior lien cannot be created against the real or personal property of the corporation at the time the note or debenture is issued; and

(3) the note or debenture is:

(A) secured by a lease or other contract executed by a solvent corporation that has a net worth of at least \$5 million and has not defaulted in the payment of any debt during the five years preceding the investment, if the required rentals or other required payments under the lease or other contract are sufficient in all circumstances to pay interest and principal when due on the bond or note; or

(B) fully guaranteed by a corporation described by Paragraph (A).

(d) Subject to Subsection (e), an insurer may invest any of the insurer's funds and accumulations in a bond, bill of exchange, or other commercial note or bill of:

(1) a solvent corporation that has not defaulted in the payment of any debt during the five years preceding the investment; or

(2) a solvent corporation that has not been in existence for the five years preceding the investment, if:

(A) the corporation has succeeded to the business and assets and has assumed the liabilities of another corporation;

(B) neither the successor corporation or the corporation succeeded has defaulted in the payment of any debt during the five years preceding the investment;

(C) the corporation has a net worth of at least \$50 million; and

(D) the corporation does not have long-term indebtedness that exceeds the corporation's net worth, as evidenced by the corporation's latest published financial statements or other financial data available to the public.

(e) The amount of an insurer's investments in the bonds, notes, debentures, or other obligations of any one corporation may not exceed five percent of the insurer's admitted assets.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.2061. AUTHORIZED INVESTMENTS FOR ALL FUNDS: BOND EXCHANGE-TRADED FUNDS. Subject to Section 425.157(b), an insurer may invest any of the insurer's funds and accumulations in a bond exchange-traded fund described by Section 425.1231(a).

Added by Acts 2019, 86th Leg., R.S., Ch. 1132 (H.B. 2694), Sec. 3, eff. September 1, 2019.

Sec. 425.207. AUTHORIZED INVESTMENTS FOR ALL FUNDS: SHARES OF SAVINGS AND LOAN ASSOCIATIONS. (a) Subject to this section, an insurer may invest any of the insurer's funds and accumulations in a share, stock, share or savings account, or investment certificate of a savings and loan association engaged in business in this state that

is qualified to participate in insurance issued by the Federal Deposit Insurance Corporation.

(b) An insurer's investment in a savings and loan association may not exceed 20 percent of the savings and loan association's total assets.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.208. AUTHORIZED INVESTMENTS FOR ALL FUNDS: BANK AND BANK HOLDING COMPANY STOCKS. (a) Subject to this section, an insurer may invest any of the insurer's funds and accumulations in:

(1) the stock of a state or national bank that is a member of the Federal Deposit Insurance Corporation; and

(2) the stock of a bank holding company as defined by the Bank Holding Company Act of 1956 (12 U.S.C. Section 1841 et seq.), as amended by the Bank Holding Company Act Amendments of 1970 (12 U.S.C. Section 1841 et seq. and Section 1971 et seq.).

(b) An insurer's investment in the stock of a bank or bank holding company may not exceed:

(1) 20 percent of the total outstanding shares of the stock of the bank or bank holding company; or

(2) 10 percent of the insurer's admitted assets.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.209. AUTHORIZED INVESTMENTS FOR ALL FUNDS: DEBENTURES OF PUBLIC UTILITY CORPORATIONS. (a) Subject to this section, an insurer may invest any of the insurer's funds and accumulations in:

(1) a debenture of a solvent public utility corporation that:

(A) has not defaulted in the payment of any debt during the five years preceding the investment; and

(B) has not failed in any one of the five years preceding the investment to have earned, after taxes, including income taxes, and after deducting proper charges for replacements, depreciation, and obsolescence, an amount applicable to interest on the corporation's outstanding indebtedness equal to at least two

times the amount of interest due for that year, or, in the case of issuance of new debentures, the earnings applicable to interest are equal to at least two times the amount of annual interest on the corporation's obligations after giving effect to the new financing; or

(2) a debenture of a solvent public utility corporation that has not been in existence for the five years preceding the investment, if:

(A) the corporation has succeeded to the business and assets and has assumed the liabilities of another public utility corporation;

(B) neither the successor corporation or the corporation succeeded has defaulted in the payment of any debt during the five years preceding the investment; and

(C) neither the successor corporation or the corporation succeeded have failed in any one of the five years preceding the investment to have earned, after taxes, including income taxes, and after deducting proper charges for replacements, depreciation, and obsolescence, an amount applicable to interest on the corporation's outstanding indebtedness equal to at least two times the amount of interest due for that year, or in the case of issuance of new debentures, the earnings applicable to interest are equal to at least two times the amount of annual interest on the corporation's obligations after giving effect to the new financing.

(b) The amount of an insurer's investment in debentures under this section may not exceed five percent of the insurer's admitted assets.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.210. AUTHORIZED INVESTMENTS FOR ALL FUNDS: PREFERRED STOCK OF PUBLIC UTILITY CORPORATIONS. (a) Subject to this section, an insurer may invest any of the insurer's funds and accumulations in:

(1) preferred stock of a solvent public utility corporation, the bonds and debentures of which are authorized investments for the insurer, and that:

(A) has not defaulted in the payment of any debt during

the five years preceding the investment; and

(B) has not failed in any one of the five years preceding the investment to have earned an amount applicable to the dividends on the preferred stock equal to at least three times the amount of dividends due in that year, or, in the case of issuance of new preferred stock, the earnings applicable to dividends are equal to at least three times the amount of the annual dividend requirements after giving effect to the new financing; or

(2) a solvent public utility corporation, the bonds and debentures of which are authorized investments for the insurer, and that has not been in existence for the five years preceding the investment, if:

(A) the corporation has succeeded to the business and assets and has assumed the liabilities of another public utility corporation;

(B) neither the successor corporation or the corporation succeeded has defaulted in the payment of any debt during the five years preceding the investment; and

(C) neither the successor corporation or the corporation succeeded have failed in any one of the five years preceding the investment to have earned an amount applicable to the dividends on the preferred stock equal to at least three times the amount of dividends due in that year, or, in the case of issuance of new preferred stock, the earnings applicable to dividends are equal to at least three times the amount of the annual dividend requirements after giving effect to the new financing.

(b) Preferred stock purchased under this section must be of an issue entitled to first claim on the net earnings of the public utility corporation, after deducting the amount necessary to service any outstanding bonds and debentures.

(c) The amount of an insurer's investment in preferred stock under this section may not exceed 2-1/2 percent of the insurer's admitted assets.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.211. AUTHORIZED INVESTMENTS FOR ALL FUNDS: BONDS ISSUED, ASSUMED, OR GUARANTEED IN INTERNATIONAL MARKET. An insurer

may invest any of the insurer's funds and accumulations in bonds issued, assumed, or guaranteed by:

- (1) the Inter-American Development Bank;
- (2) the International Bank for Reconstruction and Development (the World Bank);
- (3) the African Development Bank;
- (4) the Asian Development Bank;
- (5) the International Finance Corporation; and
- (6) the State of Israel.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.212. AUTHORIZED INVESTMENTS FOR ALL FUNDS: SECURITIES OR INVESTMENTS AUTHORIZED OR DESCRIBED BY SPECIFIC STATUTORY PROVISION. An insurer may invest any of the insurer's funds and accumulations in a security or investment authorized or described by:

- (1) Section 65.013, Finance Code;
- (2) Sections 435.041-435.047, Government Code;
- (3) Subchapter B, Chapter 1505, Government Code;
- (4) Chapter 284, Transportation Code;
- (5) Section 51.039 or 60.104, Water Code;
- (6) Chapter 160, General Laws, Acts of the 43rd Legislature, Regular Session, 1933 (Article 842a, Vernon's Texas Civil Statutes);
- (7) Chapter 230, Acts of the 49th Legislature, Regular Session, 1945 (Article 842a-1, Vernon's Texas Civil Statutes);
- (8) Chapter 110, Acts of the 51st Legislature, Regular Session, 1949 (Article 8280-133, Vernon's Texas Civil Statutes);
- (9) Chapter 340, Acts of the 51st Legislature, Regular Session, 1949 (Article 8280-137, Vernon's Texas Civil Statutes);
- (10) Chapter 398, Acts of the 51st Legislature, Regular Session, 1949 (Article 8280-138, Vernon's Texas Civil Statutes); or
- (11) Chapter 465, Acts of the 51st Legislature, Regular Session, 1949 (Article 8280-139, Vernon's Texas Civil Statutes).

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.213. AUTHORIZED INVESTMENTS FOR ALL FUNDS: OTHER SECURITIES SPECIFICALLY AUTHORIZED BY LAW. An insurer may invest any of the insurer's funds and accumulations in:

(1) an adequately secured equipment trust obligation or certificate or another adequately secured instrument evidencing:

(A) an interest in transportation equipment that is located wholly or partly within the United States; and

(B) a right to receive determined portions of rental, purchase, or other fixed obligatory payments for the use or purchase of the transportation equipment; and

(2) any other security as specifically authorized by law.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.214. AUTHORIZED INVESTMENTS FOR ALL FUNDS: LOANS SECURED BY REAL PROPERTY. (a) Subject to this section, an insurer may loan any of the insurer's funds and accumulations and take as collateral a first lien on real property to which the title is valid.

(b) The amount of a loan secured by a first lien on real property may exceed 75 percent of the property value only if:

(1) the amount does not exceed 90 percent of the property value and the property contains only a dwelling designed exclusively for occupancy by not more than four families for residential purposes; or

(2) the amount does not exceed 95 percent of the property value and:

(A) the property contains only a dwelling designed exclusively for occupancy by not more than four families for residential purposes; and

(B) the portion of the unpaid balance of the loan that exceeds 80 percent of the property value is guaranteed or insured by a mortgage guaranty insurer authorized to engage in business in this state.

(c) An insurer may not originate a loan that exceeds 75 percent of the value of the real property securing the loan.

(d) The aggregate amount of an insurer's loans secured by first liens on real property to any one corporation, company, partnership, individual, or any affiliated person or group may not exceed 10

percent of the insurer's admitted assets. The amount of any single loan secured by a first lien on real property may not exceed five percent of the insurer's admitted assets.

(e) The limitations imposed by Subsections (b)-(d) do not apply to a first lien on real property if the commissioner finds that:

(1) the making or acquiring of the lien is beneficial to and protects the interest of the insurer; and

(2) no substantial damage to the insurer's policyholders and creditors appears probable from the taking or acquiring of the lien.

(f) Subject to Subsections (g)-(j), an insurer may loan any of the insurer's funds and accumulations and take as collateral a first lien on a leasehold estate in:

(1) real property to which the title is valid; and

(2) improvements located on the property to which the title is valid.

(g) The term of a loan secured by first lien on a leasehold estate in real property may not, as of the date the loan is made, exceed a period equal to four-fifths of the unexpired term of the leasehold estate. The term of the leasehold estate may not expire sooner than the 10th anniversary of the expiration of the term of the loan.

(h) A loan secured by a first lien on a leasehold estate in real property must be payable in equal monthly, quarterly, semiannual, or annual installments on principal and interest during a period not to exceed four-fifths of the unexpired term, as of the date the loan is made, of the leasehold estate.

(i) The restrictions imposed by this section on the value of the real property securing a loan compared to the amount of the loan, and on the duration of a loan secured by a leasehold estate in real property, do not apply to a loan if:

(1) the entire amount of the indebtedness is insured or guaranteed in any manner by:

(A) the United States;

(B) the Federal Housing Administration under the National Housing Act (12 U.S.C. Section 1701 et seq.), as amended; or

(C) this state; or

(2) the difference between the entire amount of the indebtedness and the portion of the loan insured or guaranteed by an entity described by Subdivision (1) does not exceed the amount of a

loan permitted by the applicable restriction.

(j) If any part of the value of buildings is to be included in the value of real property or leasehold estate in real property to attain the minimum authorized value of the security for a loan under this section:

(1) the buildings must be insured against loss by fire by:

(A) an insurer authorized to engage in business in the state in which the real property is located; or

(B) a company recognized as acceptable for that purpose by the insurance regulatory official of the state in which the real property is located;

(2) the amount of insurance coverage may not be less than 50 percent of the value of the buildings, except that the insurance coverage is not required to exceed the outstanding balance owed to the insurer if the outstanding balance of the loan is less than 50 percent of the value of the buildings; and

(3) the loss clause under the insurance must be payable to the insurer.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.215. AUTHORIZED INVESTMENTS FOR ALL FUNDS: LOANS SECURED BY CERTAIN COLLATERAL SECURED BY REAL PROPERTY. An insurer may loan any of the insurer's funds and accumulations and take as collateral an obligation secured by a first lien on real property or a leasehold estate that is eligible to secure a loan under Section 425.214.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.216. AUTHORIZED INVESTMENTS FOR ALL FUNDS: POLICY LOANS. (a) Subject to Subsection (b), an insurer may loan any of the insurer's funds and accumulations and take as collateral an insurance policy issued by the insurer.

(b) A loan on a policy under this section may not exceed the reserve value of the policy.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.217. AUTHORIZED INVESTMENTS FOR ALL FUNDS: LOANS SECURED BY CERTAIN SECURITIES. An insurer may loan any of the insurer's funds and accumulations and take as collateral for the loan any security described by Sections 425.205-425.213 and 425.218 in which the insurer may invest any of the insurer's funds and accumulations.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.218. AUTHORIZED INVESTMENTS FOR ALL FUNDS: SECURITIES NOT OTHERWISE SPECIFIED. (a) Notwithstanding any express or implied prohibitions, and subject to this section, an insurer may invest any of the insurer's funds and accumulations in an investment that does not otherwise qualify under any other provision of this chapter.

(b) The amount of any one investment by an insurer under this section may not exceed one percent of the insurer's admitted assets.

(c) The aggregate amount of investments by an insurer under this section may not exceed the lesser of:

(1) five percent of the insurer's admitted assets; or

(2) the amount of the insurer's capital and surplus in excess of \$200,000 as shown on the last annual statement filed by the insurer with the department before the date the investment is acquired.

(d) Except as provided by another law of this state, this section does not authorize an insurer to invest any of the insurer's funds or accumulations in real property.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.219. AUTHORIZED INVESTMENTS FOR POLICY RESERVES AND SURPLUS: BONDS OF CERTAIN WATER CONTROL AND IMPROVEMENT DISTRICTS. An insurer may invest the insurer's policy reserves and surplus over and above the insurer's capital in municipal bonds issued under

Section 51.039, Water Code.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.220. AUTHORIZED INVESTMENTS FOR CAPITAL, SURPLUS, AND CONTINGENCY FUNDS: CAPITAL STOCK, BONDS, AND OTHER CORPORATE OBLIGATIONS. (a) Subject to this section and Section 425.226, an insurer may invest the insurer's capital, surplus, and contingency funds in the capital stock, bonds, bills of exchange, or other commercial notes or bills and securities of:

(1) a solvent corporation that has not defaulted in the payment of any debt during the five years preceding the investment; or

(2) a solvent corporation that has not been in existence for the five years preceding the investment, if:

(A) the corporation has succeeded to the business and assets and has assumed the liabilities of another corporation; and

(B) neither the successor corporation nor the corporation succeeded has defaulted in the payment of any debt during the five years preceding the investment.

(b) An insurer may not invest in the stock of:

(1) a manufacturing corporation with a net worth of less than \$25,000; or

(2) an oil corporation with a net worth of less than \$500,000.

(c) Except as provided by Subsection (d), an insurer's investment in the insurer's own capital stock or in the stock of a single corporation may not be in an amount exceeding 10 percent of the amount of the insurer's capital, surplus, and contingency funds.

(d) An insurer may own, and the insurer may invest not more than 25 percent of the insurer's capital, surplus, and contingency funds in, the capital stock of a single fire and casualty insurance company if that investment gives the insurer a majority of the outstanding stock of the fire and casualty insurance company.

(e) In addition to the investments authorized by this section and subject to Section 425.226, an insurer may invest in the capital stock, bonds, and other obligations of one or more solvent corporations that portion of the insurer's surplus funds that exceeds

the greater of:

(1) 10 percent of the insurer's admitted assets, as determined from the insurer's latest annual statement on file with the department; or

(2) the minimum capital and surplus requirements for incorporating a life insurance company under Chapter 841.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.221. AUTHORIZED INVESTMENTS FOR CAPITAL, SURPLUS, AND CONTINGENCY FUNDS: BONDS OR NOTES OF EDUCATIONAL OR RELIGIOUS CORPORATIONS. Subject to Section 425.226, an insurer may invest the insurer's capital, surplus, and contingency funds in a bond or note of an educational or religious corporation that has provided for the payment of a sufficient amount of the first weekly or monthly revenues of the corporation to an interest and sinking fund account in a bank or trust company as an independent paying agent.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.222. AUTHORIZED INVESTMENTS FOR CAPITAL, SURPLUS, AND CONTINGENCY FUNDS: LIFE INCOME INTERESTS IN QUALIFIED TRUSTS. (a) Subject to this section, an insurer may invest the insurer's capital, surplus, and contingency funds in a life income interest in a qualified irrevocable express testamentary trust.

(b) For purposes of this section, a trust is a qualified trust if:

(1) each fee simple recipient of any part of the corpus of the trust:

(A) is a public charity, church, educational institution, or scientific institution;

(B) is located in this state; and

(C) is recognized by the United States Internal Revenue Service as exempt from payment of income taxes;

(2) the corpus of the trust is wholly or partly composed of interests in real estate, stocks, bonds, debentures, and other securities of an aggregate total value of at least \$5 million; and

(3) the corpus of the trust produces annual income of at least \$100,000.

(c) An insurer's life income interest in a qualified trust may not exceed 10 percent of the insurer's admitted assets.

(d) Before an insurer may acquire a life income interest in a qualified trust, the insurer must present evidence satisfactory to the commissioner that shows:

(1) the interest is subject to transfer and is recognized as transferable;

(2) the interest is capable of reasonable valuation;

(3) a market for the sale of the interest exists; and

(4) the interest is supported by life insurance in:

(A) an amount not less than the admitted value of the interest; and

(B) a form approved by the commissioner.

(e) In valuing a life income interest in a qualified trust on the insurer's books, the insurer may value the interest only on the basis of the lesser of:

(1) the recognized market established in accordance with Subsection (d)(3); or

(2) the ratio that the fractional life income interest in the income of the trust bears to the total market value of the properties held by the trust that are of a type of property an insurer may lawfully acquire under the investment statutes of this state.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.223. AUTHORIZED INVESTMENTS FOR CAPITAL, SURPLUS, AND CONTINGENCY FUNDS: CAPITAL STOCK OF REINSURER. (a) Subject to Subsection (b), an insurer may invest the insurer's capital, surplus, and contingency funds in not more than 20 percent of the capital stock of any other insurance company organized under Chapter 841 whose principal business is the reinsurance, either wholly or partly, of risks ceded to that insurer by other life insurance companies.

(b) The aggregate amount of an insurer's investments under this section may not exceed 10 percent of the insurer's capital, surplus, and contingency funds.

(c) The investment authorized by this section may be made by purchase of stock issued and outstanding or by subscription to and payment for the increase in the capital stock of the reinsurer.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.224. AUTHORIZED INVESTMENTS FOR CAPITAL, SURPLUS, AND CONTINGENCY FUNDS: LOANS SECURED BY CORPORATE STOCK. (a) Subject to this section, an insurer may loan the insurer's capital, surplus, and contingency funds and take as collateral the capital stock, bonds, bills of exchange, or other commercial notes or bills or the securities of:

(1) a solvent corporation that has not defaulted in the payment of any debt during the five years preceding the investment; or

(2) a solvent corporation that has not been in existence for the five years preceding the investment, if:

(A) the corporation has succeeded to the business and assets and has assumed the liabilities of another corporation; and

(B) neither the successor corporation nor the corporation succeeded has defaulted in the payment of any debt during the five years preceding the investment.

(b) Subject to this section, an insurer may loan the insurer's capital, surplus, and contingency funds and take as collateral the bonds or notes of an educational or religious corporation that has provided for the payment of a sufficient amount of the first weekly or monthly revenues of the corporation to an interest and sinking fund account in a bank or trust company as an independent paying agent.

(c) The market value of the stock, bills of exchange, other commercial notes or bills, or securities must be at all times during the continuance of the loan at least 50 percent more than the amount loaned on the securities or obligations.

(d) An insurer may not take as collateral for any loan:

(1) the insurer's capital stock;

(2) the stock of a single corporation in an amount that exceeds 10 percent of the amount of the insurer's own capital, surplus, and contingency funds;

(3) the stock of a manufacturing corporation with a net worth of less than \$25,000;

(4) the stock of an oil corporation with a net worth of less than \$500,000; or

(5) any stock, the holder or owner of which is or may become liable for any assessment other than taxes.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.225. INVESTMENT IN FOREIGN SECURITIES. (a) An insurer authorized to engage in business in a foreign country may invest in securities of that country that are the same kind of securities as those in the United States in which an insurer is authorized by this subchapter to invest.

(b) The aggregate amount of an insurer's investments under this section may not exceed the amount of the insurer's reserves on the business in force in the foreign country.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.226. INVESTMENT IN STOCK SUBJECT TO ASSESSMENT PROHIBITED. An insurer may not invest any of the insurer's funds in a stock, the holder or owner of which is or may become liable for any assessment other than taxes.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.227. CERTAIN INVESTMENT POWERS NOT A RESTRICTION. The investment powers granted by Sections 425.207 and 425.208 may not be construed as restricting the powers granted by Sections 425.220 and 425.221.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.228. INVESTMENTS OF CEDING INSURER. (a) Subject to this section, if a domestic insurer assumes the business and takes over the assets of another domestic or a foreign insurer, all investments of the ceding insurer that were authorized, when made, by the laws of the state in which the ceding insurer was organized as proper securities for investment of the funds of an insurer and that are taken over by the assuming insurer are considered to be valid securities of the assuming insurer under the laws of this state.

(b) The commissioner must approve investments described by Subsection (a) and the terms on which those investments are taken over. The commissioner may require the assuming insurer to dispose of any of the investments on notice the commissioner considers reasonable.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.229. AUTHORIZED INVESTMENTS: REAL ESTATE FOR INSURER'S OFFICES. (a) Subject to this section, an insurer may secure, hold, and convey the following real property:

(1) one building site and office building for the insurer's accommodation in the transaction of the insurer's business and for lease;

(2) branch office buildings in this state and elsewhere within the United States in which the insurer is authorized to engage in business as necessary for the insurer's convenient accommodation in the transaction of the insurer's business and for lease; and

(3) parking facilities adjacent to or in the vicinity of each office building owned by the insurer as reasonably necessary for the insurer and the building tenants.

(b) An office building described by Subsection (a)(1) may be on ground on which the insurer owns a lease the term of which expires not sooner than the 50th anniversary of the date the insurer acquires the lease. The insurer must own, or be entitled to the use of, all the improvements on the leased ground. The value of the improvements must be at least equal to the value of the ground and at least 20 times the annual average ground rentals payable under the lease. The office building must have an annual average net rental of at least twice the annual ground rental. The insurer must be liable for and

shall pay all state and local taxes imposed against the ground and improvements. For purposes of taxation, the ground and improvements are considered to be real property owned by the insurer. The commissioner must approve the acquisition of an office building on leased ground before the insurer makes the investment.

(c) The insurer must use at least 50 percent of the space in each branch office building under Subsection (a)(2) that is available for occupancy for business purposes for the transaction of the insurer's business and not for lease to others.

(d) An insurer may make an investment under Subsection (a)(2) or (3) only in a municipality that has a population of 15,000 or more.

(e) An insurer may not make an investment under this section if, after making the investment, the insurer's aggregate investments under this section would exceed 33-1/3 percent of the insurer's admitted assets as of December 31 preceding the date of the investment, except that an insurer's aggregate investments under this section may be increased to an amount not to exceed 50 percent of the insurer's admitted assets if the commissioner approves the investment in advance, and the investment may be further increased if the additional increase is paid for only from surplus funds and is not included as an admitted asset of the insurer.

(f) The value of each investment under this section is subject to the approval of the commissioner. The commissioner may, at the time the investment is made or any time when an examination of the insurer is being made, have an investment under this section appraised by an appraiser appointed or approved by the commissioner. The insurer shall pay the reasonable expense of the appraisal. The expense of the appraisal is considered to be an expense of the examination of the insurer. An insurer may not make any increase in the valuation of real property described by Subsection (a) unless the increase in valuation is approved by the commissioner, subject to the conditions imposed by Subsection (e).

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. [2017](#)), Sec. 1, eff. April 1, 2007.

Sec. 425.230. AUTHORIZED INVESTMENTS: OIL, GAS, AND MINERALS.

(a) In this section and Section 425.231:

(1) "Producing" means producing oil, gas, or other minerals in paying quantities. A well that has been shut in is considered to be producing oil, gas, or other minerals in paying quantities if shut-in royalties are being paid.

(2) "Production payment" means a right to oil, gas, or other minerals in place or as produced that entitles the owner of the right to a specified fraction of production until the owner receives a specified amount of money, or a specified number of units of oil, gas, or other minerals.

(3) "Royalty" or "overriding royalty" means a right to oil, gas, and other minerals in place or as produced that entitles the owner of the right to a specified fraction of production without limitation to a specified amount of money or a specified number of units of oil, gas, or other minerals.

(b) Subject to this section, in addition to and without limitation on the purposes for which real property may be acquired, secured, held, or retained under Section 425.229 or 425.231, an insurer may secure, hold, retain, and convey production payments, producing royalties, and producing overriding royalties as an investment for the production of income.

(c) The aggregate amount of an insurer's investments under this section, plus the aggregate amount of the insurer's investments in home office and branch office properties under Section 425.229, may not exceed the total amount permitted by and is subject to all of the limitations imposed by Sections 425.229(e) and (f). For purposes of this subsection, an investment in production payments, producing royalties, or producing overriding royalties is considered to be an investment in property described by Section 425.229.

(d) For the purposes of Section 425.229(f), the commissioner may establish a value of a production payment, producing royalty, or producing overriding royalty as the maximum amount that the insurer purchasing the production payment, producing royalty, or producing overriding royalty could loan against a first lien on the production payment, producing royalty, or producing overriding royalty under Sections 425.214(f)-(h).

(e) An insurer may not make an investment in production payments, producing royalties, or producing overriding royalties solely for the production of income if, after making the investment, the insurer's total investment at cost in the production payments, producing royalties, or producing overriding royalties would exceed

10 percent of the insurer's admitted assets as of December 31 preceding the date of the investment.

(f) If production in paying quantities from a royalty interest or overriding royalty interest held by an insurer ends, the insurer shall sell and dispose of the royalty or overriding royalty not later than the second anniversary of the date the production ends, unless:

(1) production in paying quantities has resumed; or
 (2) the insurer obtains from the commissioner a certificate stating that the insurer's interests will suffer materially by the forced sale of the interest.

(g) The commissioner shall state in a certificate under Subsection (f)(2) the amount of time by which the period for sale is extended under that subsection.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.231. AUTHORIZED INVESTMENTS: REAL PROPERTY ACQUIRED UNDER CERTAIN CIRCUMSTANCES. (a) Subject to this section, an insurer may secure, hold, and convey the following real property:

(1) real property acquired in good faith as security for a loan previously contracted or for money due;
 (2) real property conveyed to the insurer to satisfy a debt previously contracted in the course of the insurer's dealings; and
 (3) real property purchased at a sale under a judgment, court decree, or mortgage or other lien held by the insurer.

(b) An insurer shall sell and dispose of all property described by Subsection (a) that is not necessary for the insurer's accommodation in the convenient transaction of the insurer's business, other than an interest in minerals or royalties reserved on the sale of land acquired under Subsection (a) or an interest in producing royalties or producing overriding royalties otherwise acquired, not later than the fifth anniversary of:

(1) the date the insurer acquires title to the property; or
 (2) the date the property ceases to be necessary for the accommodation of the insurer's business.

(c) An insurer may hold property acquired under Subsection (a) for a period longer than that specified by Subsection (b) if the insurer obtains a certificate from the commissioner stating that the

insurer's interests will suffer materially by the forced sale of the property. The commissioner shall state in the certificate the amount of time by which the period for sale is extended under this subsection.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 425.232. AUTHORIZED INVESTMENTS: IMPROVED INCOME-PRODUCING REAL PROPERTY. (a) In this section, "improved income-producing real property" includes all commercial and industrial real property, a substantial portion of which has been materially enhanced in value by the construction of durable, permanent-type buildings and other improvements costing an amount at least equal to the value of the real property, excluding the buildings and improvements, that is held or acquired by purchase, lease, or otherwise for the production of income. The term does not include agricultural, horticultural, farm and ranch, or residential property, or single or multiunit family dwelling property.

(b) Notwithstanding Sections 425.229, 425.230, and 425.231, subject to this section, a domestic insurer may:

(1) invest any of the insurer's funds and accumulations in improved income-producing real property or any interest in improved income-producing real property; and

(2) hold, improve, maintain, manage, lease, sell, or convey improved income-producing real property or an interest in improved income-producing real property.

(c) The aggregate amount of an insurer's investments in all income-producing real property, including improvements, may not exceed 15 percent of the insurer's admitted assets. The amount of an insurer's investment in a single piece of improved income-producing real property, including improvements, may not exceed five percent of the insurer's admitted assets. For purposes of this subsection, an insurer's admitted assets are determined from the insurer's annual statement as of the preceding December 31 and filed with the department as required by law. Section 425.229(f) applies to the value of any investment made under this section.

(d) The investment authority granted by this section is in addition to that granted by Sections 425.229, 425.230, and 425.231,

except that an insurer may not make an investment in improved income-producing real property that, when added to the insurer's investments under Section 425.229, would exceed the limitations imposed by Section 425.229(e).

(e) This section does not permit an insurer to purchase undeveloped real property for the purpose of development or subdivision.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

CHAPTER 426. RESERVES FOR WORKERS' COMPENSATION INSURANCE COMPANIES

Sec. 426.001. RESERVES REQUIRED. A workers' compensation insurance company engaged in business in this state shall maintain reserves in an amount estimated in the aggregate to provide for the payment of all losses and claims incurred, whether reported or unreported. The company may not maintain reserves in an amount that is greater than reasonably necessary for that purpose.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 426.002. COMPUTATION OF RESERVES. Reserves required by Section 426.001 must be computed in accordance with any rules adopted by the commissioner to adequately protect insureds, secure the solvency of the workers' compensation insurance company, and prevent unreasonably large reserves.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 426.003. MAINTENANCE OF RESERVES; NOTICE OF NONCOMPLIANCE.

(a) If a workers' compensation insurance company's reserves are determined under this chapter to be:

(1) inadequate, the commissioner shall notify the company and require the company to establish and maintain reasonable additional reserves; or

(2) unreasonably large, the commissioner shall notify the

company and require the company to reduce the amount of reserves to a reasonable amount.

(b) Not later than the 60th day after the date of notification of noncompliance under Subsection (a), the company shall:

- (1) restore compliance as required by Subsection (a); and
- (2) file a statement of restored compliance, accompanied by any documentation required by the commissioner.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

CHAPTER 427. SUBORDINATED INDEBTEDNESS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 427.001. **APPLICABILITY OF CHAPTER.** This chapter applies to an insurer or health maintenance organization as defined by Section 401.001.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 427.002. **RULES.** The commissioner shall adopt rules necessary to implement this chapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

SUBCHAPTER B. LOAN, ADVANCE, AND OTHER INDEBTEDNESS

Sec. 427.051. **LOAN OR ADVANCE PERMITTED.** An insurer or health maintenance organization may obtain a loan or an advance, repayable with interest, of:

- (1) cash;
- (2) cash equivalents; or
- (3) other assets that have a readily determinable value and are satisfactory to the commissioner.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 427.052. SUBORDINATED LIABILITY PERMITTED. (a) An insurer or health maintenance organization may assume a subordinated liability for repayment of a loan or advance described by Section 427.051 and payment of interest on the loan or advance if the insurer or health maintenance organization and the creditor execute a written agreement stating that the creditor may be paid only out of that portion of the insurer's or health maintenance organization's surplus that exceeds the greater of:

- (1) a minimum surplus amount set in the agreement; or
- (2) a minimum surplus amount of \$500,000.

(b) The department or commissioner may not require the agreement to provide a minimum surplus amount that is different from the amount described by this section.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 427.053. APPROVAL OF AGREEMENT REQUIRED. (a) An insurer or health maintenance organization must submit the written agreement under Section 427.052 to the commissioner for approval of the form and content of the agreement.

(b) The commissioner must approve or disapprove the agreement not later than the 30th day after the date the insurer or health maintenance organization submits the agreement. If the commissioner fails to act as required by this subsection, the agreement is considered approved.

(c) An insurer or health maintenance organization may assume a subordinated liability only after the commissioner has approved the agreement under this chapter or Subchapter C, Chapter 823.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 427.054. LIABILITY. (a) A loan or advance made under this chapter, including any interest accruing on the loan or advance, is a legal liability of the insurer or health maintenance organization, and a liability with respect to the insurer's or health maintenance organization's financial statement, only to the extent provided by the terms of the loan or advance agreement.

(b) Notwithstanding Subsection (a), if the loan or advance agreement provides for a sinking fund out of which the loan or advance is to be repaid, the loan or advance is a legal liability of the insurer or health maintenance organization, and a liability with respect to the insurer's or health maintenance organization's financial statement, only to the extent of the amounts accumulated and held in the sinking fund. By agreement of the parties, any portion of the amounts accumulated in the sinking fund may be returned to the surplus of the insurer or health maintenance organization at any time and any amount returned may not be a legal liability of the insurer or health maintenance organization or a liability with respect to the insurer's or health maintenance organization's financial statement.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 427.055. PAYMENT OF PRINCIPAL OR INTEREST ON CERTAIN LIABILITIES. (a) An insurer or health maintenance organization may not pay principal or interest on a subordinated liability assumed under Section 427.052 or Subchapter C, Chapter 823, on or after September 1, 1995, unless:

(1) the payment complies with a schedule of payments contained in the agreement approved by the commissioner in accordance with Section 427.052 or Subchapter C, Chapter 823; or

(2) if the payment does not comply with the schedule of payments contained in the agreement or the agreement does not contain a payment schedule, the insurer or health maintenance organization provides written notice to the commissioner not later than the 15th day before the scheduled payment date.

(b) A loan, debenture, revenue bond, or advance agreement issued to an insurer or health maintenance organization before September 1, 1995, and any subsequent payment of principal or interest on the indebtedness are governed by the law in effect on the date of issuance.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

SUBTITLE C. DELINQUENT INSURERS
CHAPTER 441. SUPERVISION AND CONSERVATORSHIP
SUBCHAPTER A. GENERAL PROVISIONS

Sec. 441.001. FINDINGS AND PURPOSE. (a) An insurer delinquency, or the state's inability to properly proceed in a threatened delinquency, directly or indirectly affects other insurers by creating a lack of public confidence in insurance and insurers. Insurer delinquencies destroy public confidence in the state's ability to regulate insurers. The harmful results of insurer delinquencies, including those described by this subsection, are properly minimized by laws designed to protect and assist insureds, creditors, and owners.

(b) Placing an insurer in receivership often destroys or diminishes, or is likely to destroy or diminish, the value of the insurer's assets, including:

- (1) the insurer's insurance account or in-force business;
- (2) the insurer as a going concern; and
- (3) the insurer's agency force.

(c) The value of the assets described by Subsection (b) should be preserved if the circumstances of the insurer's financial condition warrant an attempt to rehabilitate or conserve the insurer and the rehabilitation or conservation is otherwise feasible.

(d) It is a proper concern of this state and proper policy to attempt to correct or remedy insurer misconduct, ineptness, or misfortune.

(e) The purpose of this chapter is to:

- (1) provide for the rehabilitation and conservation of insurers by authorizing and requiring supervision and conservatorship by the commissioner;
- (2) authorize action to determine whether an attempt should be made to rehabilitate and conserve an insurer;
- (3) avoid, if possible and feasible, the necessity of placing an insurer under temporary or permanent receivership;
- (4) provide for the protection of an insurer's assets pending determination of whether the insurer may be successfully rehabilitated; and
- (5) alleviate concerns regarding insurance and insurers.

(f) Rehabilitation of an insurer might not be accomplished in every case, but this chapter facilitates and directs an attempt to rehabilitate an insurer without immediate resort to the harsher

remedy of receivership. If receivership becomes necessary, the preliminary supervision and conservatorship may prevent a dissipation of assets, which will benefit policyholders, creditors, and owners.

(g) For the reasons stated by this section, the substance and procedures of this chapter are the public policy of this state and are necessary to the public welfare. That policy and welfare require the availability of this chapter and the application of this chapter if circumstances warrant.

(h) This chapter provides, in conjunction with other law, a generally ordered sequence, and provides for review at each step, of supervision, concurrent conservatorship and rehabilitation, including reinsurance, and cessation of the conservatorship by rehabilitation or by receivership and liquidation if at any time that cessation is indicated or determined to be appropriate.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 441.002. DEFINITION. In this chapter, unless the purposes of this chapter clearly require or the context clearly indicates another meaning, "insurer" means a person, organization, or company, regardless of whether the person or entity is authorized or admitted, that engages in the business of insurance or that acts as a principal or agent of a person, organization, or company engaged in the business of insurance. The term includes a stock insurance company, reciprocal or interinsurance exchange, Lloyd's plan, fraternal benefit society, stipulated premium company, title insurance company, and mutual insurance company of any kind, including a statewide mutual assessment company, local mutual aid association, burial association, county mutual insurance company, and farm mutual insurance company.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 441.003. APPLICABILITY OF AND COMPLIANCE WITH CHAPTER. Compliance with this chapter is a condition of engaging in the business of insurance in this state. This chapter applies to, and is a consequence of, any other transaction with respect to an insurer or

insurance.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 441.004. ACTIONS OF COMMISSIONER. (a) In the event of an insurer's delinquency or suspected delinquency, the commissioner, in the commissioner's administrative discretion, may act under this chapter, another applicable law, or a combination of this chapter and another applicable law.

(b) If the commissioner determines to act under this chapter or is directed by a court to act under this chapter, the commissioner shall comply with the requirements of this chapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 441.005. RULES; AUTHORITY FOR ADMINISTRATIVE ACTION. (a) The commissioner may:

(1) adopt reasonable rules as necessary to implement and supplement this chapter and the purposes of this chapter; and

(2) take any administrative action required by the findings of Section 441.001.

(b) The authority granted by this section may be inferred from the context of this chapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 441.006. RULES AND PROCEDURES FOR MERGER OF INSURERS. (a) The commissioner shall adopt rules that encourage the merger of insurers in weak financial condition with insurers in strong financial condition in cases in which rehabilitation or conservation of an insurer would be inefficient or impracticable.

(b) The rules and procedures for conservatorship may not be used unless the rules and procedures adopted to promote the merger of insurers in weak financial condition are followed.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 441.007. CONFLICT WITH OTHER LAWS. If this chapter conflicts with any other law, this chapter prevails.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 441.008. INAPPLICABILITY OF CERTAIN ADMINISTRATIVE PROCEDURE PROVISIONS. Section 2001.062, Government Code, does not apply to a hearing conducted under this chapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

SUBCHAPTER B. DETERMINATION AND NOTICE

Sec. 441.051. CIRCUMSTANCES CONSTITUTING INSOLVENCY OR DELINQUENCY. For the purposes of this chapter, the circumstances in which an insurer is considered insolvent, delinquent, or threatened with delinquency include circumstances in which the insurer:

- (1) has required surplus, capital, or capital stock that is impaired to an extent prohibited by law;
- (2) continues to write new business when the insurer does not have the surplus, capital, or capital stock that is required by law to write new business;
- (3) conducts the insurer's business fraudulently; or
- (4) attempts to dissolve or liquidate without first having made provisions satisfactory to the commissioner for liabilities arising from insurance policies issued by the insurer.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 441.052. CIRCUMSTANCES CONSTITUTING INSURER EXCEEDING POWERS. For the purposes of this chapter, the circumstances in which an insurer is considered to have exceeded the insurer's powers

include circumstances in which the insurer:

- (1) refuses to permit the commissioner, the commissioner's deputy, or an examiner appointed by the department to examine the insurer's books, papers, accounts, records, or affairs;
- (2) is organized in this state and removes from the state books, papers, accounts, or records that are necessary to examine the insurer;
- (3) fails to promptly answer inquiries authorized by Section 38.001;
- (4) fails to comply with an order of the commissioner to remedy, within the time prescribed by law, a prohibited deficiency in the insurer's capital, capital stock, or surplus;
- (5) without obtaining the commissioner's prior written approval:
 - (A) totally reinsures the insurer's entire outstanding business; or
 - (B) merges or consolidates substantially all of the insurer's property or business with another insurer;
- (6) continues to write business after the insurer's certificate of authority has been revoked or suspended; or
- (7) is in a condition that makes the insurer's continuation in business hazardous to the public or to the insurer's policyholders or certificate holders.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 441.053. NOTICE TO INSURER. (a) If at any time the commissioner determines that an insurer is insolvent, has exceeded the insurer's powers, or has otherwise failed to comply with the law, the commissioner shall:

- (1) notify the insurer of that determination;
- (2) provide to the insurer a written list of the commissioner's requirements to abate the conditions on which that determination was based; and
- (3) if the commissioner determines that the insurer requires supervision, notify the insurer that the insurer is under the commissioner's supervision and that the commissioner is invoking this chapter.

(b) The commissioner may provide the notice and information to an insurer that agrees to supervision.

(c) The insurer shall comply with the commissioner's requirements.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

SUBCHAPTER C. SUPERVISION

Sec. 441.101. APPOINTMENT OF SUPERVISOR. The commissioner may appoint a supervisor to supervise an insurer.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 441.102. TIME FOR COMPLIANCE WITH REQUIREMENTS OF SUPERVISION. An insurer under supervision must comply with the commissioner's requirements under Section 441.053 not later than the 180th day after the date of the commissioner's notice of supervision.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 441.103. PAYMENT OF CLAIMS. An insurer under supervision shall continue to pay claims under an insurance policy according to the terms of the policy.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 441.104. PROHIBITED ACTS DURING SUPERVISION. During supervision, the commissioner may prohibit the insurer from taking any of the following actions without the prior approval of the commissioner or supervisor:

- (1) disposing of, conveying, or encumbering any of the insurer's assets or business in force;
- (2) withdrawing money from the insurer's bank accounts;

- (3) lending or investing the insurer's money;
 - (4) transferring the insurer's property;
 - (5) incurring a debt, obligation, or liability;
 - (6) merging or consolidating with another company;
 - (7) entering into a new reinsurance contract or treaty;
 - (8) terminating, surrendering, forfeiting, converting, or lapsing an insurance policy, except for nonpayment of premiums due;
- or
- (9) releasing, paying, or refunding premium deposits, accrued cash or loan values, unearned premiums, or other reserves on an insurance policy.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 441.105. HEARING ON SUPERVISION; TERMINATION BY CONSERVATION OR RELEASE. (a) On the commissioner's own motion or the motion of a party of record, a hearing may be scheduled relating to an insurer under supervision after at least 10 days' written notice to each party of record. Notice may be waived by the parties of record.

(b) The commissioner shall place the insurer in conservatorship if, after the hearing, it is determined that the insurer:

- (1) failed to comply with the commissioner's requirements;
- (2) has not been rehabilitated;
- (3) is insolvent; or
- (4) appears to have exceeded the insurer's powers.

(c) The commissioner may release the insurer from supervision if, after the hearing, it is determined that the insurer:

- (1) has been rehabilitated; or
- (2) is no longer in a condition that makes the insurer's continuation in business hazardous to the public or to the insurer's policyholders or certificate holders.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

SUBCHAPTER D. CONSERVATORSHIP

Sec. 441.151. APPOINTMENT OF CONSERVATOR. (a) The

commissioner may appoint a conservator for an insurer:

(1) if:

(A) after notice and opportunity for hearing, it is determined that the insurer:

(i) is insolvent;

(ii) appears to have exceeded the insurer's powers;

or

(iii) has failed to comply with any requirement of the commissioner; or

(B) the insurer agrees to the appointment of a conservator; and

(2) if it is determined that supervision is inadequate to rehabilitate the insurer.

(b) The commissioner may appoint a conservator.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 441.152. NOTICE OF CONSERVATORSHIP. (a) Not later than the seventh day after the date the commissioner enters an order appointing a conservator for an insurer as provided by Section 441.151 or Subchapter F, the commissioner shall publish notice of the conservatorship in at least one newspaper of general circulation in each county with a population of at least 100,000.

(b) The notice must include:

(1) the name of the insurer placed in conservatorship;

(2) the date the insurer was placed in conservatorship in this state;

(3) the reasons for placing the insurer in conservatorship;

(4) any action with respect to the insurer that is available to a policyholder; and

(5) any requirement with which a policyholder must comply.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 441.153. POWERS AND DUTIES OF CONSERVATOR. (a) The conservator appointed for an insurer under Section 441.151 shall immediately take charge of the insurer and all of the insurer's

property, books, records, and effects, conduct the insurer's business, and act to remove the causes and conditions that made the conservatorship order necessary, as directed by the commissioner.

(b) During the conservatorship, the conservator shall provide reports to the commissioner as required by the commissioner and may:

(1) take all necessary measures in the conservator's own name as conservator to preserve, protect, or recover any asset or property of the insurer, including a claim or cause of action that the insurer may assert; and

(2) file a suit, or prosecute and defend a suit filed by or against the insurer, as the conservator considers necessary to protect all of the interested parties or any property affected by the suit.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 441.154. PAYMENT OF CLAIMS. An insurer under conservatorship shall continue to pay claims under an insurance policy according to the terms of the policy.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 441.155. REINSURANCE DURING CONSERVATORSHIP. (a) If during a conservatorship it appears that the interest of the insurer's policyholders or certificate holders is best protected by reinsuring the policies or certificates, the conservator may, with the approval of or at the direction of the commissioner:

(1) reinsure all or part of the insurer's policies or certificates with a solvent insurer authorized to engage in business in this state; and

(2) to the extent that the insurer has reserves attributable to the reinsured policies or certificates, transfer to the reinsurer reserves in an amount sufficient to reinsure the policies or certificates.

(b) A transfer of reserves under this section may not be considered a preference of a creditor.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 441.156. HEARINGS DURING CONSERVATORSHIP. (a) On the commissioner's own motion or the motion of a party of record, a hearing relating to an insurer in conservatorship may be scheduled after at least 10 days' written notice to each party of record.

(b) The notice required by this section may be waived by the parties of record.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 441.157. IMMUNITY. A conservator and the conservator's agents and employees are not liable, and a cause of action does not arise against the conservator or an agent or employee, for an action taken or not taken by the conservator, agent, or employee in connection with the adjustment, negotiation, or settlement of a claim.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 441.158. VENUE. (a) A suit against an insurer in conservatorship or against the conservator may be filed only in Travis County unless the cause of action is based on the terms of an insurance policy issued by the insurer.

(b) A conservator appointed under this chapter may file suit in Travis County against any person to preserve, protect, or recover any asset or property of the insurer, including a claim or cause of action that may be asserted by the insurer.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 441.159. DURATION OF CONSERVATORSHIP. (a) Except as provided by Subsection (b), a conservator appointed under this

chapter shall complete the conservator's duties as required by this chapter not later than the 90th day after the date of appointment.

(b) If the commissioner issues written findings that there is a substantial likelihood of rehabilitation of the insurer in conservatorship, the commissioner may extend the conservatorship for additional successive 30-day periods. The total period of extensions may not exceed 180 consecutive days. A hearing is not required before the commissioner issues the findings.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 441.160. RETURN TO MANAGEMENT. An insurer that is rehabilitated shall be returned to management or placed under new management under reasonable conditions that best tend to prevent defeat of the purposes of the conservatorship.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

SUBCHAPTER E. PROVISIONS APPLYING TO SUPERVISION AND CONSERVATORSHIP

Sec. 441.201. CONFIDENTIALITY. (a) Hearings and orders, notices, correspondence, reports, records, and other information in the department's possession relating to the supervision or conservatorship of an insurer are confidential during the supervision or conservatorship. On termination of the supervision or conservatorship, the information in the department's custody that relates to the supervision or conservatorship is public information.

(b) This section does not prohibit access by the department to hearings or orders, notices, correspondence, reports, records, or other information.

(c) The provisions of Chapter 2001, Government Code, relating to discovery apply to the parties of record in a proceeding under this chapter.

(d) The commissioner may open a proceeding under this chapter or disclose information that is confidential under this section to a department, agency, or instrumentality of this state, another state, or the United States if the commissioner determines that opening the proceeding or disclosing the information is necessary or proper to

enforce the laws of this state, another state, or the United States.

(e) An officer or employee of the department is not liable for a release of information that is confidential under this section unless it is shown that the release was accomplished with actual malice.

(f) This section does not apply to information:

(1) if the insurer's insureds are not protected by Chapter 462, 463, or 2602, or substantially similar statutes; or

(2) on the appointment by a court of a receiver for the insurer.

(g) Notwithstanding Subsection (a), if the commissioner places a title insurance agent licensed under Title 11 or an insurance agent licensed under Title 13 under supervision or in conservatorship, the commissioner shall provide written notice of the order of supervision or conservatorship to each insurer for which the agent holds an appointment under Subchapter A, Chapter 2651, or Subchapter E, Chapter 4001, or other applicable law, on the date the supervisor or conservator is appointed.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 482 (H.B. 2542), Sec. 1, eff. September 1, 2017.

Sec. 441.202. COSTS OF SUPERVISION AND CONSERVATORSHIP. The commissioner shall determine the costs related to services provided by a supervisor or conservator under this chapter. Subject to Section 442.551, the costs shall be charged against the insurer's assets and paid as determined by the commissioner.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 441.203. COLLECTION OF FEES FROM REHABILITATED INSURER.

(a) The commissioner may collect fees from an insurer described by Section 82.002 that is successfully rehabilitated by the commissioner. The fees must be in amounts sufficient to cover the cost of rehabilitating the insurer, but may not exceed that cost.

(b) The department may use fees collected under this section only for the rehabilitation of the insurer from which the fees are collected.

(c) Fees collected under this section shall be deposited in and expended through the Texas Department of Insurance operating account.

(d) The commissioner may determine the terms of the collection or repayment of the fees.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 441.204. REVIEW AND STAY OF CERTAIN ACTS OF SUPERVISOR OR CONSERVATOR. (a) An insurer under supervision or conservatorship may request the commissioner or, in the commissioner's absence, the commissioner's appointed deputy to review an action taken or proposed to be taken by the supervisor or conservator.

(b) A request for review under this section must specify the manner in which the action is believed to not be in the insurer's best interests.

(c) A request for review under this section stays the specified action pending review by the commissioner or the commissioner's deputy.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 441.205. APPEAL OF CERTAIN ORDERS. The following orders of the commissioner may be appealed under Subchapter D, Chapter 36:

(1) an order appointing a supervisor and providing that the insurer may not engage in certain acts as provided by Section 441.104;

(2) an order appointing a conservator; and

(3) an order following the review under Section 441.204 of an action of a supervisor or conservator.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 441.206. EX PARTE MEETING WITH COMMISSIONER.

Notwithstanding any other law, the commissioner may, at the time of any proceeding or while a proceeding is pending under this chapter, meet with a supervisor or conservator appointed under this chapter and with the attorney or other representative of the supervisor or conservator, without another person present, to implement the commissioner's duties under this chapter or for the supervisor or conservator to implement that person's duties under this chapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 441.207. INSURER EMPLOYEES DURING SUPERVISION OR CONSERVATORSHIP. (a) Notwithstanding any other provision of this chapter, an insurer may employ an attorney, actuary, and accountant of the insurer's choice to assist the insurer during supervision. The supervisor shall authorize payment from the insurer for the reasonable fees and expenses of the attorney, actuary, or accountant.

(b) The supervisor, conservator, or commissioner shall, to the maximum extent possible, use the insurer's employees instead of outside consultants, actuaries, attorneys, accountants, and other personnel or department employees to minimize the expense of rehabilitation or the necessity of fees to cover the cost of rehabilitation.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

SUBCHAPTER F. OUT-OF-STATE INSURERS

Sec. 441.251. APPLICABILITY. This chapter applies to an insurer engaged in the business of insurance in this state but not domiciled in this state, regardless of whether the insurer is authorized to engage in the business of insurance in this state.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 441.252. APPOINTMENT OF ANCILLARY SUPERVISOR OR

CONSERVATOR. (a) The commissioner may appoint an ancillary supervisor or ancillary conservator for the assets located in this state of an insurer described by Section 441.251 in the same manner as the commissioner appoints a supervisor or conservator for an insurer domiciled in this state as provided by this chapter if:

- (1) the commissioner makes a determination described by Section 441.053 with regard to the insurer;
- (2) the commissioner determines that the insurer does not have the minimum surplus, capital, or capital stock required by this code for similar domestic insurers; or
- (3) the insurer agrees to the appointment.

(b) Subject to Section 441.205, the commissioner may immediately, without prior notice and hearing, appoint an ancillary conservator for the assets, property, books, and records located in this state of an insurer described by Section 441.251 if a conservator, rehabilitator, receiver, liquidator, or equivalent official is appointed in the state in which the insurer is domiciled.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 441.253. POWERS AND DUTIES OF ANCILLARY SUPERVISOR OR CONSERVATOR. (a) An ancillary supervisor or ancillary conservator appointed under this subchapter has all the powers provided by Sections 441.153 and 441.155 with respect to the insurer's assets, property, books, and records located in this state.

(b) An ancillary conservator appointed under this subchapter may:

- (1) reinsure all or part of the insurer's policies or certificates in this state with a solvent insurer authorized to engage in business in this state; and
- (2) transfer to the reinsurer as reserves any assets in the ancillary conservator's possession in an amount sufficient to reinsure the policies or certificates.

(c) A transfer of assets under this section is not considered a preference of a creditor.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 441.254. FAILURE TO COMPLY WITH REQUIREMENTS OF SUPERVISION. The failure of an insurer described by Section 441.251 to comply during supervision with the requirements of Section 441.104 with respect to any asset or policy located in this state is grounds for the immediate revocation of the insurer's certificate of authority to engage in business in this state and for the immediate appointment of an ancillary conservator to take charge of the insurer's assets located in this state.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 441.255. REFERRAL FOR REMEDIAL ACTION. The commissioner may refer an insurer described by Section 441.251 to the attorney general for remedial action, including application for appointment of a receiver under Chapter 442, on any grounds on which an insurer domiciled in this state may be referred to the attorney general for remedial action. The commissioner may refer the insurer at any time, and action against the insurer in the insurer's state of domicile is not a prerequisite.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

SUBCHAPTER G. POWERS AND DUTIES OF ATTORNEY GENERAL

Sec. 441.301. REMEDIAL ACTION BY ATTORNEY GENERAL. (a) The commissioner may, at any time and regardless of whether an insurer is under supervision or conservatorship, determine that the insurer is not in a condition to continue business in the interest of the insurer's policyholders or certificate holders. The commissioner shall give notice of that determination to the attorney general.

(b) On receipt of notice under Subsection (a), the attorney general shall file suit in the nature of quo warranto in a court in Travis County to:

- (1) forfeit the insurer's charter; or
- (2) require the insurer to comply with the law or prove to the commissioner that the insurer is solvent, and satisfy the requirement that the insurer's condition does not make the continuation of the insurer's business hazardous to the public or to

the insurer's policyholders or certificate holders.

(c) The commissioner may at any time refer an insurer to the attorney general for the purpose of taking any remedial action, including applying for the appointment of a receiver under Chapter 442.

(d) Supervision or conservatorship of the insurer is not required before the attorney general may take remedial action under this section.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 441.302. FORFEITURE AND CANCELLATION OF CHARTER ON CONCLUSION OF BUSINESS. (a) Once all an insurer's policies are reinsured or terminated and the insurer's affairs are concluded as provided by this chapter, the commissioner shall report that fact to the attorney general. On receipt of the report, the attorney general shall take action necessary to forfeit or cancel the insurer's charter.

(b) The commissioner shall report to the attorney general the commissioner's approval of the merger or consolidation of an insurer with another insurer or the reinsurance of the insurer's policies. On receipt of the report, the attorney general shall take action to forfeit or cancel the insurer's charter in the manner provided for the forfeiture or cancellation of the charter of an insurer that is totally reinsured or liquidated.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

SUBCHAPTER H. AGENTS OF RECORD FOR CERTAIN INSUREDS

Sec. 441.351. AGENTS OF RECORD. (a) Unless otherwise prohibited, the supervisor, conservator, or receiver of an insurer shall provide to the insured's agent of record a copy of each communication provided to an insured if, in the judgment of the supervisor, conservator, or receiver, providing the copy will serve to materially protect the interests of policyholders. The supervisor, conservator, or receiver may also request the assistance of any statewide association of insurance agents in providing to the

association's members information that, in the judgment of the supervisor, conservator, or receiver, may serve to materially protect policyholders' interests.

(b) If the supervisor, conservator, or receiver sells a delinquent insurer's policies to another insurer, the purchaser shall:

(1) recognize the pecuniary interest of the agent of record in the policies being sold, regardless of whether the purchaser customarily conducts the purchaser's business through insurance agents;

(2) conduct the purchaser's business with the insured through the agent of record; and

(3) provide to the agent of record a written limited agency contract providing the terms that apply to the conduct of their business together.

(c) A limited agency contract provided under Subsection (b) must provide a level of commission that is reasonable, adequate, and nonconfiscatory.

(d) This subchapter does not prohibit the agent of record from renewing with another insurer an insurance policy purchased by an insurer from a delinquent insurer.

(e) This section does not apply to:

(1) a life, accident, or health insurance policy or contract delivered or issued for delivery by an insurer that is subject to any provision of a law specified in Section 841.002 or any provision of Chapter 882, 884, 887, 888, or 982;

(2) a contract or certificate delivered or issued for delivery by a group hospital service corporation organized under Chapter 842; or

(3) a contract or evidence of coverage delivered or issued for delivery by a health maintenance organization operating under a certificate of authority issued under Chapter 843.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. [2017](#)), Sec. 1, eff. April 1, 2007.

CHAPTER 443. INSURER RECEIVERSHIP ACT

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 443.001. CONSTRUCTION AND PURPOSE. (a) This chapter may

be cited as the Insurer Receivership Act.

(b) This chapter may not be interpreted to limit the powers granted the commissioner under other provisions of law.

(c) This chapter shall be liberally construed to support the purpose stated in Subsection (e).

(d) All powers and authority of a receiver under this chapter are cumulative and are in addition to all powers and authority that are available to a receiver under law other than this chapter.

(e) The purpose of this chapter is to protect the interests of insureds, claimants, creditors, and the public generally, through:

(1) early detection of any potentially hazardous condition in an insurer and prompt application of appropriate corrective measures;

(2) improved methods for conserving and rehabilitating insurers;

(3) enhanced efficiency and economy of liquidation, through clarification of the law, to minimize legal uncertainty and litigation;

(4) apportionment of any unavoidable loss in accordance with the statutory priorities set out in this chapter;

(5) lessening the problems of interstate receivership by:
(A) facilitating cooperation between states in delinquency proceedings; and

(B) extending the scope of personal jurisdiction over debtors of the insurer located outside this state;

(6) regulation of the business of insurance by the impact of the law relating to delinquency procedures and related substantive rules; and

(7) providing for a comprehensive scheme for the receivership of insurers and those subject to this chapter as part of the regulation of the business of insurance in this state because proceedings in cases of insurer insolvency and delinquency are deemed an integral aspect of the business of insurance and are of vital public interest and concern.

Added by Acts 2005, 79th Leg., Ch. 995 (H.B. [2157](#)), Sec. 1, eff. September 1, 2005.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.001 by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 3B.004(a)(1), eff. September 1, 2007.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.001 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(a)(1), eff. September 1, 2007.

Sec. 443.002. CONFLICTS OF LAW. This chapter and the state law governing insurance guaranty associations constitute this state's insurer receivership laws and shall be construed together in a manner that is consistent. In the event of a conflict between the insurer receivership laws and the provisions of any other law, the insurer receivership laws prevail.

Added by Acts 2005, 79th Leg., Ch. 995 (H.B. 2157), Sec. 1, eff. September 1, 2005.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.002 by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(a)(1), eff. September 1, 2007.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.002 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(a)(1), eff. September 1, 2007.

Sec. 443.003. COVERED PERSONS. The provisions of this chapter apply to all:

- (1) insurers who are doing or have done an insurance business in this state and against whom claims arising from that business may exist now or in the future and to all persons subject to examination by the commissioner;
- (2) insurers who purport to do an insurance business in this state;
- (3) insurers who have insureds resident in this state;
- (4) other persons organized or doing insurance business, or in the process of organizing with the intent to do insurance business in this state;
- (5) nonprofit health corporations and all fraternal benefit societies subject to Chapters 844 and 885, respectively;
- (6) title insurance companies subject to Title 11;
- (7) health maintenance organizations subject to Chapter 843; and
- (8) surety and trust companies subject to Chapter 7,

general casualty companies subject to Chapter 861, statewide mutual assessment companies subject to Chapter 881, mutual insurance companies subject to Chapter 882 or 883, local mutual aid associations subject to Chapter 886, burial associations subject to Chapter 888, farm mutual insurance companies subject to Chapter 911, county mutual insurance companies subject to Chapter 912, Lloyd's plans subject to Chapter 941, reciprocal or interinsurance exchanges subject to Chapter 942, and fidelity, guaranty, and surety companies.

Added by Acts 2005, 79th Leg., Ch. 995 (H.B. 2157), Sec. 1, eff. September 1, 2005.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.003 by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(a)(1), eff. September 1, 2007.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.003 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(a)(1), eff. September 1, 2007.

Sec. 443.004. DEFINITIONS. (a) For the purposes of this chapter:

(1) "Affiliate," "control," and "subsidiary" have the meanings assigned by Chapter 823.

(2) "Alien insurer" means an insurer incorporated or organized under the laws of a jurisdiction that is not a state.

(3) "Creditor" or "claimant" means a person having any claim against an insurer, whether the claim is matured or not, liquidated or unliquidated, secured or unsecured, absolute, fixed, or contingent.

(4) "Delinquency proceeding" means any proceeding instituted against an insurer for the purpose of liquidating, rehabilitating, or conserving the insurer, and any proceeding under Section 443.051.

(5) "Doing business," including "doing insurance business" and the "business of insurance," includes any of the following acts, whether effected by mail, electronic means, or otherwise:

(A) the issuance or delivery of contracts of insurance, either to persons resident or covering a risk located in this state;

(B) the solicitation of applications for contracts described by Paragraph (A) or other negotiations preliminary to the

execution of the contracts;

(C) the collection of premiums, membership fees, assessments, or other consideration for contracts described by Paragraph (A);

(D) the transaction of matters subsequent to the execution of contracts described by Paragraph (A) and arising out of those contracts; or

(E) operating as an insurer under a certificate of authority issued by the department.

(6) "Domiciliary state" means the state in which an insurer is incorporated or organized or, in the case of an alien insurer, its state of entry.

(7) "Foreign insurer" means an insurer domiciled in another state.

(8) "Formal delinquency proceeding" means any rehabilitation or liquidation proceeding.

(9) "General assets" includes:

(A) all property of the estate that is not:

(i) subject to a secured claim or a valid and existing express trust for the security or benefit of specified persons or classes of persons; or

(ii) required by the insurance laws of this state or any other state to be held for the benefit of specified persons or classes of persons; and

(B) all property of the estate and the proceeds of that property in excess of the amount necessary to discharge any secured claims described by Paragraph (A).

(10) "Good faith" means honesty in fact and intention, and for the purposes of Subchapter F also requires the absence of:

(A) information that would lead a reasonable person in the same position to know that the insurer is financially impaired or insolvent; and

(B) knowledge regarding the imminence or pendency of any delinquency proceeding against the insurer.

(11) "Guaranty association" means any mechanism mandated by Chapter 462, 463, or 2602 or other laws of this state or a similar mechanism in another state that is created for the payment of claims or continuation of policy obligations of financially impaired or insolvent insurers.

(12) "Impaired" means that an insurer does not have

admitted assets at least equal to all its liabilities together with the minimum surplus required to be maintained under this code.

(13) "Insolvency" or "insolvent" means an insurer:

(A) is unable to pay its obligations when they are due;

(B) does not have admitted assets at least equal to all its liabilities; or

(C) has a total adjusted capital that is less than that required under:

(i) Chapter 822, 841, or 843, as applicable; or

(ii) applicable rules or guidelines adopted by the commissioner under Section 822.210, 841.205, or 843.404.

(14) "Insurer" means any person that has done, purports to do, is doing, or is authorized to do the business of insurance in this state, and is or has been subject to the authority of or to liquidation, rehabilitation, reorganization, supervision, or conservation by any insurance commissioner. For purposes of this chapter, any other persons included under Section 443.003 are insurers.

(15) "Netting agreement" means a contract or agreement, including terms and conditions incorporated by reference in a contract or agreement, and a master agreement (which master agreement, together with all schedules, confirmations, definitions, and addenda to the agreement and transactions under the agreement, schedules, confirmations, definitions, or addenda, are to be treated as one netting agreement) that documents one or more transactions between the parties to the contract or agreement for or involving one or more qualified financial contracts and that, among the parties to the netting agreement, provides for the netting or liquidation of qualified financial contracts, present or future payment obligations, or payment entitlements under the contract or agreement, including liquidation or close-out values relating to the obligations or entitlements.

(16) "New value" means money, money's worth in goods, services, or new credit, or release by a transferee of property previously transferred to the transferee in a transaction that is neither void nor voidable by the insurer or the receiver under any applicable law, including proceeds of the property. The term does not include an obligation substituted for an existing obligation.

(17) "Party in interest" means the commissioner, a 10 percent or greater equity security holder in the insolvent insurer,

any affected guaranty association, any nondomiciliary commissioner for a jurisdiction in which the insurer has outstanding claims liabilities, and any of the following parties that have filed a request for inclusion on the service list under Section 443.007:

(A) an insurer that ceded to or assumed business from the insolvent insurer; and

(B) an equity shareholder, policyholder, third-party claimant, creditor, and any other person, including any indenture trustee, with a financial or regulatory interest in the receivership proceeding.

(18) "Person" means individual, aggregation of individuals, partnership, corporation, or other entity.

(19) "Policy" means a written contract of insurance, written agreement for or effecting insurance, or the certificate for or effecting insurance, by whatever name. The term includes all clauses, riders, endorsements, and papers that are a part of the contract, agreement, or certificate. The term does not include a contract of reinsurance.

(20) "Property of the insurer" or "property of the estate" includes:

(A) all right, title, and interest of the insurer in property, whether legal or equitable, tangible or intangible, choate or inchoate, and includes choses in action, contract rights, and any other interest recognized under the laws of this state;

(B) entitlements that:

(i) existed prior to the entry of an order of rehabilitation or liquidation; and

(ii) may arise by operation of the provisions of this chapter or other provisions of law allowing the receiver to avoid prior transfers or assert other rights; and

(C) all records and data that are otherwise the property of the insurer, in whatever form maintained, within the possession, custody, or control of a managing general agent, third-party administrator, management company, data processing company, accountant, attorney, affiliate, or other person, including:

(i) claims and claim files;

(ii) policyholder lists;

(iii) application files;

(iv) litigation files;

(v) premium records;

- (vi) rate books and underwriting manuals;
- (vii) personnel records; and
- (viii) financial records or similar records.

(21) "Qualified financial contract" means a commodity contract, forward contract, repurchase agreement, securities contract, swap agreement, and any similar agreement that the commissioner determines by rule to be a qualified financial contract for the purposes of this chapter.

(22) "Receiver" means liquidator, rehabilitator, or ancillary conservator, as the context requires.

(23) "Receivership" means any liquidation, rehabilitation, or ancillary conservation, as the context requires.

(24) "Receivership court" refers to the court in which a delinquency proceeding is pending, unless the context requires otherwise.

(25) "Reinsurance" means transactions or contracts by which an assuming insurer agrees to indemnify a ceding insurer against all, or a part, of any loss that the ceding insurer might sustain under the policy or policies that it has issued or will issue.

(26) "Secured claim" means any claim secured by an asset that is not a general asset. The term includes the right to set off as provided in Section 443.209. The term does not include a claim arising from a constructive or resulting trust, a special deposit claim, or a claim based on mere possession.

(27) "Special deposit" means a deposit established pursuant to statute for the security or benefit of a limited class or limited classes of persons.

(28) "Special deposit claim" means any claim secured by a special deposit. The term does not include any claim secured by the general assets of the insurer.

(29) "State" means any state, district, or territory of the United States.

(30) "Transfer" includes the sale and every other and different mode, direct or indirect, of disposing of or of parting with property or with an interest in property, including a setoff, or with the possession of property or of fixing a lien upon property or upon an interest in property, absolutely or conditionally, voluntarily or involuntarily, by or without judicial proceedings. The retention of a security title in property delivered to an insurer is deemed a transfer suffered by the insurer.

(31) "Unauthorized insurer" means an insurer doing the business of insurance in this state that has not received from this state a certificate of authority or some other type of authority that allows for doing the business of insurance in this state.

(b) For purposes of this chapter, "admitted assets" and "liabilities" have the meanings assigned by the department in rules relating to risk-based capital.

(c) For purposes of Subsection (a)(21):

(1) "Commodity contract" means:

(A) a contract for the purchase or sale of a commodity for future delivery on or subject to the rules of a board of trade designated as a contract market by the Commodity Futures Trading Commission under the Commodity Exchange Act (7 U.S.C. Section 1 et seq.) or a board of trade outside the United States;

(B) an agreement that is subject to regulation under Section 19, Commodity Exchange Act (7 U.S.C. Section 23), and that is commonly known to the commodities trade as a margin account, margin contract, leverage account, or leverage contract; or

(C) an agreement or transaction that is subject to regulation under Section 4c(b), Commodity Exchange Act (7 U.S.C. Section 6c(b)), and that is commonly known to the commodities trade as a commodity option.

(2) "Forward contract" means a contract, other than a commodity contract, with a maturity date more than two days after the date the contract is entered into, that is for the purchase, sale, or transfer of a commodity, as defined by Section 1a, Commodity Exchange Act (7 U.S.C. Section 1a), or any similar good, article, service, right, or interest that is presently or in the future becomes the subject of dealing in the forward contract trade or product or byproduct of the contract. The term includes a repurchase transaction, reverse repurchase transaction, consignment, lease, swap, hedge transaction, deposit, loan, option, allocated transaction, unallocated transaction, or a combination of these or option on any of them.

(3) "Repurchase agreement" includes a reverse repurchase agreement and means an agreement, including related terms, that provides for the transfer of certificates of deposit, eligible bankers' acceptances, or securities that are direct obligations of or that are fully guaranteed as to principal and interest by the United States against the transfer of funds by the transferee of the

certificates of deposit, eligible bankers' acceptances, or securities with a simultaneous agreement by the transferee to transfer to the transferor certificates of deposit, eligible bankers' acceptances, or securities as described in this subdivision, on demand or at a date certain not later than one year after the transfers, against the transfer of funds. For the purposes of this subdivision, the items that may be subject to a repurchase agreement:

(A) include mortgage-related securities and a mortgage loan and an interest in a mortgage loan; and

(B) do not include any participation in a commercial mortgage loan unless the commissioner determines by rule to include the participation within the meaning of the term.

(4) "Securities contract" means a contract for the purchase, sale, or loan of a security, including an option for the repurchase or sale of a security, certificate of deposit, or group or index of securities or an interest in the group or index or based on the value of the group or index, an option entered into on a national securities exchange relating to foreign currencies, or the guarantee of a settlement of cash or securities by or to a securities clearing agency. For the purposes of this subdivision, the term "security" includes a mortgage loan, a mortgage-related security, and an interest in any mortgage loan or mortgage-related security.

(5) "Swap agreement" means an agreement, including the terms and conditions incorporated by reference in an agreement, that is a rate swap agreement, basis swap, commodity swap, forward rate agreement, interest rate future, interest rate option, forward foreign exchange agreement, spot foreign exchange agreement, rate cap agreement, rate floor agreement, rate collar agreement, currency swap agreement, cross-currency rate swap agreement, currency future, or currency option or any other similar agreement. The term includes any combination agreements described by this subdivision and an option to enter into any agreement described by this subdivision.

(d) The definitions under this section apply only to this chapter unless the context of another law requires otherwise.

Added by Acts 2005, 79th Leg., Ch. 995 (H.B. [2157](#)), Sec. 1, eff. September 1, 2005.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.004 by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 3B.004(a)(1), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(b), eff. September 1, 2007.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.004 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(a)(1), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(b), eff. September 1, 2007.

Sec. 443.005. JURISDICTION AND VENUE. (a) Except as authorized by Section 203(e)(3), Pub. L. No. 111-203, a delinquency proceeding may not be commenced under this chapter by a person other than the commissioner, and a court does not have jurisdiction to entertain, hear, or determine any delinquency proceeding commenced by any other person.

(b) A court of this state does not have jurisdiction, other than in accordance with this chapter, to entertain, hear, or determine any complaint praying for:

- (1) the liquidation, rehabilitation, seizure, sequestration, conservation, or receivership of any insurer; or
- (2) a stay, injunction, restraining order, or other relief preliminary, incidental, or relating to proceedings described by Subdivision (1).

(c) The receivership court, as of the commencement of a delinquency proceeding under this chapter, has exclusive jurisdiction of all property of the insurer, wherever located, including property located outside the territorial limits of the state. The receivership court has original but not exclusive jurisdiction of all civil proceedings arising:

- (1) under this chapter; or
- (2) in or related to delinquency proceedings under this chapter.

(d) In addition to other grounds for jurisdiction provided by the law of this state, a court having jurisdiction of the subject matter has jurisdiction over a person served pursuant to Rules 21 and 21a, Texas Rules of Civil Procedure, or other applicable provisions of law in an action brought by the receiver if the person served:

- (1) is or has been an agent, or other person who, at any

time, has written policies of insurance for or has acted in any manner on behalf of an insurer against which a delinquency proceeding has been instituted, in any action resulting from or incident to such a relationship with the insurer;

(2) is or has been an insurer or reinsurer who, at any time, has entered into a contract of reinsurance with an insurer against which a delinquency proceeding has been instituted, or who is an agent of or for the reinsurer, in any action on or incident to the reinsurance contract;

(3) is or has been an officer, director, manager, trustee, organizer, promoter, or other person in a position of comparable authority or influence over an insurer against which a delinquency proceeding has been instituted, in any action resulting from or incident to such a relationship with the insurer;

(4) at the time of the institution of the delinquency proceeding against the insurer, is or was holding assets in which the receiver claims an interest on behalf of the insurer in any action concerning the assets; or

(5) is obligated to the insurer in any way, in any action on or incident to the obligation.

(e) If, on motion of any party, the receivership court finds that any action, as a matter of substantial justice, should be tried in a forum outside this state, the receivership court may enter an appropriate order to stay further proceedings on the action in this state. Except as to claims against the estate, nothing in this chapter deprives a party of any contractual right to pursue arbitration. A party in arbitration may bring a claim or counterclaim against the estate, but the claim or counterclaim is subject to this chapter.

(f) Service must be made upon the person named in the petition in accordance with Rules 21 and 21a, Texas Rules of Civil Procedure. In lieu of such service, upon application to the receivership court, service may be made in any manner the receivership court directs if it is satisfactorily shown by affidavit:

(1) in the case of a corporation, that the officers of the corporation cannot be served because they have departed from the state or otherwise concealed themselves with intent to avoid service;

(2) in the case of a Lloyd's plan or reciprocal or interinsurance exchange, that the individual attorney in fact or the officers of the corporate attorney in fact cannot be served because

of departure or concealment; or

(3) in the case of an individual, that the person cannot be served because of the individual's departure or concealment.

(g) An action authorized by this section must be brought in a district court in Travis County.

(h) At any time after an order is entered pursuant to Section 443.051, 443.101, or 443.151, the commissioner or receiver may transfer the case to the county of the principal office of the person proceeded against. In the event of transfer, the court in which the proceeding was commenced, upon application of the commissioner or receiver, shall direct its clerk to transmit the court's file to the clerk of the court to which the case is to be transferred. The proceeding, after transfer, shall be conducted in the same manner as if it had been commenced in the court to which the matter is transferred.

(i) A person may not intervene in any delinquency proceeding in this state for the purpose of seeking or obtaining payment of any judgment, lien, or other claim of any kind. The claims procedure set forth in this chapter constitutes the exclusive means for obtaining payment of claims from the receivership estate. This provision is not intended to affect the rights conferred on the guaranty associations by Section 443.008(1).

(j) The foregoing provisions of this section notwithstanding, the provisions of this chapter do not confer jurisdiction on the receivership court to resolve coverage disputes between guaranty associations and those asserting claims against them resulting from the initiation of a delinquency proceeding under this chapter. The determination of any dispute with respect to the statutory coverage obligations of any guaranty association by a court or administrative agency or body with jurisdiction in the guaranty association's state of domicile is binding and conclusive as to the parties in a delinquency proceeding initiated in the receivership court, including the policyholders of the insurer. With respect to a guaranty association's obligations under a rehabilitation plan, the receivership court has jurisdiction only if the guaranty association expressly consents to the jurisdiction of the court.

Added by Acts 2005, 79th Leg., Ch. 995 (H.B. [2157](#)), Sec. 1, eff. September 1, 2005.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.005 by

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(a)(1), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(c), eff. September 1, 2007.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.005 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(a)(1), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(c), eff. September 1, 2007.

Acts 2011, 82nd Leg., R.S., Ch. 193 (S.B. 1433), Sec. 1, eff. September 1, 2011.

Sec. 443.006. EXEMPTION FROM FEES. The receiver may not be required to pay any filing, recording, transcript, or authenticating fee to any public officer in this state.

Added by Acts 2005, 79th Leg., Ch. 995 (H.B. 2157), Sec. 1, eff. September 1, 2005.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.006 by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(a)(1), eff. September 1, 2007.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.006 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(a)(1), eff. September 1, 2007.

Sec. 443.007. NOTICE, HEARING, AND APPEAL ON MATTERS SUBMITTED BY RECEIVER FOR RECEIVERSHIP COURT APPROVAL. (a) Upon written request to the receiver, a person must be placed on the service list to receive notice of matters filed by the receiver. It is the responsibility of the person requesting notice to inform the receiver in writing of any changes in the person's address or to request that the person's name be deleted from the service list. The receiver may require that the persons on the service list provide confirmation that they wish to remain on the service list. Any person who fails to confirm the person's intent to remain on the service list may be purged from the service list. Inclusion on the service list does not

confer standing in the delinquency proceeding to raise, appear, or be heard on any issue.

(b) Except as otherwise provided by this chapter, notice and hearing of any matter submitted by the receiver to the receivership court for approval under this chapter must be conducted in accordance with Subsections (c)-(g).

(c) The receiver shall file an application explaining the proposed action and the basis of the proposed action. The receiver may include any evidence in support of the application. If the receiver determines that any documents supporting the application are confidential, the receiver may submit them to the receivership court under seal for in camera inspection.

(d) The receiver shall provide notice of the application to all persons on the service list and any other parties as determined by the receiver. Notice may be provided by first class mail postage paid, electronic mail, or facsimile transmission, at the receiver's discretion. For purposes of this section, notice is deemed to be given on the date that it is deposited with the U.S. Postmaster or transmitted, as applicable, to the last known address as shown on the service list.

(e) Any party in interest objecting to the application must file an objection specifying the grounds for the objection not later than the 20th day after the date of the notice of the filing of the application or within another period as the receivership court may set, and must serve copies on the receiver and any other persons served with the application within the same period. An objecting party has the burden of showing why the receivership court should not authorize the proposed action.

(f) If no objection to the application is timely filed, the receivership court may enter an order approving the application without a hearing, or hold a hearing to determine if the receiver's application should be approved. The receiver may request that the receivership court enter an order or hold a hearing on an expedited basis.

(g) If an objection is timely filed, the receivership court may hold a hearing. If the receivership court approves the application and, upon a motion by the receiver, determines that the objection was frivolous or filed merely for delay or for another improper purpose, the receivership court shall order the objecting party to pay the receiver's reasonable costs and fees of defending the action.

Added by Acts 2005, 79th Leg., Ch. 995 (H.B. 2157), Sec. 1, eff. September 1, 2005.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.007 by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(a)(1), eff. September 1, 2007.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.007 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(a)(1), eff. September 1, 2007.

Sec. 443.008. INJUNCTIONS AND ORDERS. (a) The receivership court may issue any order, process, or judgment, including stays, injunctions, or other orders, as necessary or appropriate to carry out the provisions of this chapter or an approved rehabilitation plan.

(b) This chapter may not be construed to limit the ability of the receiver to apply to a court other than the receivership court in any jurisdiction to carry out any provision of this chapter or for the purpose of pursuing claims against any person.

(c) Except as provided by Subsection (e) or as otherwise provided by this chapter and subject to Subsection (g), the commencement of a delinquency proceeding under this chapter operates as a stay, applicable to all persons, of:

(1) the commencement or continuation, including the issuance or employment of process, of a judicial, administrative, or other action or proceeding against the insurer, including an arbitration proceeding, that was or could have been commenced before the commencement of the delinquency proceeding under this chapter, or to recover a claim against the insurer that arose before the commencement of the delinquency proceeding under this chapter;

(2) the enforcement against the insurer or against property of the insurer of a judgment obtained before the commencement of the delinquency proceeding under this chapter;

(3) any act to obtain or retain possession of property of the insurer or of property from the insurer or to exercise control over property or records of the insurer;

(4) any act to create, perfect, or enforce any lien against property of the insurer;

(5) any act to collect, assess, or recover a claim against the insurer that arose before the commencement of a delinquency

proceeding under this chapter;

(6) the commencement or continuation of an action or proceeding against a reinsurer of the insurer, by the holder of a claim against the insurer, seeking reinsurance recoveries that are contractually due to the insurer; and

(7) except as provided by Subsection (e)(1), the commencement or continuation of an action or proceeding by a governmental unit to terminate or revoke an insurance license.

(d) Except as provided in Subsection (e) or as otherwise provided by this chapter, the commencement of a delinquency proceeding under this chapter operates as a stay, applicable to all persons, of any judicial, administrative, or other action or proceeding, including the enforcement of any judgment, against any insured that was or could have been commenced before the commencement of the delinquency proceeding under this chapter, or to recover a claim against the insured that arose before or after the commencement of the delinquency proceeding under this chapter and for which the insurer is or may be liable under a policy of insurance or is obligated to defend a party. The stay provided by this subsection terminates 90 days after the date of appointment of the receiver, unless, for good cause shown, the stay is extended by order of the receivership court after notice to any affected parties and any hearing the receivership court determines is appropriate.

(e) Notwithstanding Subsection (c), the commencement of a delinquency proceeding under this chapter does not operate as a stay of:

(1) regulatory actions not described by Subsection (c)(7) that are taken by the commissioners of nondomiciliary states, including the suspension of licenses;

(2) criminal proceedings;

(3) any act to perfect or to maintain or continue the perfection of an interest in property to the extent that the act is accomplished within any relation back period under applicable law;

(4) set off as permitted by Section 443.209;

(5) pursuit and enforcement of nonmonetary governmental claims, judgments, and proceedings;

(6) presentment of a negotiable instrument and the giving of notice and protesting dishonor of the instrument;

(7) enforcement of rights against single beneficiary trusts established pursuant to and in compliance with laws relating to

credit for reinsurance;

(8) termination, liquidation, and netting of obligations under qualified financial contracts as provided for in Section 443.261;

(9) discharge by a guaranty association of statutory responsibilities under any law governing guaranty associations; or

(10) any of the following actions:

(A) an audit by a governmental unit to determine tax liability;

(B) the issuance to the insurer by a governmental unit of a notice of tax deficiency;

(C) a demand for tax returns; or

(D) the making of an assessment for any tax and issuance of a notice and demand for payment of the assessment.

(f) Except as provided by Subsection (h):

(1) the stay of an act against property of the insurer under Subsection (c) continues until the property is no longer property of the receivership estate; and

(2) the stay of any other act under Subsection (c) continues until the earlier of the time the delinquency proceeding is closed or dismissed.

(g) Notwithstanding the provisions of Subsection (c), claims against the insurer that arose before the commencement of the delinquency proceeding under this chapter may be asserted as a counterclaim in any judicial, administrative, or other action or proceeding initiated by or on behalf of the receiver against the holder of the claims.

(h) On request of a party in interest and after notice and any hearing the receivership court determines is appropriate, the receivership court may grant relief from the stay of Subsection (c) or (d), such as by terminating, annulling, modifying, or conditioning the stay:

(1) for cause as described by Subsection (i); or

(2) with respect to a stay of an act against property under Subsection (c) if:

(A) the insurer does not have equity in the property; and

(B) the property is not necessary to an effective rehabilitation plan.

(i) For purposes of Subsection (h), "cause" includes the

receiver canceling a policy, surety bond, or surety undertaking if the creditor is entitled, by contract or by law, to require the insured or the principal to have a policy, surety bond, or surety undertaking and the insured or the principal fails to obtain a replacement policy, surety bond, or surety undertaking not later than the later of:

(1) the 30th day after the date the receiver cancels the policy, surety bond, or surety undertaking; or

(2) the time permitted by contract or law.

(j) In any hearing under Subsection (h), the party seeking relief from the stay has the burden of proof on each issue, which must be established by clear and convincing evidence.

(k) The estate of an insurer that is injured by any wilful violation of a stay provided by this section is entitled to actual damages, including costs and attorney's fees. In appropriate circumstances, the receivership court may impose additional sanctions.

(l) Any guaranty association or its designated representative may intervene as a party as a matter of right or otherwise appear and participate in any court proceeding concerning a delinquency proceeding if the association is or may become liable to act as a result of the rehabilitation or liquidation of the insurer. Exercise by any guaranty association or its designated representative of the right to intervene conferred under this subsection does not constitute grounds to establish general personal jurisdiction by the courts of this state. The intervening guaranty association or its designated representative are subject to the receivership court's jurisdiction for the limited purpose for which it intervenes.

(m) Notwithstanding any other provision of law, bond may not be required of the commissioner or receiver in relation to any stay or injunction under this section.

Added by Acts 2005, 79th Leg., Ch. 995 (H.B. [2157](#)), Sec. 1, eff. September 1, 2005.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.008 by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 3B.004(a)(1), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 3B.004(d), eff. September 1, 2007.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.008 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(a)(1), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(d), eff. September 1, 2007.

Sec. 443.009. STATUTES OF LIMITATIONS. (a) If applicable law, an order, or an agreement fixes a period within which the insurer may commence an action, and this period has not expired before the date of the filing of the initial petition in a delinquency proceeding, the receiver may commence an action only before the later of:

(1) the end of the period, including any suspension of the period occurring on or after the filing of the initial petition in a delinquency proceeding; or

(2) four years after the later of the date of entry of an order for either rehabilitation or liquidation.

(b) Except as provided by Subsection (a), if applicable law, an order, or an agreement fixes a period within which the insurer may file any pleading, demand, notice, or proof of claim or loss, cure a default in a case or proceeding, or perform any other similar act, and the period has not expired before the date of the filing of the petition initiating formal delinquency proceedings, the receiver may file, cure, or perform, as the case may be, only before the later of:

(1) the end of the period, including any suspension of the period occurring on or after the filing of the initial petition in the delinquency proceeding; or

(2) 60 days after the later of the date of entry of an order for either rehabilitation or liquidation.

(c) If applicable law, an order, or an agreement fixes a period for commencing or continuing a civil action in a court other than the receivership court on a claim against the insurer, and the period has not expired before the date of the initial filing of the petition in a delinquency proceeding, then the period does not expire until the later of:

(1) the end of the period, including any suspension of the period occurring on or after the filing of the initial petition in the delinquency proceeding; or

(2) 30 days after termination or expiration of the stay

under Section 443.008 with respect to the claim.

(d) If the otherwise applicable limitations period has not expired prior to the initial filing of the petition commencing a delinquency proceeding, any other action or proceeding filed by a receiver may be commenced at any time within four years after the date upon which the cause of action accrues or four years after the date on which the receiver is appointed, whichever is later.

Added by Acts 2005, 79th Leg., Ch. 995 (H.B. 2157), Sec. 1, eff. September 1, 2005.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.009 by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(a)(1), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(e), eff. September 1, 2007.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.009 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(a)(1), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(e), eff. September 1, 2007.

Sec. 443.010. COOPERATION OF OFFICERS, OWNERS, AND EMPLOYEES.

(a) Any present or former officer, manager, director, trustee, owner, employee, or agent of any insurer, or any other persons with authority over or in charge of any segment of the insurer's affairs, shall cooperate with the commissioner or receiver in any proceeding under this chapter or any investigation preliminary to the proceeding. For purposes of this section:

(1) "person" includes any person who exercises control directly or indirectly over activities of the insurer through any holding company or other affiliate of the insurer; and

(2) "cooperate" includes:

(A) replying promptly in writing to any inquiry from the commissioner or receiver requesting the reply; and

(B) promptly making available to the commissioner or receiver any books, accounts, documents, or other records or information or property of or pertaining to the insurer and in the

person's possession, custody, or control.

(b) A person may not obstruct or interfere with the commissioner or receiver in the conduct of any delinquency proceeding or any preliminary or incidental investigation.

(c) This section may not be construed to abridge otherwise existing legal rights, including the right to resist a petition for liquidation or other delinquency proceedings, or other orders.

(d) Any person described by Subsection (a) who fails to cooperate with the commissioner or receiver, or any person who obstructs or interferes with the commissioner or receiver in the conduct of any delinquency proceeding or any preliminary or incidental investigation, or who violates any order validly issued under this chapter:

(1) commits an offense; and

(2) is subject to the imposition by the commissioner of an administrative penalty not to exceed \$10,000 and subject to the revocation or suspension of any licenses issued by the commissioner in accordance with Chapters 82 and 84.

(e) An offense under Subsection (d) is punishable by a fine not exceeding \$10,000 or imprisonment for not more than one year, or both fine and imprisonment.

Added by Acts 2005, 79th Leg., Ch. 995 (H.B. 2157), Sec. 1, eff. September 1, 2005.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.010 by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(a)(1), eff. September 1, 2007.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.010 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(a)(1), eff. September 1, 2007.

Sec. 443.011. ACTIONS BY AND AGAINST RECEIVER. (a) An allegation by the receiver of improper or fraudulent conduct against any person may not be the basis of a defense to the enforcement of a contractual obligation owed to the insurer by a third party, unless the conduct is found to have been materially and substantially related to the contractual obligation for which enforcement is sought.

(b) A prior wrongful or negligent action of any present or

former officer, manager, director, trustee, owner, employee, or agent of the insurer may not be asserted as a defense to a claim by the receiver under a theory of estoppel, comparative fault, intervening cause, proximate cause, reliance, mitigation of damages, or otherwise, except that the affirmative defense of fraud in the inducement may be asserted against the receiver in a claim based on a contract, and a principal under a surety bond or a surety undertaking is entitled to credit against any reimbursement obligation to the receiver for the value of any property pledged to secure the reimbursement obligation to the extent that the receiver has possession or control of the property or that the insurer or its agents commingled or otherwise misappropriated the property. Evidence of fraud in the inducement is admissible only if the evidence is contained in the records of the insurer.

(c) An action or inaction by the department or the insurance regulatory authorities in any state may not be asserted as a defense to a claim by the receiver.

(d) Except as provided by Subsection (e), a judgment or order entered against an insured or the insurer in contravention of any stay or injunction under this chapter, or at any time by default or collusion, may not be considered as evidence of liability or of the amount of damages in adjudicating claims filed in the estate arising out of the subject matter of the judgment or order.

(e) Subsection (d) does not apply to guaranty associations' claims for amounts paid on settlements and judgments in pursuit of their statutory obligations.

(f) The receiver may not be deemed a governmental entity for the purposes of any state law awarding fees to a litigant who prevails against a governmental entity.

Added by Acts 2005, 79th Leg., Ch. 995 (H.B. [2157](#)), Sec. 1, eff. September 1, 2005.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.011 by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 3B.004(a)(1), eff. September 1, 2007.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.011 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. [3167](#)), Sec. 9.004(a)(1), eff. September 1, 2007.

Sec. 443.012. UNRECORDED OBLIGATIONS AND DEFENSES OF AFFILIATES. (a) In any proceeding or claim by the receiver, an affiliate, controlled or controlling person, or present or former officer, manager, director, trustee, or shareholder of the insurer may not assert any defense, unless evidence of the defense was recorded in the books and records of the insurer at or about the time the events giving rise to the defense occurred and, if required by statutory accounting practices and procedures, was timely reported on the insurer's official financial statements filed with the department.

(b) An affiliate, controlled or controlling person, or present or former officer, manager, director, trustee, or shareholder of the insurer may not assert any claim, unless the obligations were recorded in the books and records of the insurer at or about the time the obligations were incurred and, if required by statutory accounting practices and procedures, were timely reported on the insurer's official financial statements filed with the department.

(c) Claims by the receiver against any affiliate, controlled or controlling person, or present or former officer, manager, director, trustee, or shareholder of the insurer based on unrecorded or unreported transactions are not barred by this section.

Added by Acts 2005, 79th Leg., Ch. 995 (H.B. 2157), Sec. 1, eff. September 1, 2005.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.012 by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(a)(1), eff. September 1, 2007.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.012 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(a)(1), eff. September 1, 2007.

Sec. 443.013. EXECUTORY CONTRACTS AND UNEXPIRED LEASES. (a) The receiver may assume or reject any executory contract or unexpired lease of the insurer.

(b) Neither the filing of a petition commencing delinquency proceedings under this chapter nor the entry of an order for a delinquency proceeding constitutes a breach or anticipatory breach of any contract or lease of the insurer.

(c) If there has been a default in an executory contract or

unexpired lease of the insurer, the receiver may not assume the contract or lease unless, at the time of the assumption of the contract or lease, the receiver:

- (1) cures or provides adequate assurance that the receiver will promptly cure the default; and
- (2) provides adequate assurance of future performance under the contract or lease.

(d) Subsection (c) does not apply to a default that is a breach of a provision relating to:

- (1) the insolvency or financial condition of the insurer at any time before the closing of the delinquency proceeding;
- (2) the appointment of or taking possession by a receiver in a case under this chapter or a custodian before the commencement of the delinquency proceeding; or
- (3) the satisfaction of any penalty rate or provision relating to a default arising from any failure of the insurer to perform nonmonetary obligations under the executory contract or unexpired lease.

(e) A claim arising from the rejection, under this section or a plan of rehabilitation, of an executory contract or unexpired lease of the insurer that has not been assumed shall be determined, treated, and classified as if the claim had arisen before the date of the filing of a successful petition commencing the delinquency proceeding.

Added by Acts 2005, 79th Leg., Ch. 995 (H.B. [2157](#)), Sec. 1, eff. September 1, 2005.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.013 by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 3B.004(a)(1), eff. September 1, 2007.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.013 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. [3167](#)), Sec. 9.004(a)(1), eff. September 1, 2007.

Sec. 443.0135. CONTRACTS FOR SPECIAL DEPUTIES. (a) Except as provided by Subsection (c), the receiver shall use a competitive bidding process in the selection of any special deputies appointed under Section 443.102 or 443.154. The process must include procedures to promote the participation of historically underutilized

businesses that have been certified by the comptroller under Section 2161.061, Government Code.

(b) A proposal submitted in connection with a bid solicitation under Subsection (a) must describe the efforts that have been made to include historically underutilized businesses as subcontractors and the plan for using the historically underutilized businesses in the administration of the receivership estate. A special deputy appointed under Section 443.102 or 443.154 shall make a good faith effort to implement the plan and shall report to the receiver the special deputy's efforts to identify and subcontract with historically underutilized businesses.

(c) In the event of an emergency, the receiver may appoint a special deputy without soliciting competitive bids. For the purposes of this subsection, an emergency exists if:

(1) a court has made a determination described by Section 202(a)(1)(A)(iv)(I), Pub. L. No. 111-203; or

(2) the receiver concludes that the competitive bidding process would delay the appointment of a special deputy and that the delay could be hazardous to the insurer's policyholders or creditors or the general public.

Added by Acts 2005, 79th Leg., Ch. 995 (H.B. [2157](#)), Sec. 1, eff. September 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 3B.004(f), eff. September 1, 2007.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.0135 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. [3167](#)), Sec. 9.004(a)(1), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. [3167](#)), Sec. 9.004(f), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 937 (H.B. [3560](#)), Sec. 1.98, eff. September 1, 2007.

Acts 2011, 82nd Leg., R.S., Ch. 193 (S.B. [1433](#)), Sec. 2, eff. September 1, 2011.

Sec. 443.014. IMMUNITY AND INDEMNIFICATION OF RECEIVER AND ASSISTANTS. (a) For the purposes of this section, the persons

entitled to immunity and indemnification and those entitled to immunity only, as applicable, are:

(1) all present and former receivers responsible for the conduct of a delinquency proceeding under this chapter;

(2) all of the receiver's present and former assistants, including:

(A) all present and former special deputies and assistant special deputies engaged by contract or otherwise;

(B) all persons whom the receiver, special deputies, or assistant special deputies have employed to assist in a delinquency proceeding under this chapter; and

(C) any state employees acting with respect to a delinquency proceeding under this chapter; and

(3) all of the receiver's present and former contractors, including all persons with whom the receiver, special deputies, or assistant special deputies have contracted to assist in a delinquency proceeding under this chapter, including attorneys, accountants, auditors, actuaries, investment bankers, financial advisors, and any other professionals or firms who are retained or contracted with by the receiver as independent contractors and all employees of the contractors.

(b) The receiver, the receiver's assistants, and the receiver's contractors have immunity under this chapter, as described by Subsections (c) and (d).

(c) The receiver, the receiver's assistants, and the receiver's contractors are immune from suit and liability, both personally and in their representative capacities, for any claim for damage to or loss of property or personal injury or other civil liability caused by or resulting from any alleged act, error, or omission of the receiver or any assistant or contractor that arises out of or by reason of their duties or employment or is taken at the direction of the receivership court, providing that the alleged act, error, or omission is performed in good faith.

(d) Any immunity granted by this section is in addition to any immunity granted by other law.

(e) The receiver and the receiver's assistants are entitled to indemnification under this chapter, as described by Subsections (f)-(1).

(f) If any legal action is commenced against the receiver or any assistant, whether against the receiver or assistant personally

or in their official capacity, alleging property damage, property loss, personal injury, or other civil liability caused by or resulting from any alleged act, error, or omission of the receiver or any assistant arising out of or by reason of their duties or employment, the receiver and any assistant are indemnified from the assets of the insurer for all expenses, attorney's fees, judgments, settlements, decrees, or amounts due and owing or paid in satisfaction of or incurred in the defense of the legal action, unless it is determined upon a final adjudication on the merits that the alleged act, error, or omission of the receiver or assistant giving rise to the claim:

(1) did not arise out of or by reason of their duties or employment; or

(2) was caused by intentional or wilful and wanton misconduct.

(g) Attorney's fees and any and all related expenses incurred in defending a legal action for which immunity or indemnity is available under this section must be paid from the assets of the insurer, as the fees and expenses are incurred, and in advance of the final disposition of the legal action upon receipt of an agreement by or on behalf of the receiver or assistant to repay the attorney's fees and expenses, if it is ultimately determined upon a final adjudication on the merits that the receiver or assistant is not entitled to immunity or indemnity under this section.

(h) Any indemnification for expense payments, judgments, settlements, decrees, attorney's fees, surety bond premiums, or other amounts paid or to be paid from the insurer's assets pursuant to this section are an administrative expense of the insurer.

(i) In the event of any actual or threatened litigation against a receiver or any assistant for whom immunity or indemnity may be available under this section, a reasonable amount of funds, which in the judgment of the receiver may be needed to provide immunity or indemnity, must be segregated and reserved from the assets of the insurer as security for the payment of indemnity until:

(1) all applicable statutes of limitation have run;

(2) all actual or threatened actions against the receiver or any assistant have been completely and finally resolved; and

(3) all obligations under this section have been satisfied.

(j) Instead of segregating and reserving funds under Subsection (i), the receiver may, in the receiver's discretion, obtain a surety

bond or make other arrangements that will enable the receiver to secure fully the payment of all obligations under this section.

(k) If any legal action against an assistant for whom indemnity may be available under this section is settled prior to final adjudication on the merits, the receiver must pay the settlement amount on behalf of the assistant, or indemnify the assistant for the settlement amount, unless the receiver determines that the claim:

(1) did not arise out of or by reason of the assistant's duties or employment; or

(2) was caused by the intentional or wilful and wanton misconduct of the assistant.

(l) In any legal action in which a claim is asserted against the receiver, that portion of any settlement relating to the alleged act, error, or omission of the receiver is subject to the approval of the receivership court. The receivership court may not approve that portion of the settlement if it determines that the claim:

(1) did not arise out of or by reason of the receiver's duties or employment; or

(2) was caused by the intentional or wilful and wanton misconduct of the receiver.

(m) Nothing contained or implied in this section may operate or be construed or applied to deprive the receiver, the receiver's assistants, or receiver's contractors of any immunity, indemnity, benefits of law, rights, or defense otherwise available.

(n) The immunity and indemnification provided to the receiver's assistants and the immunity provided to the receiver's contractors under this section do not apply to any action by the receiver against that person.

(o) Subsection (b) applies to any suit based in whole or in part on any alleged act, error, or omission that takes place on or after September 1, 2005.

(p) Subsections (e)-(l) apply to any suit that is pending on or filed after September 1, 2005, without regard to when the alleged act, error, or omission took place.

Added by Acts 2005, 79th Leg., Ch. 995 (H.B. [2157](#)), Sec. 1, eff. September 1, 2005.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.014 by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 3B.004(a)(1), eff. September 1, 2007.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.014 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(a)(1), eff. September 1, 2007.

Sec. 443.015. APPROVAL AND PAYMENT OF EXPENSES. (a) The receiver may pay any expenses under contracts, leases, employment agreements, or other arrangements entered into by the insurer prior to receivership, as the receiver deems necessary for the purposes of this chapter. The receiver is not required to pay any expenses that the receiver determines are not necessary, and may reject any contract pursuant to Section 443.013.

(b) Receivership expenses other than those described in Subsection (a) must be paid in accordance with Subsections (c)-(f).

(c) The receiver shall submit to the receivership court an application pursuant to Section 443.007 to approve:

(1) the terms of compensation of each special deputy or contractor with respect to which the total amount of the compensation is reasonably expected by the receiver for the duration of the delinquency proceeding to exceed \$250,000, or another amount established by the receivership court; and

(2) any other anticipated expense in excess of \$25,000, or another amount established by the receivership court.

(d) The receiver may, as the receiver deems appropriate, submit an application to approve any compensation, anticipated expenses, or incurred expenses not described by Subsection (c)(1).

(e) The receiver may pay any expenses not requiring receivership court approval and any expenses approved by the rehabilitation or liquidation order as the expenses are incurred.

(f) The approval of expenses by the receivership court does not prejudice the right of the receiver to seek any recovery, recoupment, disgorgement, or reimbursement of fees based on contract or causes of action recognized in law or in equity.

(g) On a quarterly basis, or as otherwise provided by the receivership court, the receiver shall submit to the receivership court a report summarizing the expenses incurred during the period.

(h) Receivership court approval may not be required to pay expenses incurred by the receiver in connection with the appeal of an order of the receivership court.

(i) All expenses of receivership shall be paid from the assets

of the insurer, except as provided by this subsection. In the event that the property of the insurer does not contain sufficient cash or liquid assets to defray the expenses incurred, the commissioner may advance funds from the account established under Section 443.304(c). Any amounts advanced shall be repaid to the account out of the first available money of the insurer.

Added by Acts 2005, 79th Leg., Ch. 995 (H.B. 2157), Sec. 1, eff. September 1, 2005.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.015 by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(a)(1), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(g), eff. September 1, 2007.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.015 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(a)(1), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(g), eff. September 1, 2007.

Sec. 443.016. FINANCIAL REPORTING. (a) Not later than the 120th day after the date of entry of an order of receivership by the receivership court, and at least quarterly after that date, the receiver shall file a financial report with the receivership court. A financial report filed under this subsection at a minimum, must include:

(1) a statement of the assets and liabilities of the insurer;

(2) the changes in those assets and liabilities; and

(3) all funds received or disbursed by the receiver during the period covered by the report.

(b) The receivership court shall require a financial report filed under Subsection (a) to comply with all receivership financial reporting requirements specified by the National Association of Insurance Commissioners and adopted in this state by rule by the commissioner.

(c) Not later than the 120th day after the date of entry of an

order of liquidation by the receivership court, and at least quarterly after that date, or at other intervals as may be agreed to between the liquidator and the guaranty associations, but in no event less than annually, each affected guaranty association shall file reports with the liquidator. The reports must be in a format compatible with that specified by the National Association of Insurance Commissioners. Reports under this subsection shall be filed with the receivership court.

Added by Acts 2005, 79th Leg., Ch. 995 (H.B. 2157), Sec. 1, eff. September 1, 2005.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.016 by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(a)(1), eff. September 1, 2007.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.016 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(a)(1), eff. September 1, 2007.

Sec. 443.017. RECORDS. (a) Upon entry of an order of rehabilitation or liquidation, the receiver is vested with title to all of the books, documents, papers, policy information, and claim files, and all other records of the insurer, of whatever nature, in whatever medium, and wherever located, regardless of whether the records are in the custody and control of a third-party administrator, managing general agent, attorney, or other representative of the insurer. The receiver may immediately take possession and control of all of the records of the insurer, and of the premises where the records are located. A third-party administrator, managing general agent, attorney, or other representative of the insurer shall release all records described by this subsection to the receiver, or the receiver's designee, at the request of the receiver. A guaranty association that has or may have obligations under a policy issued by the insurer has the right, with the receiver's approval, to take actions as are necessary to obtain directly from any third-party administrator, managing general agent, attorney, or other representative of the insurer all records described by this section that pertain to the insurer's business and that are appropriate or necessary for the guaranty association to fulfill the association's statutory obligations.

(b) The receiver has the authority to certify the records of a delinquent insurer described by Subsection (a) and the records of the receiver's office created and maintained in connection with a delinquent insurer, as follows:

(1) records of a delinquent insurer may be certified by the receiver in an affidavit stating that the records:

(A) are true and correct copies of records of the insurer; and

(B) were received from the custody of the insurer or found among its effects; and

(2) records created by or filed with the receiver's office in connection with a delinquent insurer may be certified by the receiver's affidavit stating that the records are true and correct copies of records maintained by the receiver's office.

(c) Original books, documents, papers, and other records, or copies of original records certified under Subsection (b), when admitted in evidence, are prima facie evidence of the facts disclosed.

(d) The records of a delinquent insurer held by the receiver may not be considered records of the department for any purposes, and Chapter 552, Government Code, does not apply to those records.

Added by Acts 2005, 79th Leg., Ch. 995 (H.B. 2157), Sec. 1, eff. September 1, 2005.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.017 by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(a)(1), eff. September 1, 2007.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.017 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(a)(1), eff. September 1, 2007.

SUBCHAPTER B. PROCEEDINGS

Sec. 443.051. RECEIVERSHIP COURT'S SEIZURE ORDER. (a) The commissioner may file in a district court of Travis County a petition with respect to an insurer domiciled in this state, an unauthorized insurer, or, pursuant to Section 443.401, a foreign insurer:

(1) alleging that grounds exist that would justify a court order for a formal delinquency proceeding against the insurer under this chapter;

(2) alleging that the interests of policyholders, creditors, or the public will be endangered by delay; and

(3) setting forth the contents of a seizure order deemed to be necessary by the commissioner.

(b) Upon a filing under Subsection (a), the receivership court may issue, ex parte and without notice or hearing, the requested seizure order directing the commissioner to take possession and control of all or a part of the property, books, accounts, documents, and other records of an insurer, and of the premises occupied by it for transaction of its business, and until further order of the receivership court, enjoining the insurer and its officers, managers, agents, and employees from disposition of its property and from the transaction of its business except with the written consent of the commissioner. Any person having possession or control of and refusing to deliver any of the books, records, or assets of a person against whom a seizure order has been issued commits an offense. An offense under this subsection is punishable in the manner described by Section 443.010(e).

(c) A petition that prays for injunctive relief must be verified by the commissioner or the commissioner's designee, but need not plead or prove irreparable harm or inadequate remedy at law. The commissioner shall provide only the notice as the receivership court may require.

(d) The receivership court shall specify in the seizure order the duration of the seizure order, which shall be a period the receivership court deems necessary for the commissioner to ascertain the condition of the insurer. On motion of the commissioner or the insurer, or the court's own motion, the receivership court may, from time to time, hold hearings as it deems desirable after notice as it deems appropriate, and may extend, shorten, or modify the terms of the seizure order. The receivership court shall vacate the seizure order if the commissioner fails to commence a formal delinquency proceeding under this chapter after having had a reasonable opportunity to do so. An order of the receivership court pursuant to a formal proceeding under this chapter vacates the seizure order.

(e) Entry of a seizure order under this section does not constitute a breach or an anticipatory breach of any contract of the insurer.

(f) An insurer subject to an ex parte seizure order under this section may petition the receivership court at any time after the

issuance of a seizure order for a hearing and review of the seizure order. The receivership court shall hold the hearing and conduct the review not later than the 15th day after the date of the request. A hearing under this subsection may be held privately in chambers, and a hearing shall be held privately in chambers if the insurer proceeded against so requests.

(g) If, at any time after the issuance of a seizure order, it appears to the receivership court that any person whose interest is or will be substantially affected by the seizure order did not appear at the hearing and has not been served, the receivership court may order that notice be given to the person. An order that notice be given does not stay the effect of any seizure order previously issued by the receivership court.

(h) Whenever the commissioner makes any seizure as provided by Subsection (b), on the demand of the commissioner, the sheriff of any county and the police department of any municipality shall furnish the commissioner with the deputies, patrolmen, or officers as may be necessary to assist the commissioner in making and enforcing the seizure order.

(i) In all proceedings and judicial reviews under this section, all records of the insurer, department files, court records and papers, and other documents, so far as they pertain to or are a part of the record of the proceedings, are confidential, and all papers filed with the clerk of the court shall be held by the clerk in a confidential file as permitted by law, except to the extent necessary to obtain compliance with any order entered in connection with the proceedings, unless and until:

- (1) the court, after hearing argument in chambers, orders otherwise;
- (2) the insurer requests that the matter be made public; or
- (3) the commissioner applies for an order under Section 443.057.

Added by Acts 2005, 79th Leg., Ch. 995 (H.B. [2157](#)), Sec. 1, eff. September 1, 2005.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.051 by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 3B.004(a)(1), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 3B.004(h),

eff. September 1, 2007.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.051 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(a)(1), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(h), eff. September 1, 2007.

Sec. 443.052. COMMENCEMENT OF FORMAL DELINQUENCY PROCEEDING.

(a) Except as authorized by Section 203(e)(3), Pub. L. No. 111-203, any formal delinquency proceeding against a person shall be commenced by filing a petition in the name of the commissioner or department.

(b) The petition must state the grounds upon which the proceeding is based and the relief requested and may include a prayer for restraining orders and injunctive relief as described in Section 443.008. On the filing of the petition or order, a copy shall be forwarded by first class mail or electronic communication as permitted by the receivership court to the insurance regulatory officials and guaranty associations in states in which the insurer did business.

(c) Any petition that prays for injunctive relief must be verified by the commissioner or the commissioner's designee, but need not plead or prove irreparable harm or inadequate remedy at law. The commissioner shall provide only the notice as the receivership court may require.

(d) If any temporary restraining order is prayed for:

(1) the receivership court may issue an initial order containing the relief requested;

(2) the receivership court shall set a time and date for the return of summons, not later than 10 days after the time and date of the issuance of the initial order, at which time the person proceeded against may appear before the receivership court for a summary hearing;

(3) the order must state the time and date of its issuance; and

(4) the order may not continue in effect beyond the time and date set for the return of summons, unless the receivership court expressly enters one or more orders extending the restraining order.

(e) If a temporary restraining order is not requested, the

receivership court shall cause summons to be issued. The summons must specify a return date not later than the 30th day after the date of issuance and that an answer must be filed at or before the return date.

Added by Acts 2005, 79th Leg., Ch. 995 (H.B. 2157), Sec. 1, eff. September 1, 2005.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.052 by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(a)(1), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(i), eff. September 1, 2007.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.052 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(a)(1), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(i), eff. September 1, 2007.

Acts 2011, 82nd Leg., R.S., Ch. 193 (S.B. 1433), Sec. 3, eff. September 1, 2011.

Sec. 443.053. RETURN OF SUMMONS AND SUMMARY HEARING. (a) The receivership court shall hold a summary hearing at the time and date for the return of summons on a petition to commence a formal delinquency proceeding.

(b) If a person is not served with summons on a petition to commence a formal delinquency proceeding and fails to appear for the summary hearing, the receivership court shall:

- (1) continue the summary hearing not more than 10 days;
- (2) provide for alternative service of summons upon the person; and
- (3) extend any restraining order.

(c) Upon a showing of good faith efforts to effect personal service upon a person who has failed to appear for a continued summary hearing, the receivership court shall order notice of the petition to commence a formal delinquency proceeding to be published. The order and notice shall specify a return date not less than 10 or later than 20 days after the date of publication and that the

restraining order has been extended to the continued hearing date.

(d) If a person fails to appear for a summary hearing on a petition to commence a formal delinquency proceeding after service of summons, the receivership court shall enter judgment in favor of the commissioner against that person.

(e) A person who appears for the summary hearing on a petition to commence a formal delinquency proceeding shall file the person's answer at the hearing, and the receivership court shall:

(1) determine whether to extend any temporary restraining orders pending final judgment; and

(2) set the case for trial on a date not later than 10 days after the date of the summary hearing.

(f) The receivership court may not grant a continuance for filing an answer.

Added by Acts 2005, 79th Leg., Ch. 995 (H.B. 2157), Sec. 1, eff. September 1, 2005.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.053 by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(a)(1), eff. September 1, 2007.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.053 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(a)(1), eff. September 1, 2007.

Sec. 443.054. PROCEEDINGS FOR EXPEDITED TRIAL: CONTINUANCES, DISCOVERY, EVIDENCE. (a) The receivership court shall proceed to hear the case on the petition to commence a formal delinquency proceeding at the time and date set forth for trial. To the extent practicable, the receivership court shall give precedence to the matter over all other matters. To the extent authorized by law, the receivership court may assign the matter to other judges if necessary to comply with the need for expedited proceedings under this chapter.

(b) Continuances for trial may be granted only in extreme circumstances.

(c) The receivership court shall admit into evidence, as self-authenticated, certified copies of any of the following when offered by the commissioner:

(1) the financial statements made by the insurer or an affiliate;

(2) examination reports of the insurer or an affiliate made by or on behalf of the commissioner; and

(3) any other document filed with any insurance department by the insurer or an affiliate.

(d) The facts contained in any examination report of the insurer or an affiliate made by or on behalf of the commissioner are presumed to be true as of the date of the hearing if the examination was made as of a date not more than 270 days before the date the petition was filed. The presumption is rebuttable, and shifts the burden of production and persuasion to the insurer.

(e) Discovery is limited to grounds alleged in the petition and shall be concluded on an expedited basis.

Added by Acts 2005, 79th Leg., Ch. 995 (H.B. 2157), Sec. 1, eff. September 1, 2005.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.054 by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(a)(1), eff. September 1, 2007.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.054 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(a)(1), eff. September 1, 2007.

Sec. 443.055. DECISION AND APPEALS. (a) The receivership court shall enter judgment on the petition to commence formal delinquency proceedings not later than the 15th day after the date of conclusion of the evidence.

(b) The judgment is final when entered. Any appeal must be prosecuted on an expedited basis and must be taken not later than the fifth day after the date of entry of the judgment. A request for reconsideration, review, or appeal, or posting of a bond does not dissolve or stay the judgment.

Added by Acts 2005, 79th Leg., Ch. 995 (H.B. 2157), Sec. 1, eff. September 1, 2005.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.055 by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(a)(1), eff. September 1, 2007.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.055 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(a)(1), eff. September 1, 2007.

Sec. 443.056. CONFIDENTIALITY. (a) The commissioner, rehabilitator, or liquidator may share documents, materials, or other information in the possession, custody, or control of the department without regard to the confidentiality of those documents, materials, or information, pertaining to an insurer that is the subject of a proceeding under this chapter with other state, federal, and international regulatory agencies, with the National Association of Insurance Commissioners and its affiliates and subsidiaries, with state, federal, and international law enforcement authorities, with an auditor appointed by the receivership court in accordance with Section 443.355, and, pursuant to Section 443.105, with representatives of guaranty associations that may have statutory obligations as a result of the insolvency of the insurer, provided that the recipient agrees to maintain the confidentiality, if any, of the documents, material, or other information. Nothing in this section limits the power of the commissioner to disclose information under other applicable law.

(b) A domiciliary receiver shall permit a commissioner of another state or a guaranty association to obtain a listing of policyholders and certificate holders residing in the requestor's state, including current addresses and summary policy information, provided that the commissioner of the other state or the guaranty association agrees to maintain the confidentiality of the records and agrees that the records will be used only for regulatory or guaranty association purposes. Access to records may be limited to normal business hours. In the event that the domiciliary receiver believes that certain information is sensitive and that disclosure may cause a diminution in recovery, the receiver may apply for a protective order imposing additional restrictions on access.

(c) The Texas Workers' Compensation Commission shall report to the department any information that a workers' compensation insurer has committed acts that indicate that the insurer is impaired or insolvent. A report made under this subsection is confidential under this section.

(d) The confidentiality obligations imposed by this section end upon the entry of an order of liquidation against the insurer, unless otherwise agreed to by the parties or pursuant to an order of the receivership court.

(e) A waiver of any applicable privilege or claim of confidentiality does not occur as a result of any disclosure, or any sharing of documents, materials, or other information, made pursuant to this section.

Added by Acts 2005, 79th Leg., Ch. 995 (H.B. 2157), Sec. 1, eff. September 1, 2005.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.056 by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(a)(1), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(j), eff. September 1, 2007.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.056 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(a)(1), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(j), eff. September 1, 2007.

Sec. 443.057. GROUNDS FOR CONSERVATION, REHABILITATION, OR LIQUIDATION. A petition with respect to an insurer domiciled in this state or an unauthorized insurer for an order of rehabilitation or liquidation may be filed on any one or more of the following grounds:

- (1) the insurer is impaired;
- (2) the insurer is insolvent;
- (3) the insurer is about to become insolvent, with "about to become insolvent" being defined as reasonably anticipated that the insurer will not have liquid assets to meet its next 90 days' current obligations;
- (4) the insurer has neglected or refused to comply with an order of the commissioner to make good within the time prescribed by law any deficiency, whenever its capital and minimum required surplus, if a stock company, or its surplus, if a company other than stock, has become impaired;
- (5) the insurer, its parent company, its subsidiaries, or its affiliates have converted, wasted, or concealed property of the insurer or have otherwise improperly disposed of, dissipated, used, released, transferred, sold, assigned, hypothecated, or removed the

property of the insurer;

(6) the insurer is in a condition such that it could not meet the requirements for organization and authorization as required by law, except as to the amount of the original surplus required of a stock company under Title 6, and except as to the amount of the surplus required of a company other than a stock company in excess of the minimum surplus required to be maintained;

(7) the insurer, its parent company, its subsidiaries, or its affiliates have concealed, removed, altered, destroyed, or failed to establish and maintain books, records, documents, accounts, vouchers, and other pertinent material adequate for the determination of the financial condition of the insurer by examination under Chapter 401 or has failed to properly administer claims or maintain claims records that are adequate for the determination of its outstanding claims liability;

(8) at any time after the issuance of an order under Section 404.003 or Chapter 441, or at the time of instituting any proceeding under this chapter, it appears to the commissioner that, upon good cause shown, it would not be in the best interest of the policyholders, creditors, or the public to proceed with the conduct of the business of the insurer;

(9) the insurer is in a condition such that the further transaction of business would be hazardous financially, according to Subchapter A, Chapter 404, or otherwise, to its policyholders, creditors, or the public;

(10) there is reasonable cause to believe that there has been embezzlement from the insurer, wrongful sequestration or diversion of the insurer's property, forgery or fraud affecting the insurer, or other illegal conduct in, by, or with respect to the insurer that, if established, would endanger assets in an amount threatening the solvency of the insurer;

(11) control of the insurer is in a person who is:

(A) dishonest or untrustworthy; or

(B) so lacking in insurance company managerial experience or capability as to be hazardous to policyholders, creditors, or the public;

(12) any person who in fact has executive authority in the insurer, whether an officer, manager, general agent, director, trustee, employee, shareholder, or other person, has refused to be examined under oath by the commissioner concerning the insurer's

affairs, whether in this state or elsewhere or if examined under oath, refuses to divulge pertinent information reasonably known to the person; and after reasonable notice of the fact, the insurer has failed promptly and effectively to terminate the employment and status of the person and all the person's influence on management;

(13) after demand by the commissioner under Chapter 401 or under this chapter, the insurer has failed promptly to make available for examination any of its own property, books, accounts, documents, or other records, or those of any subsidiary or related company within the control of the insurer or of any person having executive authority in the insurer, so far as they pertain to the insurer;

(14) without first obtaining the written consent of the commissioner, the insurer has transferred, or attempted to transfer, in a manner contrary to Chapter 823 or any law relating to bulk reinsurance, substantially its entire property or business, or has entered into any transaction the effect of which is to merge, consolidate, or reinsure substantially its entire property or business in or with the property or business of any other person;

(15) the insurer or its property has been or is the subject of an application for the appointment of a receiver, trustee, custodian, conservator, sequestrator, or similar fiduciary of the insurer or its property otherwise than as authorized under the insurance laws of this state;

(16) within the previous five years, the insurer has wilfully and continuously violated its charter, articles of incorporation or bylaws, any insurance law of this state, or any valid order of the commissioner;

(17) the insurer has failed to pay within 60 days after the due date any obligation to any state or political subdivision of a state or any judgment entered in any state, if the court in which the judgment was entered had jurisdiction over the subject matter, except that nonpayment is not a ground until 60 days after any good faith effort by the insurer to contest the obligation has been terminated, whether it is before the commissioner or in the courts;

(18) the insurer has systematically engaged in the practice of reaching settlements with and obtaining releases from claimants, and then unreasonably delayed payment, failed to pay the agreed-upon settlements, or systematically attempted to compromise with claimants or other creditors on the ground that it is financially unable to pay its claims or obligations in full;

(19) the insurer has failed to file its annual report or other financial report required by statute within the time allowed by law;

(20) the board of directors or the holders of a majority of the shares entitled to vote, or a majority of those individuals entitled to the control of those entities specified by Section 443.003, request or consent to rehabilitation or liquidation under this chapter;

(21) the insurer does not comply with its domiciliary state's requirements for issuance to it of a certificate of authority, or its certificate of authority has been revoked by its state of domicile;

(22) when authorized by department rules; or

(23) a court has made a determination described by Section 202(a)(1)(A)(iv)(I), Pub. L. No. 111-203.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(k), eff. September 1, 2007.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.057 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(a)(1), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(k), eff. September 1, 2007.

Acts 2011, 82nd Leg., R.S., Ch. 193 (S.B. 1433), Sec. 4, eff. September 1, 2011.

Sec. 443.058. ENTRY OF ORDER. If any of the grounds provided in Section 443.057 are established, the receivership court shall grant the petition and issue the order of rehabilitation or liquidation requested in the petition.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(1), eff. September 1, 2007.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.058 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(a)(1), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(1), eff. September 1, 2007.

Acts 2011, 82nd Leg., R.S., Ch. 193 (S.B. 1433), Sec. 5, eff. September 1, 2011.

Sec. 443.059. EFFECT OF PETITION OR ORDER ON CONTRACT OR LEASE. Neither the filing of a petition under this chapter nor the entry of any order of seizure, rehabilitation, or liquidation constitutes a breach or an anticipatory breach of any contract or lease of the insurer.

Added by Acts 2005, 79th Leg., Ch. 995 (H.B. 2157), Sec. 1, eff. September 1, 2005.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.059 by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(a)(1), eff. September 1, 2007.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.059 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(a)(1), eff. September 1, 2007.

SUBCHAPTER C. REHABILITATION

Sec. 443.101. REHABILITATION ORDERS. (a) An order to rehabilitate the business of an insurer must appoint the commissioner and the commissioner's successors in office as the rehabilitator and must direct the rehabilitator to take possession of the property of the insurer wherever located and to administer it subject to this chapter. The rehabilitator is entitled to request the receivership court to appoint a single judge to supervise the rehabilitation and hear any cases or controversies arising out of or related to the rehabilitation. Rehabilitation proceedings are exempt from any dormancy or similar program maintained by the receivership court for the early closure of civil actions. The filing or recording of the order with the clerk of the court or recorder of deeds of the county in which the principal business of the company is conducted, or, in the case of real estate, the county in which its principal office or place of business is located, imparts the same notice as a deed, bill of sale, or other evidence of title filed or recorded with the recorder of deeds would impart. The order to rehabilitate the

insurer must, by operation of law, vest title to all property of the insurer in the rehabilitator.

(b) Any order issued under this section must require accountings to the receivership court by the rehabilitator. Accountings must be at the intervals specified by the receivership court in its order, but not less frequently than semi-annually. Each accounting must include a report concerning the rehabilitator's opinion as to the likelihood that a plan under Section 443.103 will be prepared by the rehabilitator and the timetable for doing so.

(c) In recognition of the need for a prompt and final resolution for all persons affected by a plan of rehabilitation, any appeal from an order of rehabilitation or an order approving a plan of rehabilitation must be heard on an expedited basis. A stay of an order of rehabilitation or an order approving a plan of rehabilitation may not be granted unless the appellant demonstrates that extraordinary circumstances warrant delaying the recovery under the plan of rehabilitation of all other persons, including policyholders. If the plan provides an appropriate mechanism for adjustment in the event of any adverse ruling from an appeal, a stay may not be granted.

Added by Acts 2005, 79th Leg., Ch. 995 (H.B. [2157](#)), Sec. 1, eff. September 1, 2005.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.101 by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 3B.004(a)(1), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 3B.004(m), eff. September 1, 2007.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.101 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. [3167](#)), Sec. 9.004(a)(1), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. [3167](#)), Sec. 9.004(m), eff. September 1, 2007.

Sec. 443.102. POWERS AND DUTIES OF REHABILITATOR. (a) The rehabilitator may appoint one or more special deputies. A special deputy serves at the pleasure of the rehabilitator and has all the

powers and responsibilities of the rehabilitator granted under this section, unless specifically limited by the rehabilitator. The rehabilitator may employ or contract with legal counsel, actuaries, accountants, appraisers, consultants, clerks, assistants, and other personnel as may be deemed necessary. Any special deputy or any other person with whom the rehabilitator contracts under this subsection may act on behalf of the commissioner only in the commissioner's capacity as rehabilitator. Any person with whom the rehabilitator contracts under this subsection is not considered an agent of the state, and any contract entered into under this subsection does not constitute a contract with the state. The provisions of any law governing the procurement of goods and services by the state does not apply to any contract entered into by the commissioner as rehabilitator. The compensation of any special deputies, employees, and contractors and all expenses of taking possession of the insurer and of conducting the rehabilitation shall be fixed by the rehabilitator, with the approval of the receivership court in accordance with Section 443.015, and shall be paid out of the property of the insurer. The persons appointed under this subsection serve at the pleasure of the rehabilitator. If the rehabilitator deems it necessary to the proper performance of the rehabilitator's duties under this chapter, the rehabilitator may appoint an advisory committee of policyholders, claimants, or other creditors, including guaranty associations. The advisory committee serves at the pleasure of the rehabilitator and without compensation or reimbursement for expenses. The rehabilitator or the receivership court in rehabilitation proceedings conducted under this chapter may not appoint another committee of any nature.

(b) The rehabilitator may take action as the rehabilitator deems necessary or appropriate to reform and revitalize the insurer, including canceling policies, insurance and reinsurance contracts other than life or health insurance or annuities, or surety bonds or surety undertakings or transferring policies, insurance and reinsurance contracts, or surety bonds or surety undertakings to a solvent assuming insurer, with court approval. The rehabilitator has all the powers of the directors, officers, and managers of the insurer, whose authority is suspended, except as redelegated by the rehabilitator. The rehabilitator has full power to direct and manage, hire and discharge employees, and deal with the property and business of the insurer.

(c) If it appears to the rehabilitator that there has been criminal or tortious conduct or breach of any contractual or fiduciary obligation detrimental to the insurer by any officer, manager, agent, broker, employee, affiliate or other person, the rehabilitator may pursue all appropriate legal remedies on behalf of the insurer.

(d) The rehabilitator may assert all defenses available to the insurer as against third persons, including statutes of limitations, statutes of frauds, and the defense of usury. A waiver of any defense by the insurer after a petition under this chapter has been filed does not bind the rehabilitator.

(e) The enumeration, in this section, of the powers and authority of the rehabilitator may not be construed as a limitation upon the rehabilitator, nor shall it exclude in any manner the right to do other acts not specifically enumerated or otherwise provided for, as may be necessary or appropriate for the accomplishment of or in aid of the purpose of rehabilitation.

(f) The rehabilitator may exercise all powers:

- (1) possessed on August 31, 2005, by a receiver appointed for the purpose of rehabilitating an insurer; or
- (2) conferred on a rehabilitator after that date by the laws of this state that are not inconsistent with this chapter.

Added by Acts 2005, 79th Leg., Ch. 995 (H.B. [2157](#)), Sec. 1, eff. September 1, 2005.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.102 by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 3B.004(a)(1), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 3B.004(n), eff. September 1, 2007.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.102 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. [3167](#)), Sec. 9.004(a)(1), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. [3167](#)), Sec. 9.004(n), eff. September 1, 2007.

Acts 2011, 82nd Leg., R.S., Ch. 193 (S.B. [1433](#)), Sec. 6, eff. September 1, 2011.

Sec. 443.103. REHABILITATION PLANS. (a) The rehabilitator shall prepare and file a plan to effect rehabilitation with the receivership court not later than the first anniversary of the entry of the rehabilitation order or another further time as the receivership court may allow. Upon application of the rehabilitator for approval of the plan, and after the notice and hearings the receivership court may prescribe, the receivership court may approve or disapprove the proposed plan or may modify it and approve it as modified. Any plan approved under this section must be, in the judgment of the receivership court, fair and equitable to all parties concerned. If the plan is approved, the rehabilitator shall carry out the plan. A plan for a life insurer may propose imposition of a moratorium upon loan and cash surrender rights under policies, for a period not to exceed one year from the entry of the rehabilitation order approving the rehabilitation plan, unless the receivership court, for good cause shown, extends the moratorium.

(b) Once a plan has been filed, any party in interest may object to the plan.

(c) A plan must:

(1) except as provided by Subsection (e), provide no less favorable treatment of a claim or class of claims than would occur in liquidation, unless the holder of a particular claim or interest agrees to a less favorable treatment of that particular claim or interest;

(2) provide adequate means for the plan's implementation;

(3) contain information concerning the financial condition of the insurer and the operation and effect of the plan, as far as is reasonably practicable in light of the nature and history of the insurer, the condition of the insurer's books and records, and the nature of the plan; and

(4) provide for the disposition of the books, records, documents, and other information relevant to the duties and obligations covered by the plan.

(d) A plan may include any other provision not inconsistent with the provisions of this chapter, including:

(1) payment of distributions;

(2) assumption or reinsurance of all or a portion of the insurer's remaining liabilities by, and transfer of assets and related books and records to, an authorized insurer or other entity;

(3) to the extent appropriate, application of insurance

company regulatory market conduct standards to any entity administering claims on behalf of the receiver or assuming direct liabilities of the insurer;

(4) contracting with a state guaranty association or any other qualified entity to perform the administration of claims;

(5) annual independent financial and performance audits of any entity administering claims on behalf of the receiver that is not otherwise subject to examination pursuant to state insurance law; and

(6) termination of the insurer's liabilities other than those under policies of insurance as of a date certain.

(e) A plan may designate and separately treat one or more separate subclasses of claims consisting only of claims within the subclasses that are for or reduced to de minimis amounts. For purposes of this subsection, a "de minimis amount" means any amount equal to or less than a maximum de minimis amount approved by the receivership court as being reasonable and necessary for administrative convenience.

Added by Acts 2005, 79th Leg., Ch. 995 (H.B. [2157](#)), Sec. 1, eff. September 1, 2005.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.103 by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 3B.004(a)(1), eff. September 1, 2007.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.103 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. [3167](#)), Sec. 9.004(a)(1), eff. September 1, 2007.

Sec. 443.104. TERMINATION OF REHABILITATION. (a) When the rehabilitator believes further attempts to rehabilitate an insurer would substantially increase the risk of loss to creditors, policyholders, or the public or would be futile, the rehabilitator may move for an order of liquidation. In accordance with Section 443.105, the rehabilitator or the rehabilitator's designated representative shall coordinate with the guaranty associations that may become liable as a result of the liquidation and any national association of guaranty associations to plan for transition to liquidation.

(b) Because the protection of the interests of insureds, claimants, and the public requires the timely performance of all

insurance policy obligations, if the payment of policy obligations is suspended in substantial part for a period of six months at any time after the appointment of the rehabilitator and the rehabilitator has not filed an application for approval of a plan under Section 443.103, the rehabilitator shall petition the receivership court for an order of liquidation.

(c) The rehabilitator or the directors of the insurer may at any time petition the receivership court for, or the receivership court on its own motion may enter, an order terminating rehabilitation of an insurer. Subject to the provisions of Section 443.351, if the receivership court finds that rehabilitation has been accomplished and that grounds for rehabilitation under Section 443.057 no longer exist, it shall order that the insurer be restored to title and possession of its property and the control of the business.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(o), eff. September 1, 2007.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.104 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(a)(1), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(o), eff. September 1, 2007.

Sec. 443.105. COORDINATION WITH GUARANTY ASSOCIATIONS. (a) The receiver shall notify any potentially obligated guaranty association or the guaranty association's representative concerning the entry of a rehabilitation order and shall update the guaranty association or its representative regarding significant developments that impact efforts to rehabilitate the insurer. On a determination by the rehabilitator that rehabilitation efforts may not be successful, the rehabilitator shall participate in cooperative efforts with the potentially obligated guaranty associations. To facilitate an orderly transition to liquidation, the rehabilitator shall make available to the guaranty associations the information necessary to discharge their responsibilities upon becoming statutorily obligated. To the extent that information is available,

or as it becomes available, the rehabilitator shall provide appropriate information to guaranty associations in the states in which the insurer transacted business.

(b) For the purposes of Subsection (a), "appropriate information" may include the following for lines of business written by the insurer, whether covered or not covered by guaranty associations:

- (1) a general description of the different types of business written or assumed by the insurer;
- (2) claim counts and policy counts by state and by line of business;
- (3) claim and policy reserves;
- (4) account values and cash surrender values;
- (5) policy loans;
- (6) interest crediting history;
- (7) premiums and mode of payment;
- (8) unpaid claims and amounts;
- (9) sample policies and endorsements;
- (10) a listing of different locations of claim files;
- (11) if third-party administrators were used, copies of executed contracts and a description of the contractual arrangements; and
- (12) information concerning claims in litigation or dispute, including a listing of claims with assigned defense counsel for those claims going to trial in the near future after a possible liquidation date.

(c) For the purposes of Subsection (a), "appropriate information" also includes information concerning states in which the insurer is or was licensed and periods for which the insurer is or was licensed and other information reasonably requested by a guaranty association necessary for the guaranty association to fulfill its statutory duties.

(d) In the case of a property and casualty insurer, the rehabilitator, in cooperation with the guaranty associations, shall make all reasonable efforts to prepare the insurer's electronic policy and claims data so that, upon the entry of an order of liquidation, the data will be ready for transmission using the Uniform Data Standards as promulgated by the National Association of Insurance Commissioners.

(e) The list of what appropriate information includes under

Subsections (b) and (c) is not necessarily an exclusive list. Other information may be necessary to ensure that an orderly transition to liquidation occurs, and that information may be appropriately provided by the receiver.

Added by Acts 2005, 79th Leg., Ch. 995 (H.B. 2157), Sec. 1, eff. September 1, 2005.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.105 by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(a)(1), eff. September 1, 2007.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.105 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(a)(1), eff. September 1, 2007.

SUBCHAPTER D. LIQUIDATION

Sec. 443.151. LIQUIDATION ORDERS. (a) An order to liquidate the business of an insurer shall appoint the commissioner and any successor in office as the liquidator and shall direct the liquidator to take possession of the property of the insurer and to administer it subject to this chapter. The liquidator is entitled to request the receivership court to appoint a single judge to supervise the liquidation and to hear any cases or controversies arising out of or related to the liquidation. Liquidation proceedings are exempt from any dormancy or similar program maintained by the receivership court for the early closure of civil actions. As of the entry of the final order of liquidation, the liquidator is vested by operation of law with the title to all of the property, contracts, rights of action, and books and records of the insurer ordered liquidated, wherever located. The filing or recording of the order with the clerk of the court and the recorder of deeds of the county in which the insurer's principal office or place of business is located or, in the case of real estate, the county where the property is located, imparts the same notice as a deed, bill of sale, or other evidence of title filed or recorded with that recorder of deeds would impart.

(b) Upon issuance of the order of liquidation, the rights and liabilities of the insurer and of its creditors, policyholders, shareholders, members, and all other persons interested in its estate become fixed as of the date of entry of the order of liquidation, except as provided by Sections 443.152 and 443.255, unless otherwise

fixed by the court.

(c) An order to liquidate the business of an alien insurer in this state must be in the same terms and has the same legal effect as an order to liquidate a domestic insurer.

(d) At the time of petitioning for an order of liquidation, or at any time after petitioning, the commissioner may petition the receivership court for a judicial declaration of insolvency. After providing the notice and hearing as it deems proper, the receivership court may make the declaration of insolvency.

(e) In the event an order of liquidation is set aside on appeal, the company may not be released from delinquency proceedings except in accordance with Section 443.351.

Added by Acts 2005, 79th Leg., Ch. 995 (H.B. 2157), Sec. 1, eff. September 1, 2005.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.151 by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(a)(1), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(p), eff. September 1, 2007.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.151 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(a)(1), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(p), eff. September 1, 2007.

Sec. 443.152. CONTINUANCE OF COVERAGE. (a) Notwithstanding any policy or contract language or any other statute, all reinsurance contracts by which the insurer has assumed the insurance obligations of another insurer are canceled upon entry of an order of liquidation.

(b) Notwithstanding any policy or contract language or any other statute, all policies, insurance contracts other than reinsurance by which the insurer has ceded insurance obligations to another person, and surety bonds or surety undertakings, other than life or health insurance or annuities, in effect at the time of issuance of an order of liquidation, unless further extended by the

receiver with the approval of the receivership court, continue in force only until the earlier of:

(1) the 30th day after the date of entry of the liquidation order;

(2) the date of expiration of the policy coverage;

(3) the date the insured has replaced the insurance coverage with equivalent insurance with another insurer or otherwise terminated the policy;

(4) the date the liquidator has effected a transfer of the policy obligation pursuant to Section 443.154(h); or

(5) the date proposed by the liquidator and approved by the receivership court to cancel coverage.

(c) An order of liquidation under Section 443.151 must terminate coverages at the time specified by Subsections (a) and (b) for purposes of any other statute.

(d) Policies of life or health insurance or annuities covered by a guaranty association and any portion of policies of life or health insurance or annuities covered by a guaranty association continue in force for the period and under the terms provided for by any applicable guaranty association law. Policies of life or health insurance or annuities not covered by a guaranty association and any portion of policies of life or health insurance or annuities not covered by a guaranty association terminate under Subsection (b), except to the extent the liquidator proposes and the receivership court approves the use of property of the estate, consistent with Section 443.301, for the purpose of continuing the contracts or coverage by transferring them to an assuming reinsurer.

(e) The cancellation of any bond or surety undertaking does not release any cosurety or guarantor.

(f) The obligations of the insolvent insurer's reinsurers are not released or discharged by a cancellation under this section.

Added by Acts 2005, 79th Leg., Ch. 995 (H.B. [2157](#)), Sec. 1, eff. September 1, 2005.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.152 by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 3B.004(a)(1), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 3B.004(q), eff. September 1, 2007.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.152 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(a)(1), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(q), eff. September 1, 2007.

Sec. 443.153. SALE OR DISSOLUTION OF INSURER'S CORPORATE ENTITY. (a) Notwithstanding the entry of a liquidation order, the liquidator may apply for an order to sell or dissolve the corporate entity or charter of a domestic insurer or the United States branch of an alien insurer domiciled in this state at any time after an order of liquidation of the insurer has been granted, consistent with the provisions of this section.

(b) Upon an application to sell the corporate entity or charter, with notice as prescribed in this chapter, the receivership court may enter an order:

(1) separating the corporate entity or charter, together with any of its licenses to do business and the assets the liquidator deems appropriate to the transaction, from the remaining estate in liquidation and all of the remaining estate's assets and the claims or interests of all claimants, creditors, policyholders, and stockholders;

(2) canceling all outstanding stock and other securities of and other equity interests in the corporate entity or charter, provided that the cancellation may not affect any claim against the estate by a holder of an equity interest;

(3) authorizing the issuance and sale of new stock or other securities for the purpose of transferring to one or more buyers control and ownership of the corporate entity or charter; and

(4) authorizing the sale of the corporate entity or charter, together with any of its authorizations or licenses to do business and the general assets of the estate the liquidator deems to be appropriate to the transaction, free and clear from the claims or interest of all claimants, creditors, policyholders, and stockholders.

(c) The sale of the corporate entity or charter may be made in the manner and on the terms and conditions applied for by the liquidator and ordered by the receivership court. Any sale is

subject to the domiciliary state's laws regarding acquisition of an insurer, Chapter 823, and any other law regarding the transfer of control of insurers. The proceeds from the sale of the corporate entity or charter become a part of the property of the estate in liquidation. The separate corporate entity or charter, together with any of its authorizations or licenses to do business and such assets as the liquidator deems appropriate to the transaction, are, following the sale of the corporate entity or charter, free and clear from the claims or interest of all claimants, creditors, policyholders, and stockholders of the corporation in liquidation.

(d) This section shall be liberally construed to accomplish its purposes to:

(1) provide an expeditious and effective procedure to realize the maximum proceeds possible from the sale of a corporate entity or charter separated from an estate in liquidation; and

(2) ensure that the purchasers receive clear and marketable titles.

(e) If permission to sell the corporate entity or charter is not granted prior to discharge of the liquidator, in accordance with this section or otherwise with receivership court approval:

(1) the receivership court may order dissolution of the corporate entity or charter;

(2) dissolution shall be deemed complete by operation of law upon the discharge of the liquidator if the insurer is insolvent; or

(3) dissolution may be ordered by the receivership court upon the discharge of the liquidator if the insurer is under a liquidation order for some other reason.

Added by Acts 2005, 79th Leg., Ch. 995 (H.B. [2157](#)), Sec. 1, eff. September 1, 2005.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.153 by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 3B.004(a)(1), eff. September 1, 2007.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.153 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. [3167](#)), Sec. 9.004(a)(1), eff. September 1, 2007.

Sec. 443.154. POWERS OF LIQUIDATOR. (a) The liquidator may

appoint a special deputy or deputies to act for the liquidator under this chapter and employ or contract with legal counsel, actuaries, accountants, appraisers, consultants, clerks, assistants, and other personnel the liquidator may deem necessary to assist in the liquidation. A special deputy has all powers of the liquidator granted by this section, unless specifically limited by the liquidator, and serves at the pleasure of the liquidator. A special deputy or any other person with whom the liquidator contracts under this subsection may act on behalf of the commissioner only in the commissioner's capacity as liquidator. Any person with whom the liquidator contracts is not considered to be an agent of the state and any contract under this subsection is not a contract with the state. The provisions of any law governing the procurement of goods and services by the state do not apply to any contract entered into by the commissioner as liquidator. This subsection does not waive any immunity granted by Section 443.014 or create any cause of action against the state.

(b) The liquidator may determine the reasonable compensation for any special deputies, employees, or contractors retained by the liquidator as provided in Subsection (a) and pay compensation in accordance with Section 443.015.

(c) The liquidator may appoint, with the approval of the receivership court, an advisory committee of policyholders, claimants, or other creditors, including guaranty associations, if the committee be deemed necessary. The advisory committee serves at the pleasure of the liquidator, and the decision to appoint an advisory committee is at the sole discretion of the liquidator. The advisory committee serves without compensation or reimbursement for expenses. The liquidator or the receivership court in liquidation proceedings conducted under this chapter may not appoint another committee of any nature.

(d) The liquidator may hold hearings, subpoena witnesses to compel their attendance, administer oaths, examine any person under oath, compel any persons to subscribe to their testimony after it has been correctly reduced to writing, and, in connection with a power under this subsection, require the production of any books, papers, records, or other documents that the liquidator deems relevant to the inquiry.

(e) The liquidator may audit the books and records of all agents of the insurer to the extent that those books and records

relate to the business activities of the insurer.

(f) The liquidator may collect all debts and moneys due and claims belonging to the insurer, wherever located, and may:

(1) institute action in other jurisdictions, in order to forestall garnishment and attachment proceedings against the debts;

(2) do other acts as necessary or expedient to collect, conserve, or protect the insurer's property, including the power to sell, compromise, or assign debts for purposes of collection upon such terms and conditions as the liquidator deems consistent with this chapter; and

(3) pursue any creditor's remedies available to enforce the insurer's claims.

(g) The liquidator may conduct public and private sales of the property of the insurer.

(h) The liquidator may use property of the estate of an insurer under a liquidation order to transfer to a solvent assuming insurer policy obligations or the insurer's obligations under surety bonds and surety undertakings as well as collateral held by the insurer with respect to the reimbursement obligations of the principals under those surety bonds and surety undertakings, if the transfer can be arranged without prejudice to applicable priorities under Section 443.301. If all insureds, principals, third-party claimants, and obligees under the policies, surety bonds, and surety undertakings consent or if the receivership court so orders, the estate has no further liability under the transferred policies, surety bonds, or surety undertakings after the transfer is made.

(i) The liquidator may, subject to Subsection (y), acquire, hypothecate, encumber, lease, improve, sell, transfer, abandon, or otherwise dispose of or deal with any property of the estate at its market value or upon terms and conditions that are fair and reasonable. The liquidator also has the power to execute, acknowledge, and deliver any and all deeds, assignments, releases, and other instruments necessary or proper to effectuate any sale of property or other transaction in connection with the liquidation.

(j) The liquidator may borrow money on the security of the property of the estate or without security and execute and deliver all documents necessary to that transaction for the purpose of facilitating the liquidation. Any funds borrowed under this subsection may be repaid as an administrative expense and have priority over any other claims in Class 1 under the priority of

distribution.

(k) The liquidator may enter into contracts as necessary to carry out the order to liquidate and, subject to the provisions of Section 443.013, may assume or reject any executory contract or unexpired lease to which the insurer is a party.

(l) The liquidator may continue to prosecute and institute in the name of the insurer or in the liquidator's own name any and all suits and other legal proceedings, in this state or elsewhere, and abandon the prosecution of claims the liquidator deems unprofitable to pursue further. If the insurer is dissolved under Section 443.153, the liquidator has the power to apply to any court in this state or elsewhere for leave to substitute the liquidator for the insurer as a party.

(m) The liquidator may prosecute any action that may exist on behalf of the creditors, members, policyholders, shareholders of the insurer, or the public against any person, except to the extent that a claim is personal to a specific creditor, member, policyholder, or shareholder and recovery on such claim would not inure to the benefit of the estate. This subsection does not infringe or impair any of the rights provided to a guaranty association pursuant to its enabling statute or otherwise.

(n) The liquidator may take possession of the records and property of the insurer as may be convenient for the purposes of efficient and orderly execution of the liquidation. Guaranty associations must be allowed reasonable access to the records of the insurer as is necessary for the guaranty associations to carry out their statutory obligations.

(o) The liquidator may deposit in one or more banks in this state the amounts that are required for meeting current administration expenses and dividend distributions.

(p) The liquidator may invest all amounts not currently needed, unless the receivership court orders otherwise.

(q) The liquidator may file any necessary documents for record in the office of any recorder of deeds or record office in this state or elsewhere where property of the insurer is located.

(r) The liquidator may assert all defenses available to the insurer as against third persons, including statutes of limitation, statutes of frauds, and the defense of usury. A waiver of any defense by the insurer after a petition is filed under this chapter does not bind the liquidator. When a guaranty association has an

obligation to defend any suit, the liquidator shall defer to the association's obligation.

(s) The liquidator may exercise and enforce all the rights, remedies, and powers of any creditor, shareholder, policyholder, or member, including any power to avoid any transfer or lien that may be avoidable under this chapter or otherwise.

(t) The liquidator may intervene in any proceeding wherever instituted that might lead to the appointment of a receiver or trustee and act as the receiver or trustee whenever the appointment is offered.

(u) The liquidator may enter into agreements with any receivers or commissioners of any other states.

(v) The liquidator may exercise all powers held by receivers on August 31, 2005, or conferred on receivers after that date by the laws of this state not inconsistent with this chapter.

(w) The liquidator is vested with all the rights of the entity or entities in receivership.

(x) The enumeration, in this section, of the powers and authority of the liquidator may not be construed as a limitation upon the liquidator, nor may it exclude in any manner the right to do other acts not specifically enumerated or otherwise provided for, to the extent necessary or appropriate for the accomplishment of or in aid of the purpose of liquidation.

(y) The liquidator may hypothecate, encumber, lease, sell, transfer, abandon, or otherwise dispose of or deal with any property of the insurer, settle or resolve any claim brought by the liquidator on behalf of the insurer, or commute or settle any claim of reinsurance under any contract of reinsurance, as follows:

(1) if the property or claim has a market or settlement value that does not exceed the lesser of \$1 million or 10 percent of the general assets of the estate as shown on the receivership's financial statements, the liquidator may take action at the liquidator's discretion, provided that the receivership court may, upon petition of the liquidator, increase the threshold upon a showing that compliance with this requirement is burdensome to the liquidator in administering the estate and is unnecessary to protect the material interests of creditors;

(2) in all instances other than those described in Subdivision (1), the liquidator may take the action only after obtaining approval of the receivership court as provided by Section

443.007;

(3) the liquidator may, at the liquidator's discretion, request the receivership court to approve a proposed action as provided by Section 443.007 if the value of the property or claim appears to be less than the threshold provided by Subdivision (1) but cannot be ascertained with certainty, or for any other reason as determined by the liquidator; and

(4) after obtaining approval of the receivership court as provided in Section 443.007, the liquidator may, subject to Subsection (z), transfer rights to payment under ceding reinsurance agreements covering policies to a third-party transferee.

(z) The transferee of a right to payment under Subsection (y)(4) has the rights to collect and enforce collection of the reinsurance for the amount payable to the ceding insurer or to its receiver, without diminution because of the insolvency or because the receiver has failed to pay all or a portion of the claim, based on the amounts paid or allowed pursuant to Section 443.211. The transfer of the rights does not give rise to any defense regarding the reinsurer's obligations under the reinsurance agreement regardless of whether an agreement or other applicable law prohibits the transfer of rights under the reinsurance agreement. Except as provided in this subsection, any transfer of rights pursuant to Subsection (y)(4) does not impair any rights or defenses of the reinsurer that existed prior to the transfer or that would have existed in the absence of the transfer. Except as otherwise provided in this subsection, any transfer of rights pursuant to Subsection (y)(4) does not relieve the transferee or the liquidator from obligations owed to the reinsurer pursuant to the reinsurance or other agreement.

(aa) The liquidator is not obligated to defend any action against the insurer or insured. Any insureds not defended by a guaranty association may provide their own defense, and include the cost of the defense as part of their claims, if the defense was an obligation of the insurer. The right of the liquidator to contest coverage on a particular claim is preserved without the necessity for an express reservation of rights.

Added by Acts 2005, 79th Leg., Ch. 995 (H.B. [2157](#)), Sec. 1, eff. September 1, 2005.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.154 by

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(a)(1), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(r), eff. September 1, 2007.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.154 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(a)(1), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(r), eff. September 1, 2007.

Acts 2011, 82nd Leg., R.S., Ch. 193 (S.B. 1433), Sec. 7, eff. September 1, 2011.

Sec. 443.155. NOTICE TO CREDITORS AND OTHERS. (a) Unless the receivership court otherwise directs, the liquidator shall give or cause to be given notice of the liquidation order as soon as possible:

(1) by first class mail or electronic communication as permitted by the receivership court to:

(A) any guaranty association that is or may become obligated as a result of the liquidation and any national association of guaranty associations;

(B) all the insurer's agents, brokers, or producers of record with current appointments or current licenses to represent the insurer and all other agents, brokers, or producers as the liquidator deems appropriate at their last known address; and

(C) all persons or entities known or reasonably expected to have claims against the insurer, at their last known address as indicated by the records of the insurer, and all state and federal agencies with an interest in the proceeding; and

(2) by publication in a newspaper of general circulation in the county in which the insurer has its principal place of business and in any other locations as the liquidator deems appropriate.

(b) The notice of the entry of an order of liquidation must contain or provide directions for obtaining the following information:

(1) a statement that the insurer has been placed in liquidation;

(2) a statement that certain acts are stayed under Section 443.008 and describe any additional injunctive relief ordered by the receivership court;

(3) a statement whether, and to what extent, the insurer's policies continue in effect;

(4) to the extent applicable, a statement that coverage by state guaranty associations may be available for all or part of policy benefits in accordance with applicable state guaranty laws;

(5) a statement of the deadline for filing claims, if established, and the requirements for filing a proof of claim pursuant to Section 443.251 on or before that date;

(6) a statement of the date, time, and location of any initial status hearing scheduled at the time the notice is sent;

(7) a description of the process for obtaining notice of matters before the receivership court; and

(8) any other information the liquidator or the receivership court deems appropriate.

(c) If notice is given in accordance with this section, the distribution of property of the insurer under this chapter is conclusive with respect to all claimants, whether or not they received notice.

(d) Notwithstanding the other provisions of this section, the liquidator has no duty to locate any persons or entities if no address is found in the records of the insurer or if mailings are returned to the liquidator because of inability to deliver at the address shown in the insurer's books and records. In these circumstances the notice by publication as required by this chapter or actual notice received is sufficient notice. Written certification by the liquidator or other knowledgeable person acting for the liquidator that the notices were deposited in the United States mail, postage prepaid, or that the notices have been electronically transmitted is prima facie evidence of mailing and receipt. All claimants shall keep the liquidator informed of any changes of address.

(e) Notwithstanding Subsection (a)(1)(C), upon application of the liquidator, the receivership court may:

(1) find that notice by publication as required in this section is sufficient notice to those persons holding an occurrence policy that expired more than four years prior to the entry of the order of liquidation and under which there are no pending claims; or

(2) order other notice to persons described by Subdivision (1) as it deems appropriate.

(f) The liquidator shall notify the Texas Workers' Compensation Commission upon the entry of the liquidation order if the insurer has issued workers' compensation coverage in effect in this state. Upon request of the liquidator, the Texas Workers' Compensation Commission shall submit a list of active cases pending before the commission that relate to workers' compensation coverage issued by the insurer.

Added by Acts 2005, 79th Leg., Ch. 995 (H.B. 2157), Sec. 1, eff. September 1, 2005.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.155 by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(a)(1), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(s), eff. September 1, 2007.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.155 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(a)(1), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(s), eff. September 1, 2007.

Sec. 443.156. DUTIES OF AGENTS. (a) Every person who represented the insurer as an agent and receives notice in the form prescribed in Section 443.155 that the insurer is the subject of a liquidation order, not later than the 30th day after the date of the notice, shall provide to the liquidator, in addition to the information the agent may be required to provide pursuant to Section 443.010, the information in the agent's records related to any policy issued by the insurer through the agent and any policy issued by the insurer through an agent under contract to the agent. For purposes of this subsection, a policy is issued through an agent if the agent has a property interest in the expiration of the policy or if the agent has had in the agent's possession a copy of the declarations of the policy at any time during the life of the policy, except where the ownership of the expiration of the policy has been transferred to another.

(b) Any agent failing to provide information to the liquidator as required in Subsection (a) may be subject to payment of an administrative penalty under Chapter 84 of not more than \$1,000. In addition, the agent's license may be suspended under Chapter 4005.

Added by Acts 2005, 79th Leg., Ch. 995 (H.B. 2157), Sec. 1, eff. September 1, 2005.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.156 by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(a)(1), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(t), eff. September 1, 2007.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.156 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(a)(1), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(t), eff. September 1, 2007.

Acts 2021, 87th Leg., R.S., Ch. 355 (H.B. 4030), Sec. 1, eff. September 1, 2021.

SUBCHAPTER E. ASSET RECOVERY

Sec. 443.201. TURNOVER OF ASSETS. (a) If the receiver determines that funds or property in the possession of another person are rightfully the property of the estate, the receiver shall deliver to the person a written demand for immediate delivery of the funds or property, referencing this section by number and the court and docket number of the receivership action, and notifying the person that any claim of right to the funds or property by the person must be presented to the receivership court not later than the 20th day after the date of the written demand. Any person who holds funds or other property belonging to an entity subject to an order of receivership under this chapter shall deliver the funds or other property to the receiver on demand. Should the person allege any right to retain the funds or other property, the person, not later than the 20th day after the date of receipt of the demand that the funds or property be delivered to the receiver, shall file with the receivership court a pleading setting out that right. The person shall serve a copy of

the pleading on the receiver. The pleading must inform the receivership court as to the nature of the claim to the funds or property, the alleged value of the property or amount of funds held, and what action, pending determination of the dispute, has been taken by the person to preserve and protect the property or to preserve any funds. The relinquishment of possession of funds or property by any person who has received a demand pursuant to this section does not constitute a waiver of a right to make a claim in the receivership.

(b) If requested by the receiver, the receivership court shall hold a hearing to determine where and under what conditions the person shall hold the property or funds pending determination of the dispute. The receivership court may impose conditions as it may deem necessary or appropriate for the preservation of the property or funds until the receivership court can determine the validity of the person's claim to the property or funds. If any property or funds are allowed to remain in the possession of the person after demand made by the receiver, that person is strictly liable to the estate for any waste, loss, or damage to or diminution of value of the property or funds retained.

(c) If a person has filed a pleading alleging any right to retain funds or property as provided by Subsection (a), the receivership court shall hold a subsequent hearing to determine the entitlement of the person to the funds or property claimed by the receiver.

(d) If a person fails to deliver the funds or property or to file the pleading described by Subsection (a) within the period described by Subsection (a), the receivership court may, upon petition of the receiver and upon a copy of the petition being served by the receiver to that person, issue its summary order directing the immediate delivery of the funds or property to the receiver and finding that the person has waived all claims of right to the funds or property.

Added by Acts 2005, 79th Leg., Ch. 995 (H.B. [2157](#)), Sec. 1, eff. September 1, 2005.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.201 by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 3B.004(a)(1), eff. September 1, 2007.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.201 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. [3167](#)), Sec. 9.004(a)(1),

eff. September 1, 2007.

Sec. 443.202. RECOVERY FROM AFFILIATES. (a) The receiver has a right to recover from any affiliate of the insurer any property of the insurer transferred to or for the benefit of the affiliate, or the property's value, if the transfer was made within the two years preceding the initial petition for receivership.

(b) A transfer is not recoverable under Subsection (a) if the affiliate shows that, when the transfer was made:

(1) the insurer was solvent;

(2) the transfer was lawful; and

(3) neither the insurer nor the affiliate knew or reasonably should have known that the transfer, under then-applicable statutory accounting standards, would:

(A) place the insurer:

(i) in violation of applicable capital or surplus requirements;

(ii) below the applicable minimum risk-based capital level; or

(iii) in violation of writing ratios under Article 1.32 or analogous requirements under Section 843.406; or

(B) cause the insurer's filed financial statements not to present fairly the capital and surplus of the insurer.

Added by Acts 2005, 79th Leg., Ch. 995 (H.B. [2157](#)), Sec. 1, eff. September 1, 2005.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.202 by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 3B.004(a)(1), eff. September 1, 2007.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.202 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. [3167](#)), Sec. 9.004(a)(1), eff. September 1, 2007.

Sec. 443.203. UNAUTHORIZED POST-PETITION TRANSFERS. (a) Except as provided by this section, the receiver may avoid any transfer of an interest of the insurer in property or any obligation incurred by the insurer that:

(1) was made or occurred after the petition for

receivership was filed; and

(2) is not authorized by the receiver and approved by the receivership court or otherwise authorized in accordance with this chapter.

(b) Except to the extent that a transfer or obligation avoidable under Subsection (a) is otherwise voidable under this chapter, a transferee or obligee of a transfer or obligation avoided under Subsection (a) that takes for value and in good faith, at the option of the receivership court, has a lien or may retain any interest transferred or enforce any obligation incurred, as applicable, to the extent that the transferee or obligee gave value to the insurer in exchange for the transfer or obligation.

Added by Acts 2005, 79th Leg., Ch. 995 (H.B. 2157), Sec. 1, eff. September 1, 2005.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.203 by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(a)(1), eff. September 1, 2007.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.203 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(a)(1), eff. September 1, 2007.

Sec. 443.204. VOIDABLE PREFERENCES AND LIENS. (a) A "preference" is a transfer of any interest in property of an insurer that:

(1) is made to or for the benefit of a creditor and for or on account of an antecedent debt and is made or suffered by the insurer within two years preceding the filing of a successful petition commencing delinquency proceedings; and

(2) enables the creditor to receive more than the creditor would receive if the insurer were liquidated under this chapter, the transfer had not been made, and the creditor was entitled to receive payment of the debt to the extent provided by this chapter.

(b) Any preference may be avoided by the receiver if:

(1) the insurer was insolvent at the time of the transfer;

(2) the transfer was made within 120 days before the date of filing of the petition commencing delinquency proceedings;

(3) the creditor receiving the transfer or to be benefited by the transfer, or the creditor's agent acting with reference to the

transfer, had, at the time the transfer was made, reasonable cause to believe that the insurer was insolvent or was about to become insolvent; or

(4) the creditor receiving the transfer was:

(A) an officer or director of the insurer;

(B) an employee, attorney, or other person who was in fact in a position to effect a level of control or influence over the actions of the insurer comparable to that of an officer or director, without regard to whether the person held that position; or

(C) an affiliate.

(c) The receiver may not avoid a transfer under this section:

(1) to the extent that the transfer was:

(A) intended by the insurer and the creditor to or for whose benefit the transfer was made to be a contemporaneous exchange for new value given to the insurer and in fact was a substantially contemporaneous exchange; or

(B) made in the ordinary course of business or financial affairs between the insurer and the transferee and made according to ordinary business terms in payment of a debt incurred by the insurer in the ordinary course of business or financial affairs of the insurer and the transferee; or

(2) to or for the benefit of a creditor, to the extent that, after the transfer, the creditor gave new value to or for the benefit of the insurer that was:

(A) not secured by an otherwise unavoidable security interest; and

(B) on account of which new value the insurer did not make an otherwise unavoidable transfer to or for the benefit of the creditor.

(d) For purposes of this section:

(1) a transfer of property other than real property is deemed to be made or suffered at the time the transfer becomes so far perfected that any subsequent lien obtainable by legal or equitable proceedings on a simple contract could not become superior to the rights of the transferee;

(2) a transfer of real property is deemed to be made or suffered when the transfer is so far perfected that a subsequent bona fide purchaser from the insurer could not obtain rights superior to the rights of the transferee;

(3) a transfer that creates an equitable lien is not deemed

to be perfected if there are available means by which a legal lien could be created; and

(4) a transfer not perfected prior to the filing of a petition for receivership is deemed to be made immediately before the filing commencing delinquency proceedings.

(e) The provisions of this section apply without regard to whether there are or were creditors who might have obtained liens or persons who might have become bona fide purchasers.

(f) Within the meaning of Subsection (d), "a lien obtainable by legal or equitable proceedings on a simple contract" is a lien arising in the ordinary course of proceedings upon the entry or docketing of a judgment or decree, or upon attachment, garnishment, execution, or similar process, whether before, upon, or after judgment or decree and whether before or upon levy. The term does not include liens that under applicable law are given a special priority over other liens that are prior in time.

(g) Within the meaning of Subsection (d), a lien obtainable by legal or equitable proceedings could become superior to the rights of a transferee, or a purchaser could obtain rights superior to the rights of a transferee if the consequences would follow only from the lien or purchase itself, or from the lien or purchase followed by any step wholly within the control of the respective lienholder or purchaser, with or without the aid of ministerial action by public officials. A lien could not, however, become superior and a purchase could not create superior rights for the purpose of Subsection (d) through any acts subsequent to the obtaining of the lien or subsequent to the purchase that require the agreement or concurrence of any third party or that require any further judicial action or ruling.

(h) A transfer of property for or on account of a new and contemporaneous consideration that is deemed under Subsection (d) to be made or suffered after the transfer because of delay in perfecting the transfer does not become a transfer for or on account of an antecedent debt if any acts required by the applicable law to be performed to perfect the transfer against liens or bona fide purchasers' rights are performed within 21 days or any period expressly allowed by the law, whichever is less. A transfer to secure a future loan, if the loan is actually made, or a transfer that becomes security for a future loan, has the same effect as a transfer for or on account of a new and contemporaneous

consideration.

(i)(1) If any lien deemed voidable under Subsection (b) has been dissolved by the furnishing of a bond or other obligation, the surety on which has been indemnified directly or indirectly by the transfer of or the creation of a lien upon any property of an insurer before the filing of a petition commencing delinquency proceedings under this chapter, the indemnifying transfer or lien is also deemed voidable.

(2) The property affected by any lien deemed voidable under Subsection (b) and Subdivision (1) is discharged from the lien, and that property and any of the indemnifying property transferred to or for the benefit of a surety passes to the receiver, except that the receivership court may on due notice order any lien deemed voidable under this section to be preserved for the benefit of the estate and may direct that a conveyance be executed as may be proper or adequate to evidence the title of the receiver.

(3) Reasonable notice of any hearing in the proceeding shall be given to all parties as required by law, including the obligee of a releasing bond or other like obligation. If an order is entered for the recovery of indemnifying property in kind or for the avoidance of an indemnifying lien, the receivership court may in the same proceeding ascertain the value of the property or lien. If the value of the property or lien is less than the amount for which the property is indemnified or than the amount of the lien, the transferee or lienholder may elect to retain the property or lien upon payment to the receiver of its value, as determined by the receivership court, within a reasonable time determined by the receivership court.

(4) The liability of the surety under a releasing bond or other similar obligation shall be discharged to the extent of the value of the indemnifying property recovered or the indemnifying lien nullified and avoided by the receiver, or if the property is retained under Subdivision (3) to the extent of the amount paid to the receiver.

(j) This section may not be construed to prejudice any other claim by the receiver against any person.

Added by Acts 2005, 79th Leg., Ch. 995 (H.B. [2157](#)), Sec. 1, eff. September 1, 2005.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.204 by

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(a)(1), eff. September 1, 2007.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.204 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(a)(1), eff. September 1, 2007.

Sec. 443.205. FRAUDULENT TRANSFERS AND OBLIGATIONS. (a) The receiver may avoid any transfer of an interest of the insurer in property, any reinsurance transaction, or any obligation incurred by an insurer that was made or incurred on or within two years before the date of the initial filing of a petition commencing delinquency proceedings under this chapter, if the insurer voluntarily or involuntarily:

(1) made the transfer or incurred the obligation with actual intent to hinder, delay, or defraud any person to which it was or became indebted on or after the date that the transfer was made or the obligation was incurred; or

(2) received less than a reasonably equivalent value in exchange for the transfer or obligation.

(b) Except to the extent that a transfer or obligation voidable under this section is voidable under other provisions of this chapter, a transferee or obligee that takes for value and in good faith a voidable transfer or obligation has a lien on or may retain any interest transferred or may enforce any obligation incurred, as the case may be, to the extent that the transferee or obligee gave value to the insurer in exchange for the transfer or obligation.

(c) For purposes of this section, a transfer is made when the transfer is so perfected that a subsequent bona fide purchaser from the insurer cannot acquire an interest in the property transferred that is superior to the interest in the property of the transferee, but if the transfer is not so perfected before the commencement of the delinquency proceeding, the transfer is deemed to have been made immediately before the date of the initial filing of the petition commencing delinquency proceedings.

(d) For purposes of this section, "value" means property or satisfaction or securing of a present or antecedent debt of the insurer.

Added by Acts 2005, 79th Leg., Ch. 995 (H.B. 2157), Sec. 1, eff.

September 1, 2005.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.205 by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(a)(1), eff. September 1, 2007.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.205 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(a)(1), eff. September 1, 2007.

Sec. 443.206. RECEIVER AS LIEN CREDITOR. (a) The receiver may avoid any transfer of or lien upon the property of, or obligation incurred by, an insurer that the insurer or a policyholder, creditor, member, or stockholder of the insurer may have avoided without regard to any knowledge of the receiver, the commissioner, the insurer, or any policyholder, creditor, member, or stockholder of the insurer regardless of whether such a policyholder, creditor, member, or stockholder exists.

(b) The receiver is deemed a creditor without knowledge for purposes of pursuing claims under the Uniform Fraudulent Transfer Act, the Uniform Fraudulent Conveyance Act, or similar provisions of state or federal law.

Added by Acts 2005, 79th Leg., Ch. 995 (H.B. 2157), Sec. 1, eff. September 1, 2005.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.206 by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(a)(1), eff. September 1, 2007.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.206 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(a)(1), eff. September 1, 2007.

Sec. 443.207. LIABILITY OF TRANSFEREE. (a) Except as otherwise provided in this section, to the extent that the receiver obtains an order under Section 443.201 or avoids a transfer under Section 443.202, 443.203, 443.204, 443.205, or 443.206, the receiver may recover the property transferred, or the value of the property, from:

(1) the initial transferee of the transfer or the entity for whose benefit the transfer was made; or

(2) any immediate or mediate transferee of the initial transferee.

(b) The receiver may not recover under Subsection (a)(2) from:

(1) a transferee that takes for value, including satisfaction or securing of a present or antecedent debt, in good faith, and without knowledge of the voidability of the transfer avoided; or

(2) any immediate or mediate good faith transferee of the transferee.

(c) Any transfer avoided in accordance with this chapter is preserved for the benefit of the receivership estate, but only with respect to property of the insurer.

(d) In addition to the remedies specifically provided under Sections 443.201-443.206 and Subsection (a), if the receiver is successful in establishing a claim to the property or any part of the property, the receiver is entitled to recover judgment for:

(1) rental for the use of the tangible property from the later of the entry of the receivership order or the date of the transfer;

(2) in the case of funds or intangible property, the greater of:

(A) the actual interest or income earned by the property; or

(B) interest at the statutory rate for judgments from the later of the date of the entry of the receivership order or the date of the transfer; and

(3) except as to recoveries from guaranty associations, all costs, including investigative costs and other expenses necessary to the recovery of the property or funds, and reasonable attorney's fees.

(e) In any action under this section, the receivership court may allow the receiver to seek recovery of the property involved or the property's value.

(f) In any action under Sections 443.201-443.206, the receiver has the burden of proving the avoidability of a transfer, and the person against whom recovery or avoidance is sought has the burden of proving the nature and extent of any affirmative defense.

Added by Acts 2005, 79th Leg., Ch. 995 (H.B. [2157](#)), Sec. 1, eff. September 1, 2005.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.207 by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(a)(1), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(u), eff. September 1, 2007.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.207 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(a)(1), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(u), eff. September 1, 2007.

Sec. 443.208. CLAIMS OF HOLDERS OF VOID OR VOIDABLE RIGHTS.

(a) A claim of a creditor who has received or acquired a preference, lien, conveyance, transfer, assignment, or encumbrance voidable under this chapter may not be allowed unless the creditor surrenders the preference, lien, conveyance, transfer, assignment, or encumbrance. If the avoidance is effected by a proceeding in which a final judgment has been entered, the claim may not be allowed unless the money is paid or the property is delivered to the receiver not later than the 30th day after the date of the entering of the final judgment, except that the receivership court may allow further time if there is an appeal or other continuation of the proceeding.

(b) A claim allowable under Subsection (a) by reason of the avoidance, whether voluntary or involuntary, or a preference, lien, conveyance, transfer, assignment, or encumbrance, may be filed as an excused late filing under Section 443.251(b) if filed not later than the 30th day after the date of the avoidance, or within the further time allowed by the receivership court under Subsection (a).

Added by Acts 2005, 79th Leg., Ch. 995 (H.B. 2157), Sec. 1, eff. September 1, 2005.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.208 by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(a)(1), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(v), eff. September 1, 2007.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.208 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(a)(1), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(v), eff. September 1, 2007.

Sec. 443.209. SETOFFS. (a) All mutual debts or mutual credits, whether arising out of one or more contracts between the insurer and another person in connection with any action or proceeding under this chapter, must be set off and only the balance shall be allowed or paid, except as provided by Subsection (b).

(b) A setoff may not be allowed in favor of any person if:

(1) the obligation of the insurer to the person:

(A) would not, at the date of the commencement of the delinquency proceeding, entitle the person to share as a claimant in the assets of the insurer; or

(B) was purchased by or transferred to the person:

(i) after the commencement of the delinquency proceeding; or

(ii) for the purpose of increasing setoff rights;

(2) the obligation of the insurer is owed to an affiliate of the person, or any other entity or association other than the person;

(3) the obligation of the person:

(A) is as a trustee or fiduciary; or

(B) is to pay:

(i) an assessment levied against the members of a mutual insurer, reciprocal or interinsurance exchange, or Lloyd's plan; or

(ii) a balance upon a subscription to the capital stock of a capital stock insurance company; or

(4) the obligations between the person and the insurer arise from reinsurance transactions in which either the person or the insurer has assumed risks and obligations from the other party and then has ceded back to that party substantially the same risks and obligations.

(c) The receiver shall provide an interested person with accounting statements identifying all debts that are due and payable.

If a person owes the insurer amounts that are due and payable against which the person asserts a setoff of mutual credits that, in the future, may become due and payable from the insurer, the person shall promptly pay the amounts due and payable to the receiver. Notwithstanding any other provision of this chapter, the receiver shall promptly and fully refund, to the extent of a person's prior payments under this section, any mutual credits that become due and payable to the person by the insurer.

Added by Acts 2005, 79th Leg., Ch. 995 (H.B. 2157), Sec. 1, eff. September 1, 2005.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.209 by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(a)(1), eff. September 1, 2007.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.209 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(a)(1), eff. September 1, 2007.

Sec. 443.210. ASSESSMENTS. (a) As soon as practicable, but not later than the fourth anniversary of the date of an order of receivership of an insurer issuing assessable policies, the receiver shall make a report to the receivership court setting forth:

- (1) the reasonable value of the assets of the insurer;
- (2) the insurer's probable total liabilities;
- (3) the probable aggregate amount of the assessment necessary to pay all claims of creditors and expenses in full, including expenses of administration and costs of collecting the assessment; and
- (4) a recommendation as to whether an assessment should be made and in what amount.

(b) Upon the basis of the report provided in Subsection (a), including any supplements and amendments to the report, the receivership court may approve, solely on application by the receiver, one or more assessments against all members of the insurer who are subject to assessment. The order approving the assessment shall provide instructions regarding notice of the assessment, deadlines for payment, and other instructions to the receiver regarding collection of the assessment.

(c) Subject to any applicable legal limits on ability to

assess, the aggregate assessment must be for the amount that the sum of the probable liabilities, the expenses of administration, and the estimated cost of collection of the assessment, exceeds the value of existing assets, with due regard being given to assessments that cannot be collected economically.

(d) After levy of assessment under Subsection (b), the receiver shall petition the receivership court for an order directing each member who has not paid the assessment pursuant to the levy to show cause why a judgment for the assessment should not be entered.

(e) At least 20 days before the return day of the order to show cause, the receiver shall give notice of the order to show cause to each member liable on the assessment. Notice must be given by first class mail mailed to the member's last known address as it appears on the insurer's records, by publication, or by another method of notification as directed by the receivership court. Failure of the member or subscriber to receive the notice of the assessment or of the order, within the time specified in the assessment or order or at all, is not a defense in a proceeding to collect the assessment.

(f) If a member does not appear and serve verified objections upon the receiver on or before the return day of the order to show cause under Subsection (d), the receivership court shall make an order adjudging the member liable for the amount of the assessment against the member under Subsection (d) together with costs, and the receiver shall have a judgment against the member for the amount of the assessment and costs in the order.

(g) If on or before the return day of the order to show cause, the member appears and serves verified objections upon the receiver, the receivership court may hear and determine the matter or may appoint a referee to hear it and make an order as the facts warrant. In the event that the receiver determines that the objections do not warrant relief from assessment, the member may request the receivership court to review the matter and vacate the order to show cause.

(h) The receiver may enforce any order or collect any judgment under Subsection (f) by any lawful means.

(i) Any assessment of a subscriber or member of an insurer made by the receiver pursuant to the order of receivership court fixing the aggregate amount of the assessment against all members or subscribers and approving the classification and formula made by the receiver under this section is prima facie correct.

(j) Any claim filed by an assessee who fails to pay an assessment, after the conclusion of any legal action by the assessee objecting to the assessment, is deemed a late filed claim under Section 443.251.

Added by Acts 2005, 79th Leg., Ch. 995 (H.B. 2157), Sec. 1, eff. September 1, 2005.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.210 by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(a)(1), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(w), eff. September 1, 2007.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.210 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(a)(1), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(w), eff. September 1, 2007.

Sec. 443.211. REINSURER'S LIABILITY. (a) If the receiver has claims under policies covered by reinsurance, the liability of the reinsurer to the receiver under the policies reinsured may not be diminished because of the insolvency of the insurer, regardless of any provisions in the reinsurance contract to the contrary, except under the following circumstances:

(1) a contract or other written agreement entered into before the delinquency proceeding that is otherwise permitted by law specifically provides another payee of the reinsurance in the event of the insolvency of the ceding insurer;

(2) the assuming insurer, under an assumption reinsurance agreement and with the consent of the direct insured, has assumed, as direct obligations of the assuming insurer, the policy obligations of the ceding insurer to the payees under policies and in substitution for the obligations of the ceding insurer to those payees; or

(3) a life and health insurance guaranty association has made the election to succeed to the rights and obligations of the insolvent insurer under a contract of reinsurance in accordance with the life and health guaranty association laws of this state or its

domiciliary state or another applicable law, rule, order, or assignment contract, in which case payments shall be made directly to or at the direction of the guaranty association.

(b) Except as provided by Subsection (a), any reinsurance shall be payable to the receiver under a policy reinsured by the assuming insurer on the basis of claims:

- (1) allowed under Section 443.253; or
- (2) paid under:
 - (A) Chapter 462, 463, or 2602; or
 - (B) the guaranty associations of other states.

(c) The liquidator or receiver, as applicable, shall give written notice to affected reinsurers of the pendency of a claim against the receiver under a reinsured policy within a reasonable time after the claim is filed in the delinquency proceeding. During the pendency of the claim any affected reinsurer may:

- (1) investigate the claim; and
- (2) intervene, at the reinsurer's own expense, in any proceeding where the claim is to be adjusted and assert any defense or defenses which it may deem available to the delinquent company, the liquidator, or the receiver.

(d) Subject to court approval, an expense incurred under Subsection (c)(1) or (2) shall be chargeable against the delinquent company as part of the expense of liquidation, to the extent of a proportionate share of the benefit which may accrue to the delinquent company solely as a result of the defense undertaken by the assuming insurer.

(e) If two or more assuming insurers are involved in the same claim and a majority in interest elect to intervene and assert a defense to a claim described by Subsection (c), an expense incurred under Subsection (c)(1) or (2) shall be apportioned in accordance with the terms of the reinsurance agreement as though the expense had been incurred by the ceding insurer.

(f) Nothing in this chapter shall be construed as authorizing the receiver, or other entity, to compel payment from a non-life reinsurer on the basis of estimated incurred but not reported losses or outstanding reserves, except outstanding reserves with respect to claims made pursuant to Section 443.255 and approved workers compensation claims filed under Section 443.252(d).

Added by Acts 2005, 79th Leg., Ch. 995 (H.B. [2157](#)), Sec. 1, eff.

September 1, 2005.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.211 by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(a)(1), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(x), eff. September 1, 2007.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.211 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(a)(1), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(x), eff. September 1, 2007.

Acts 2011, 82nd Leg., R.S., Ch. 193 (S.B. 1433), Sec. 8, eff. September 1, 2011.

Sec. 443.212. RECOVERY OF PREMIUMS OWED. (a) An insured shall pay, either directly to the receiver or to any agent that has paid or is obligated to pay the receiver on behalf of the insured, any unpaid earned premium or retrospectively rated premium due the insurer based on the termination of coverage under Section 443.152. Premium on surety business is deemed earned at inception if a policy term cannot be determined. All other premium is deemed earned and is prorated equally over the determined policy term, regardless of any provision in the bond, guaranty, contract or other agreement.

(b) Any person, other than the insured, shall turn over to the receiver any unpaid premium due and owing as shown on the records of the insurer, including any amount representing commissions, for the full policy term due the insurer at the time of the entry of the receivership order, whether earned or unearned, based on the termination of coverage under Section 443.152. The unpaid premium due the receiver from any person other than the insured excludes any premium not collected from the insured and not earned based on the termination of coverage under Section 443.152.

(c) Any person, other than the insured, responsible for the remittance of a premium, shall turn over to the receiver any unearned commission of the person based on the termination of coverage under Section 443.152. Credits, setoffs, or both may not be allowed to an agent, broker, premium finance company, or any other person for any

amounts advanced to the insurer by the person on behalf of, but in the absence of a payment by, the insured, or for any other amount paid by the person to any other person after the entry of the order of receivership.

(d) Persons that collect premium or finance premium under a premium finance contract that is due the insurer in receivership are deemed to hold that premium in trust as fiduciaries for the benefit of the insurer and to have availed themselves of the laws of this state, regardless of any provision to the contrary in any agency contract or other agreement.

(e) Any premium finance company is obligated to pay any amounts due the insurer from premium finance contracts, whether the premium is earned or unearned. The receiver has the right to collect any unpaid financed premium directly from the premium finance company or directly from the insured that is a party to the premium finance contract.

(f) Upon satisfactory evidence of a violation of this section by a person other than an insured, the commissioner may pursue one or more of the following courses of action:

(1) suspend, revoke, or refuse to renew the licenses of the offending party or parties; and

(2) impose:

(A) an administrative penalty under Chapter 84 of not more than \$1,000 for each act in violation of this section by the party or parties; and

(B) any other sanction or penalty authorized by Chapter 82.

Added by Acts 2005, 79th Leg., Ch. 995 (H.B. [2157](#)), Sec. 1, eff. September 1, 2005.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.212 by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 3B.004(a)(1), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 3B.004(y), eff. September 1, 2007.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.212 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. [3167](#)), Sec. 9.004(a)(1), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(y), eff. September 1, 2007.

Sec. 443.213. ADMINISTRATION OF DEDUCTIBLE AGREEMENTS AND POLICYHOLDER COLLATERAL. (a) Any collateral held to secure the obligations of a policyholder under a deductible agreement with an insurer subject to a delinquency proceeding under this chapter must be maintained and administered as provided in this section. For purposes of this section, a "deductible agreement" is any combination of one or more policies, endorsements, contracts, or security agreements that:

(1) provide for the policyholder to bear the risk of loss within a specified amount per claim or occurrence covered under a policy of insurance; and

(2) may be subject to an aggregate limit of policyholder reimbursement obligations.

(b) This section applies to any collateral described by Subsection (a), regardless of whether the collateral is held by, for the benefit of, or assigned to the insurer under a deductible agreement. The collateral shall be used to secure the policyholder's obligation to fund or reimburse claims payments within the agreed deductible amount, subject to this section.

(c) If the contract between the policyholder and the insurer allows the policyholder to fund claims within the deductible amount through a third-party administrator or otherwise, the receiver shall allow that funding arrangement to continue, except as prohibited by Title 5, Labor Code. If a policyholder funds claims within the deductible amount, the receiver or any guaranty association has no obligation to pay claims for the amount funded by the policyholder, and the policyholder or its third-party administrator is not obligated to reimburse a guaranty association for any amount funded. A charge of any kind may not be made against a guaranty association based on the funding of claims payments by a policyholder under this subsection.

(d) If the receiver is holding collateral provided by a policyholder to secure both a deductible agreement and other obligations of the policyholder, the receiver shall:

(1) allocate the collateral among these obligations in accordance with the deductible agreement; or

(2) in the absence of an allocation provision in the deductible agreement and with the approval of the receivership court, allocate the collateral equitably among these obligations.

(e) If, under Subsection (d), the collateral secures reimbursement obligations under more than one line of insurance, the receiver shall equitably allocate the collateral among the various lines based on the estimated ultimate exposure within the deductible amount for each line.

(f) If a guaranty association is obligated to pay claims under a policy under Subsection (d), the receiver shall give notice to the guaranty associations of any allocation under this section.

(g) Once all claims covered by the collateral have been paid and the receiver is satisfied that no new claims may be presented, the receiver shall release any remaining collateral to the policyholder in accordance with the provisions of the contract and of this chapter.

(h) To the extent a guaranty association is required by applicable law to pay any claims for which the insurer would have been entitled to reimbursement from the policyholder, the following provisions apply:

(1) The receiver shall promptly invoice the policyholder for the reimbursement due under the agreement, and the policyholder is obligated to pay the amount invoiced to the receiver for the benefit of the guaranty associations that paid the claims. Neither the insolvency of the insurer nor the insurer's inability to perform any obligations under the deductible agreement is a defense to the policyholder's reimbursement obligation under the deductible agreement. At the time the policyholder reimbursements are collected, the receiver shall promptly forward those amounts to the guaranty association, based on the claims paid by the guaranty association that were subject to the deductible.

(2) If the collateral is insufficient to reimburse the guaranty association for claims paid within the deductible, the receiver shall use any existing collateral to make a partial reimbursement to the guaranty association, subject to any allocation under Subsection (d), (e), or (f). If more than one guaranty association has a claim against the same collateral, the receiver shall prorate payments to each guaranty association based on the amount of the claims each guaranty association has paid.

(3) The receiver is entitled to deduct from reimbursements

owed to a guaranty association or collateral to be returned to a policyholder reasonable actual expenses incurred in fulfilling the receiver's responsibilities under this section. Expenses incurred to collect reimbursements for the benefit of a guaranty association are subject to the approval of the guaranty association. Any remaining expenses that are not deducted from the reimbursements are payable subject to Section 443.015.

(4) The receiver shall provide any affected guaranty associations with a complete accounting of the receiver's deductible billing and collection activities on a quarterly basis, or at other intervals as may be agreed to between the receiver and the guaranty associations. Accountings under this subdivision must include copies of the policyholder billings, the reimbursements collected, the available amounts and use of collateral for each account, and any prorating of payments.

(5) If the receiver fails to make a good faith effort to collect reimbursements due from a policyholder under a deductible agreement within 120 days of receipt of claims payment reports from a guaranty association, the guaranty association may, after notice to the receiver, collect the reimbursements that are due, and, in so doing, the guaranty association shall have the same rights and remedies as the receiver. A guaranty association shall report any amounts collected under this subdivision and expenses incurred in collecting those amounts to the receiver.

(6) The receiver shall periodically adjust the collateral held as the claims subject to the deductible agreement are paid, provided that adequate collateral is maintained. The receiver is not required to adjust the collateral more than once a year. The receiver shall inform the guaranty associations of all collateral reviews, including the basis for the adjustment.

(7) Reimbursements received or collected by a guaranty association under this section may not be considered a distribution of the insurer's assets. A guaranty association shall provide the receiver with an accounting of any amounts it has received or collected under this section and any expenses incurred in connection with that receipt or collection. The amounts received, net of any expenses incurred in connection with collection of the amounts, must be set off against the guaranty association's claim filed under Section 443.251 for the payments that were reimbursed.

(8) To the extent that a guaranty association pays a claim

within the deductible amount that is not reimbursed by either the receiver or by policyholder payments, the guaranty association has a claim for those amounts in the delinquency proceeding in accordance with Section 443.251.

(9) Nothing in this section limits any rights of a guaranty association under applicable law to obtain reimbursement for claims payments made by the guaranty association under policies of the insurer or for the association's related expenses.

(i) If a claim that is subject to a deductible agreement and secured by collateral is not covered by any guaranty association, the following provisions apply:

(1) The receiver is entitled to retain as an asset of the estate any collateral or deductible reimbursements obtained by the receiver.

(2) If a policyholder fails to assume an obligation under a deductible agreement to pay a claim, the receiver shall use the collateral to adjust and pay the claim to the extent that the available collateral, after any allocation under Subsection (d), (e), or (f), is sufficient to pay all outstanding and anticipated claims within the deductible. If the collateral is exhausted and all reasonable means of collection against the insured have been exhausted, the remaining claims shall be subject to the provisions of Sections 443.251 and 443.301.

(3) The receiver is entitled to deduct from collateral reasonable actual expenses incurred in fulfilling the receiver's responsibilities under this section. Any remaining expenses that are not deducted from the reimbursements are payable subject to Section 443.015.

Added by Acts 2005, 79th Leg., Ch. 995 (H.B. [2157](#)), Sec. 1, eff. September 1, 2005.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.213 by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 3B.004(a)(1), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 3B.004(z), eff. September 1, 2007.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.213 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. [3167](#)), Sec. 9.004(a)(1), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(z),
eff. September 1, 2007.

SUBCHAPTER F. CLAIMS

Sec. 443.251. FILING OF CLAIMS. (a) Except as provided by this subsection, proof of all claims must be filed with the liquidator in the form required by Section 443.252 on or before the last day for filing specified in the notice required under Section 443.155, which date may not be later than 18 months after entry of the order of liquidation, unless the receivership court, for good cause shown, extends the time, except that proofs of claims for cash surrender values or other investment values in life insurance and annuities and for any other policies insuring the lives of persons need not be filed unless the liquidator expressly so requires. The receivership court, only upon application of the liquidator, may allow alternative procedures and requirements for the filing of proofs of claim or for allowing or proving claims. Upon application, if the receivership court dispenses with the requirements of filing a proof of claim by a person or a class or group of persons, a proof of claim for the person, class, or group is deemed to have been filed for all purposes, except that the receivership court's waiver of proof of claim requirements does not impact guaranty association proof of claim filing requirements or coverage determinations to the extent the guaranty fund statute or filing requirements are inconsistent with the receivership court's waiver of proof.

(b) The liquidator shall permit a claimant that makes a late filing to share ratably in distributions, whether past or future, as if the claim were not filed late, to the extent that the payment will not prejudice the orderly administration of the liquidation, under the following circumstances:

(1) the eligibility to file a proof of claim was not known to the claimant, and the claimant filed a proof of claim not later than the 90th day after the date of first learning of the eligibility;

(2) a transfer to a creditor was avoided under Section 443.202, 443.203, 443.204, or 443.206, or was voluntarily surrendered under Section 443.208, and the filing satisfies the conditions of Section 443.208; or

(3) the valuation under Section 443.260, of security held by a secured creditor shows a deficiency, and the claim for the deficiency is filed not later than the 30th day after the valuation.

(c) The liquidator may petition the receivership court to set a date before which all late claims under Subsection (b) must be filed.

(d) The liquidator shall permit guaranty associations to file claims late and to receive a ratable share of distributions, whether past or future, as if the claims were not late.

Added by Acts 2005, 79th Leg., Ch. 995 (H.B. 2157), Sec. 1, eff. September 1, 2005.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.251 by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(a)(1), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(aa), eff. September 1, 2007.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.251 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(a)(1), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(aa), eff. September 1, 2007.

Sec. 443.252. PROOF OF CLAIM. (a) Proof of claim consists of a statement signed by the claimant or on behalf of the claimant that includes all of the following, as applicable:

- (1) the particulars of the claim, including the consideration given for it;
- (2) the identity and amount of the security on the claim;
- (3) the payments, if any, made on the debt;
- (4) that the sum claimed is justly owing and that there is no setoff, counterclaim, or defense to the claim;
- (5) any right of priority of payment or other specific right asserted by the claimant;
- (6) the name and address of the claimant and the attorney, if any, who represents the claimant; and
- (7) the claimant's social security or federal employer identification number.

(b) The liquidator may require that:

- (1) a prescribed form be used; and
- (2) other information and documents be included.

(c) At any time the liquidator may:

- (1) require the claimant to present information or evidence supplementary to that required under Subsection (a); and
- (2) take testimony under oath, require production of affidavits or depositions, or otherwise obtain additional information or evidence.

(d) Any guaranty association must be permitted to file a single omnibus proof of claim for all claims of the association in connection with payment of claims of the insurer. The omnibus proof of claim may be periodically updated by the association, and the association may be required to submit a reasonable amount of documentation in support of the claim. A guaranty association's claim under this subsection may include amounts for anticipated payments after the closing of the receivership including incurred but not reported claims.

Added by Acts 2005, 79th Leg., Ch. 995 (H.B. 2157), Sec. 1, eff. September 1, 2005.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.252 by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(a)(1), eff. September 1, 2007.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.252 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(a)(1), eff. September 1, 2007.

Sec. 443.253. ALLOWANCE OF CLAIMS. (a) Except as provided in Subsections (i) and (l), the liquidator shall review all claims duly filed in the liquidation proceeding and shall further investigate as the liquidator considers necessary. Consistent with the provisions of this chapter, the liquidator may allow, disallow, or compromise the amount for which claims will be recommended to the receivership court, unless the liquidator is required by law to accept claims as settled by a person or organization, including a guaranty association, subject to any statutory or contractual rights of the affected reinsurers to participate in the claims allowance process. No claim under a policy of insurance may be allowed for an amount in

excess of the applicable policy limits.

(b) Pursuant to the review, the liquidator shall provide written notice of the claim determination by any means authorized by Section 443.007 to the claimant or the claimant's attorney and may provide notice to any reinsurer that is or may be liable in respect of the claim. The notice must set forth the amount of the claim allowed by the liquidator, if any, and the priority class of the claim as established in Section 443.301.

(c) Not later than the 45th day after the mailing of the notice as set forth in Subsection (b), those noticed may submit written objections to the liquidator. Any submitted objections must clearly set out all facts and the legal basis, if any, for the objections and the reasons why the claim should be allowed at a different amount or in a different priority class. If no timely objection is filed, the determination is final.

(d) A claim that has not become mature as of the coverage termination date established under Section 443.201 because payment on the claim is not yet due may be allowed as if it were mature. A claim that is allowed under this subsection may be discounted to present value based upon a reasonable estimated date of the payment, if the liquidator determines that the present value of the payment is materially less than the amount of the payment.

(e) A judgment or order against an insured or the insurer entered after the date of the initial filing of a successful petition for receivership, or within 120 days before the initial filing of the petition, or a judgment or order against an insured or the insurer entered at any time by default or by collusion need not be considered as evidence of liability or of the amount of damages.

(f) Claims under employment contracts by directors, officers, or persons in fact performing similar functions or having similar powers are limited to payment for services rendered prior to any order of receivership, unless explicitly approved in writing by:

- (1) the commissioner prior to an order of receivership;
- (2) the rehabilitator before the entry of an order of liquidation; or
- (3) the liquidator after the entry of an order of liquidation.

(g) The total liability of the insurer to all claimants arising out of the same act or policy may not be greater than the insurer's total liability would have been were the insurer not in liquidation.

(h) The liquidator shall disallow claims for de minimis amounts as determined by the receivership court as being reasonable and necessary for administrative convenience.

(i) A claim that does not contain all the applicable information required by Section 443.252 need not be further reviewed or adjudicated, and may be denied or disallowed by the liquidator subject to the notice and objection procedures in this section.

(j) The liquidator may reconsider a claim on the basis of additional information and amend the recommendation to the receivership court. The claimant must be afforded the same notice and opportunity to be heard on all changes in the recommendation as in its initial determination. The receivership court may amend its allowance or disallowance as appropriate.

(k) The liquidator is not required to process claims for any class until it appears reasonably likely that property will be available for a distribution to that class. If there are insufficient assets to justify processing all claims for any class listed in Section 443.301, the liquidator shall report the facts to the receivership court and make such recommendations as may be appropriate for handling the remainder of the claims.

(l) Any claim by a lessor for damages resulting from the termination of a lease of real property shall be disallowed to the extent that the claim exceeds:

(1) the rent reserved by the lease, without acceleration, for the longer of one year or 15 percent of the remaining term of the lease, not to exceed three years, following the earlier of:

(A) the date of the filing of the petition; or

(B) the date on which the lessor repossessed or the lessee surrendered the leased property; and

(2) any unpaid rent due under the lease, without acceleration, on the earlier of the dates described by Subdivision (1).

(m) If a claim is fully covered by a guaranty association, the liquidator has no obligation to process the claim in accordance with this section and may refuse to process the claim in accordance with this section.

Added by Acts 2005, 79th Leg., Ch. 995 (H.B. [2157](#)), Sec. 1, eff. September 1, 2005.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.253 by

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(a)(1), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(bb), eff. September 1, 2007.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.253 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(a)(1), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(bb), eff. September 1, 2007.

Acts 2011, 82nd Leg., R.S., Ch. 193 (S.B. 1433), Sec. 9, eff. September 1, 2011.

Sec. 443.254. CLAIMS UNDER OCCURRENCE POLICIES, SURETY BONDS, AND SURETY UNDERTAKINGS. (a) Subject to the provisions of Section 443.253, any insured has the right to file a claim for the protection afforded under the insured's policy, regardless of whether a claim is known at the time of filing, if the policy is an occurrence policy.

(b) Subject to the provisions of Section 443.253, an obligee under a surety bond or surety undertaking has the right to file a claim for the protection afforded under the surety bond or surety undertaking issued by the insurer under which the obligee is the beneficiary, regardless of whether a claim is known at the time of filing.

(c) After a claim is filed under Subsection (a) or (b), at the time that a specific claim is made by or against the insured or by the obligee, the insured or the obligee shall supplement the claim, and the receiver shall treat the claim as a contingent or unliquidated claim under Section 443.255.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(cc), eff. September 1, 2007.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.254 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(a)(1), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(cc),

eff. September 1, 2007.

Sec. 443.255. ALLOWANCE OF CONTINGENT AND UNLIQUIDATED CLAIMS.

(a) A claim of an insured or third party may be allowed under Section 443.253, regardless of the fact that the claim was contingent or unliquidated, if any contingency is removed in accordance with Subsection (b) and the value of the claim is determined. For purposes of this section, a claim is contingent if:

(1) the accident, casualty, disaster, loss, event, or occurrence insured, reinsured, or bonded or reinsured against occurred on or before the date fixed under Section 443.151; and

(2) the act or event triggering the insurer's obligation to pay has not occurred as of the date fixed under Section 443.151.

(b) Unless the receivership court directs otherwise, a contingent claim may be allowed if the claimant has presented proof reasonably satisfactory to the liquidator of the insurer's obligation to pay or the claim was based on a cause of action against an insured of the insurer and:

(1) it may be reasonably inferred from proof presented upon the claim that the claimant would be able to obtain a judgment; and

(2) the person has furnished suitable proof, unless the receivership court for good cause shown otherwise directs, that no further valid claims can be made against the insurer arising out of the cause of action other than those already presented.

(c) The liquidator may petition the receivership court to set a date before which all claims under this section are final. In addition to the notice requirements of Section 443.007, the liquidator shall give notice of the filing of the petition to all claimants with claims that remain contingent or unliquidated under this section.

Added by Acts 2005, 79th Leg., Ch. 995 (H.B. 2157), Sec. 1, eff. September 1, 2005.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.255 by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(a)(1), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(dd), eff. September 1, 2007.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.255 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(a)(1), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(dd), eff. September 1, 2007.

Sec. 443.256. SPECIAL PROVISIONS FOR THIRD-PARTY CLAIMS. (a) When any third party asserts a cause of action against an insured of an insurer in liquidation, the third party may file a claim with the liquidator on or before the last day for filing claims.

(b) Whether or not the third party files a claim, the insured may file a claim on the insured's own behalf in the liquidation.

(c) The liquidator may make recommendations to the receivership court for the allowance of an insured's claim after consideration of the probable outcome of any pending action against the insured on which the claim is based, the probable damages recoverable in the action, and the probable costs and expenses of defense. After allowance by the receivership court, the liquidator shall withhold any distribution payable on the claim, pending the outcome of litigation and negotiation between the insured and the third party. The liquidator may reconsider the claim as provided in Section 443.253(j). As claims against the insured are settled or barred, the insured or third party, as appropriate, shall be paid from the amount withheld the same percentage distribution as was paid on other claims of like priority, based on the lesser of the amount actually due from the insured by action or paid by agreement plus the reasonable costs and expense of defense, or the amount allowed on the claims by the receivership court. After all claims are settled or barred, any sum remaining from the amount withheld shall revert to the undistributed property of the insurer.

(d) If several claims founded upon one policy are timely filed under this section, whether by third parties or as claims by the insured, and the aggregate amount of the timely filed allowed claims exceeds the aggregate policy limits, the liquidator may:

(1) apportion the policy limits ratably among the timely filed allowed claims; or

(2) give notice to the insured, known third parties, and affected guaranty associations that the aggregate policy limits have

been exceeded. On and after the 30th day after the date of the liquidator's notice, further amounts may not be allowed, the policy limits shall be apportioned ratably among the timely filed allowed claims, and any additional claims shall be rejected.

(e) Claims by the insured under Subsection (d) must be evaluated as described by Subsection (c). If any insured's claim is subsequently reduced under Subsection (c), the amount freed by the reduction must be apportioned ratably among the claims which have been reduced under Subsection (d).

(f) A claim may not be allowed under this section to the extent the claim is covered by any guaranty association.

(g) A claimant may withdraw a proof of claim with the liquidator's approval. The liquidator may approve the withdrawal only upon a showing of good cause and after giving notice of the withdrawal to the insured.

(h) The filing of a proof of claim in connection with a claim against an insured has the following effect on the rights of the claimant and the insured:

(1) By filing a proof of claim, a claimant waives any right to pursue the personal assets of the insured with respect to the claim, to the extent of the coverage or policy limits provided by the insurer, and agrees that to the extent of the coverage or policy limits provided by the insurer, the claimant will seek satisfaction of the claim against the insured solely from distributions paid by the liquidator on the claim and from any payments that a guaranty association may pay on account of the claim, except as provided in this section.

(2) The waiver provided under this section is conditioned upon the cooperation of the insured with the liquidator and any applicable guaranty association in the defense of the claim. The waiver provided under this section does not operate to:

(A) discharge the guaranty association from any of the association's responsibilities and duties;

(B) release the insured with respect to any claim in excess of the coverage or policy limits provided by the insurer or any other responsible party; or

(C) release the insured with respect to any claim by a guaranty association for reimbursement under the law applicable to the guaranty association.

(3) The waiver provided under this section is void if:

(A) a claimant withdraws the claimant's proof of claim under Subsection (g); or

(B) the liquidator avoids insurance coverage in connection with a proof of the claim.

(4) The liquidator shall provide, where applicable, notice of the election of remedies provision in this section on any proof of claim form the liquidator distributes. The notice must be inserted above the claimant's signature line in typeface not smaller than the typeface of the rest of the notice and, in any event not smaller than a 14-point font, and must include a statement substantially similar to the following: "I understand by filing this claim in the estate of the insurer I am waiving any right to pursue the personal assets of the insured to the extent that there are policy limits or coverage provided by the now insolvent insurer."

Added by Acts 2005, 79th Leg., Ch. 995 (H.B. [2157](#)), Sec. 1, eff. September 1, 2005.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.256 by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 3B.004(a)(1), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 3B.004(ee), eff. September 1, 2007.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.256 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. [3167](#)), Sec. 9.004(a)(1), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. [3167](#)), Sec. 9.004(ee), eff. September 1, 2007.

Sec. 443.257. DISPUTED CLAIMS. (a) When objections to the liquidator's proposed treatment of a claim are filed and the liquidator does not alter the determination of the claim as a result of the objections, the liquidator shall ask the receivership court for a hearing pursuant to Section 443.007.

(b) The provisions of this section are not applicable to disputes with respect to coverage determinations by a guaranty association as part of the association's statutory obligations.

(c) The final disposition by the receivership court of a

disputed claim is deemed a final judgment for purposes of appeal.

Added by Acts 2005, 79th Leg., Ch. 995 (H.B. 2157), Sec. 1, eff. September 1, 2005.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.257 by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(a)(1), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(ff), eff. September 1, 2007.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.257 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(a)(1), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(ff), eff. September 1, 2007.

Sec. 443.258. LIQUIDATOR'S RECOMMENDATIONS TO RECEIVERSHIP COURT. The liquidator shall present to the receivership court, for approval, reports of claims settled or determined by the liquidator under Section 443.253. The reports must be presented from time to time as determined by the liquidator and must include information identifying the claim and the amount and priority class of the claim.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(gg), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(gg), eff. September 1, 2007.

Sec. 443.259. CLAIMS OF CODEBTORS. If a creditor does not timely file a proof of the creditor's claim, an entity that is liable to the creditor together with the insurer, or that has secured the creditor, may file a proof of the claim.

Added by Acts 2005, 79th Leg., Ch. 995 (H.B. 2157), Sec. 1, eff. September 1, 2005.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.259 by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(a)(1),

eff. September 1, 2007.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.259 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(a)(1), eff. September 1, 2007.

Sec. 443.260. SECURED CREDITORS' CLAIMS. (a) The value of any security held by a secured creditor must be determined in one of the following ways:

(1) by converting the same into money according to the terms of the agreement pursuant to which the security was delivered to the creditor; or

(2) by agreement or litigation between the creditor and the liquidator.

(b) If a surety has paid any losses or loss adjustment expenses under its own surety instrument before any petition initiating a delinquency proceeding is filed and the principal to the instrument has posted collateral that remains available to reimburse the losses or loss adjustment expenses at the time the petition is filed and that collateral has not been credited against the payments made, then the receiver has the first priority to use the collateral to reimburse the surety for any pre-petition losses and expenses.

(c) If the principal under a surety bond or surety undertaking has pledged any collateral, including a guaranty or letter of credit, to secure the principal's reimbursement obligation to the insurer issuing the bond or undertaking, the claim of any obligee, or subject to the discretion of the receiver, of any completion contractor under the surety bond or surety undertaking must be satisfied first out of the collateral or its proceeds.

(d) In making any distribution to an obligee or completion contractor under Subsection (c), the receiver shall retain a sufficient reserve for any other potential claim against that collateral.

(e) If collateral is insufficient to satisfy in full all potential claims against it under Subsections (c) and (g), the claims against the collateral must be paid on a pro rata basis, and an obligee or completion contractor under Subsection (c) has a claim, subject to allowance under Section 443.253, for any deficiency.

(f) If the time to assert claims against a surety bond or a surety undertaking has expired, and all claims described by this

section have been satisfied in full, any remaining collateral pledged under the surety bond or surety undertaking must be returned to the principal under the bond or undertaking.

(g) To the extent that a guaranty association has made a payment relating to a claim against a surety bond, the guaranty association shall first be reimbursed for that payment and related expenses out of the available collateral or proceeds related to the surety bond. To the extent that the collateral is sufficient, the guaranty association shall be reimbursed 100 percent of its payment. If the collateral is insufficient to satisfy in full all potential claims against the collateral under Subsection (c) and this subsection, a guaranty association that has paid claims on the surety bond is entitled to a pro rata share of the available collateral in accordance with Subsection (e), and the guaranty association has claims against the general assets of the estate in accordance with Section 443.253 for any deficiency. Any payment made to a guaranty association under this subsection from collateral may not be deemed early access or otherwise deemed a distribution out of the general assets or property of the estate, and the guaranty association receiving payment shall subtract any payment from the collateral from the association's final claims against the estate.

(h) An amount determined under Subsection (a) shall be credited upon the secured claim, and the claimant may file a proof of claim, subject to all other provisions of this chapter for any deficiency, which must be treated as an unsecured claim. If the claimant surrenders the claimant's security to the liquidator, the entire claim is treated as if unsecured.

(i) The liquidator may recover from property securing an allowed secured claim the reasonable, necessary costs and expenses of preserving or disposing of the property to the extent of any benefit to the holder of such claim.

Added by Acts 2005, 79th Leg., Ch. 995 (H.B. [2157](#)), Sec. 1, eff. September 1, 2005.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.260 by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 3B.004(a)(1), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 3B.004(hh), eff. September 1, 2007.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.260 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(a)(1), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(hh), eff. September 1, 2007.

Sec. 443.261. QUALIFIED FINANCIAL CONTRACTS. (a)

Notwithstanding any other provision of this chapter, including any other provision of this chapter permitting the modification of contracts, or other law of this state, a person may not be stayed or prohibited from exercising:

(1) a contractual right to terminate, liquidate, or close out any netting agreement or qualified financial contract with an insurer because of:

(A) the insolvency, financial condition, or default of the insurer at any time, provided that the right is enforceable under applicable law other than this chapter; or

(B) the commencement of a formal delinquency proceeding under this chapter;

(2) any right under a pledge, security, collateral, or guarantee agreement, or any other similar security arrangement or credit support document, relating to a netting agreement or qualified financial contract; or

(3) subject to any provision of Section 443.209(b), any right to set off or net out any termination value, payment amount, or other transfer obligation arising under or in connection with a netting agreement or qualified financial contract where the counterparty or its guarantor is organized under the laws of the United States or a state or foreign jurisdiction approved by the Securities Valuation Office of the National Association of Insurance Commissioners as eligible for netting.

(b) Upon termination of a netting agreement, the net or settlement amount, if any, owed by a nondefaulting party to an insurer against which an application or petition has been filed under this chapter shall be transferred to, or on the order of the receiver for, the insurer, even if the insurer is the defaulting party and notwithstanding any provision in the netting agreement that may provide that the nondefaulting party is not required to pay any net

or settlement amount due to the defaulting party upon termination. Any limited two-way payment provision in a netting agreement with an insurer that has defaulted is deemed to be a full two-way payment provision as against the defaulting insurer. Any such property or amount is, except to the extent it is subject to one or more secondary liens or encumbrances, a general asset of the insurer.

(c) In making any transfer of a netting agreement or qualified financial contract of an insurer subject to a proceeding under this chapter, the receiver shall either:

(1) transfer to one party, other than an insurer subject to a proceeding under this chapter, all netting agreements and qualified financial contracts between a counterparty or any affiliate of the counterparty and the insurer that is the subject of the proceeding, including:

(A) all rights and obligations of each party under each netting agreement and qualified financial contract; and

(B) all property, including any guarantees or credit support documents, securing any claims of each party under each netting agreement and qualified financial contract; or

(2) transfer none of the netting agreements, qualified financial contracts, rights, obligations, or property referred to in Subdivision (1), with respect to the counterparty and any affiliate of the counterparty.

(d) If a receiver for an insurer makes a transfer of one or more netting agreements or qualified financial contracts, the receiver shall use its best efforts to notify any person who is party to the netting agreements or qualified financial contracts of the transfer not later than noon, the receiver's local time, on the business day following the transfer. For purposes of this subsection, "business day" means a day other than a Saturday, a Sunday, or any day on which either the New York Stock Exchange or the Federal Reserve Bank of New York is closed.

(e) Notwithstanding any other provision of this chapter, a receiver may not avoid a transfer of money or other property arising under or in connection with a netting agreement or qualified financial contract, or any pledge, security, or collateral or guarantee agreement or any other similar security arrangement or credit support document relating to a netting agreement or qualified financial contract, that is made before the commencement of a formal delinquency proceeding under this chapter. However, a transfer may

be avoided under Section 443.205(a) if the transfer was made with actual intent to hinder, delay, or defraud the insurer, a receiver appointed for the insurer, or existing or future creditors.

(f) In exercising any of the receiver's powers under this chapter to disaffirm or repudiate a netting agreement or qualified financial contract, the receiver shall take action with respect to each netting agreement or qualified financial contract and all transactions entered into in connection with the agreement or contract in its entirety. Notwithstanding any other provision of this chapter, any claim of a counterparty against the estate arising from the receiver's disaffirmance or repudiation of a netting agreement or qualified financial contract that has not been previously affirmed in the liquidation or immediately preceding rehabilitation case must be determined and must be allowed or disallowed as if the claim had arisen before the date of the filing of the petition for liquidation or, if a rehabilitation proceeding is converted to a liquidation proceeding, as if the claim had arisen before the date of the filing of the petition for rehabilitation. The amount of the claim must be the actual direct compensatory damages determined as of the date of the disaffirmance or repudiation of the netting agreement or qualified financial contract. For purposes of this subsection, the term "actual direct compensatory damages" does not include punitive or exemplary damages, damages for lost profit or lost opportunity, or damages for pain and suffering but does include normal and reasonable costs of cover or other reasonable measures of damages utilized in the derivatives market for the contract and agreement claims.

(g) For purposes of this section, the term "contractual right" includes any right, whether or not evidenced in writing, arising under:

- (1) statutory or common law;
- (2) a rule or bylaw of a national securities exchange, national securities clearing organization, or securities clearing agency;
- (3) a rule, bylaw, or resolution of the governing body of a contract market or its clearing organization; or
- (4) law merchant.

(h) The provisions of this section do not apply to persons who are affiliates of the insurer that is the subject of the proceeding.

(i) All rights of counterparties under this chapter apply to netting agreements and qualified financial contracts entered into on

behalf of the general account or separate accounts if the assets of each separate account are available only to counterparties to netting agreements and qualified financial contracts entered into on behalf of that separate account.

Added by Acts 2005, 79th Leg., Ch. 995 (H.B. 2157), Sec. 1, eff. September 1, 2005.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.261 by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(a)(1), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(ii), eff. September 1, 2007.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.261 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(a)(1), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(ii), eff. September 1, 2007.

SUBCHAPTER G. DISTRIBUTIONS

Sec. 443.301. PRIORITY OF DISTRIBUTION. The priority of payment of distributions on unsecured claims must be in accordance with the order in which each class of claims is set forth in this section. Every claim in each class shall be paid in full, or adequate funds retained for their payment, before the members of the next class receive payment, and all claims within a class must be paid substantially the same percentage of the amount of the claim. Except as provided by Subsections (a)(2), (a)(3), (i), and (k), subclasses may not be established within a class. No claim by a shareholder, policyholder, or other creditor shall be permitted to circumvent the priority classes through the use of equitable remedies. The order of distribution of claims shall be:

(a) Class 1. (1) The costs and expenses of administration expressly approved or ratified by the liquidator, including the following:

(A) the actual and necessary costs of preserving or recovering the property of the insurer;

(B) reasonable compensation for all services rendered

on behalf of the administrative supervisor or receiver;

(C) any necessary filing fees;

(D) the fees and mileage payable to witnesses;

(E) unsecured loans obtained by the receiver; and

(F) expenses, if any, approved by the rehabilitator of the insurer and incurred in the course of the rehabilitation that are unpaid at the time of the entry of the order of liquidation.

(2) The reasonable expenses of a guaranty association, including overhead, salaries and other general administrative expenses allocable to the receivership to include administrative and claims handling expenses and expenses in connection with arrangements for ongoing coverage, other than expenses incurred in the performance of duties under Section 462.002(3), 463.108, 463.111, 463.113, 463.353, or 2602.113 or similar duties under the statute governing a similar organization in another state. In the case of the Texas Property and Casualty Insurance Guaranty Association and other property and casualty guaranty associations, the expenses shall include loss adjustment expenses, including adjusting and other expenses and defense and cost containment expenses. In the event that there are insufficient assets to pay all of the costs and expenses of administration under Subsection (a)(1) and the expenses of a guaranty association, the costs and expenses under Subsection (a)(1) shall have priority over the expenses of a guaranty association. In this event, the expenses of a guaranty association shall be paid on a pro rata basis after the payment of costs and expenses under Subsection (a)(1) in full.

(3) For purposes of Subsection (a)(1)(E), any unsecured loan obtained by the receiver, unless by its terms it otherwise provides, has priority over all other costs of administration. Absent agreement to the contrary, all claims in this subclass share pro rata.

(4) Except as expressly approved by the receiver, any expenses arising from a duty to indemnify the directors, officers, or employees of the insurer are excluded from this class and, if allowed, are Class 5 claims.

(b) Class 2. (1) All claims under policies of insurance, including third-party claims; claims under annuity contracts, including funding agreements, guaranteed investment contracts, and synthetic guaranteed investment contracts; claims under nonassessable policies for unearned premium; claims of obligees and, subject to the

discretion of the receiver, completion contractors, under surety bonds and surety undertakings other than bail bonds, mortgage or financial guaranties, or other forms of insurance offering protection against investment risk; claims by principals under surety bonds and surety undertakings for wrongful dissipation of collateral by the insurer or its agents; and claims incurred during the extension of coverage provided for in Section 443.152. For purposes of this subdivision, "annuity contract," "funding agreement," "guaranteed investment contract," and "synthetic guaranteed investment contract" have the meanings assigned by Section 1154.003.

(2) All other claims incurred in fulfilling the statutory obligations of a guaranty association not included in Class 1, including indemnity payments on covered claims and, in the case of the Life, Accident, Health, and Hospital Service Insurance Guaranty Association or another life and health guaranty association, all claims as a creditor of the impaired or insolvent insurer for all payments of and liabilities incurred on behalf of covered claims or covered obligations of the insurer and for the funds needed to reinsure those obligations with a solvent insurer.

(3) Claims for benefits under a health care plan issued by a health maintenance organization.

(4) Claims under insurance policies or contracts for benefits issued by an unauthorized insurer.

(5) Notwithstanding any provision of this chapter, the following claims are excluded from Class 2 priority:

(A) obligations of the insolvent insurer arising out of reinsurance contracts;

(B) obligations, excluding unearned premium claims on policies other than reinsurance agreements, incurred after:

(i) the expiration date of the insurance policy;

(ii) the policy has been replaced by the insured or canceled at the insured's request; or

(iii) the policy has been canceled as provided by this chapter;

(C) obligations to insurers, insurance pools, or underwriting associations and their claims for contribution, indemnity, or subrogation, equitable or otherwise;

(D) any claim that is in excess of any applicable limits provided in the insurance policy issued by the insurer;

(E) any amount accrued as punitive or exemplary damages

unless expressly covered under the terms of the policy;

(F) tort claims of any kind against the insurer and claims against the insurer for bad faith or wrongful settlement practices; and

(G) claims of the guaranty associations for assessments not paid by the insurer, which must be paid as claims in Class 5.

(c) Class 3. Claims of the federal government not included in Class 2.

(d) Class 4. Debts due employees for services or benefits to the extent that the debts do not exceed \$5,000 or two months salary, whichever is the lesser, and represent payment for services performed within one year before the entry of the initial order of receivership. This priority is in lieu of any other similar priority that may be authorized by law as to wages or compensation of employees.

(e) Class 5. Claims of other unsecured creditors not included in Classes 1 through 4, including claims under reinsurance contracts, claims of guaranty associations for assessments not paid by the insurer, and other claims excluded from Class 2.

(f) Class 6. Claims of any state or local governments, except those specifically classified elsewhere in this section. Claims of attorneys for fees and expenses owed them by an insurer for services rendered in opposing a formal delinquency proceeding. In order to prove the claim, the claimant must show that the insurer that is the subject of the delinquency proceeding incurred the fees and expenses based on its best knowledge, information, and belief, formed after reasonable inquiry, indicating opposition was in the best interests of the insurer, was well grounded in fact, and was warranted by existing law or a good faith argument for the extension, modification, or reversal of existing law, and that opposition was not pursued for any improper purpose, such as to harass or to cause unnecessary delay or needless increase in the cost of the litigation.

(g) Class 7. Claims of any state or local government for a penalty or forfeiture, but only to the extent of the pecuniary loss sustained from the act, transaction, or proceeding out of which the penalty or forfeiture arose, with reasonable and actual costs occasioned thereby. The balance of the claims must be treated as Class 9 claims under Subsection (i).

(h) Class 8. Except as provided in Sections 443.251(b) and (d), late filed claims that would otherwise be classified in Classes

2 through 7.

(i) Class 9. Surplus notes, capital notes or contribution notes or similar obligations, premium refunds on assessable policies, and any other claims specifically assigned to this class. Claims in this class are subject to any subordination agreements related to other claims in this class that existed before the entry of the liquidation order.

(j) Class 10. Interest on allowed claims of Classes 1 through 9, according to the terms of a plan proposed by the liquidator and approved by the receivership court.

(k) Class 11. Claims of shareholders or other owners arising out of their capacity as shareholders or other owners, or any other capacity, except as they may be qualified in Class 2, 5, or 10. Claims in this class are subject to any subordination agreements related to other claims in this class that existed before the entry of the liquidation order.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(jj), eff. September 1, 2007.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.301 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(a)(1), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(jj), eff. September 1, 2007.

Acts 2011, 82nd Leg., R.S., Ch. 193 (S.B. 1433), Sec. 10, eff. September 1, 2011.

Acts 2015, 84th Leg., R.S., Ch. 1187 (S.B. 1196), Sec. 1, eff. September 1, 2015.

Sec. 443.302. PARTIAL AND FINAL DISTRIBUTIONS OF ASSETS. (a) With the approval of the receivership court, the liquidator may declare and pay one or more distributions to claimants whose claims have been allowed. Distributions paid under this subsection must be paid at substantially the same percentage of the amount of the claim.

(b) In determining the percentage of distributions to be paid on these claims, the liquidator may consider the estimated value of the insurer's property, including estimated reinsurance recoverables

in connection with the insurer's estimated liabilities for unpaid losses and loss expenses and for incurred but not reported losses and loss expenses, and the estimated value of the insurer's liabilities, including estimated liabilities for unpaid losses and loss expenses and for incurred but not reported losses and loss expenses.

(c) Distribution of property in kind may be made at valuations set by agreement between the liquidator and the creditor and approved by the receivership court.

(d) Notwithstanding the provisions of Subsection (a) and Subchapter D, the liquidator is authorized to pay benefits under a workers' compensation policy after the entry of the liquidation order if:

(1) the insurer has accepted liability and no bona fide dispute exists;

(2) payments under the policy commenced before the entry of the liquidation order; and

(3) future or past indemnity or medical payments are due under the policy.

(e) Claim payments made under Subsection (d) may continue until the date that a guaranty association assumes responsibility for claim payments under the policy.

(f) Any claim payments made under Subsection (d) and any related expenses must be treated as early access payments under Section 443.303 to the guaranty association responsible for the claims.

Added by Acts 2005, 79th Leg., Ch. 995 (H.B. [2157](#)), Sec. 1, eff. September 1, 2005.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.302 by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 3B.004(a)(1), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 3B.004(kk), eff. September 1, 2007.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.302 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. [3167](#)), Sec. 9.004(a)(1), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. [3167](#)), Sec. 9.004(kk), eff. September 1, 2007.

Sec. 443.303. EARLY ACCESS PAYMENTS. (a) For purposes of this section, "distributable assets" means all general assets of the liquidation estate less:

(1) amounts reserved, to the extent necessary and appropriate, for the entire Section 443.301(a) expenses of the liquidation through and after its closure; and

(2) to the extent necessary and appropriate, reserves for distributions on claims other than those of the guaranty associations falling within the priority classes of claims established in Section 443.301(b).

(b) Early access payments to guaranty associations must be made as soon as possible after the entry of a liquidation order and as frequently as possible after the entry of the order, but at least annually if distributable assets are available to be distributed to the guaranty associations, and must be in amounts consistent with this section. Amounts advanced to an affected guaranty association pursuant to this section shall be accounted for as advances against distributions to be made under Section 443.302. Where sufficient distributable assets are available, amounts advanced are not limited to the claims and expenses paid to date by the guaranty associations; however, the liquidator may not distribute distributable assets to the guaranty associations in excess of the anticipated entire claims of the guaranty associations falling within the priority classes of claims established in Sections 443.301(a) and (b).

(c) Within 120 days after the entry of an order of liquidation by the receivership court, and at least annually after the entry of the order, the liquidator shall apply to the receivership court for approval to make early access payments out of the general assets of the insurer to any guaranty associations having obligations arising in connection with the liquidation or shall report that there are no distributable assets at that time based on financial reporting as required in Section 443.016. The liquidator may apply to the receivership court for approval to make early access payments more frequently than annually based on additional information or the recovery of material assets.

(d) Within 60 days after approval by the receivership court of the applications in Subsection (c), the liquidator shall make any early access payments to the affected guaranty associations as

indicated in the approved application.

(e) Notice of each application for early access payments, or of any report required pursuant to this section, must be given in accordance with Section 443.007 to the guaranty associations that may have obligations arising from the liquidation. Notwithstanding the provisions of Section 443.007, the liquidator shall provide these guaranty associations with at least 30 days' actual notice of the filing of the application and with a complete copy of the application prior to any action by the receivership court. Any guaranty association that may have obligations arising in connection with the liquidation has:

(1) the right to request additional information from the liquidator, who may not unreasonably deny such request; and

(2) the right to object as provided by Section 443.007 to any part of each application or to any report filed by the liquidator pursuant to this section.

(f) In each application regarding early access payments, the liquidator shall, based on the best information available to the liquidator at the time, provide, at a minimum, the following:

(1) to the extent necessary and appropriate, the amount reserved for the entire expenses of the liquidation through and after its closure and for distributions on claims falling within the priority classes of claims established in Sections 443.301(b) and (c);

(2) the computation of distributable assets and the amount and method of equitable allocation of early access payments to each of the guaranty associations; and

(3) the most recent financial information filed with the National Association of Insurance Commissioners by the liquidator.

(g) Each guaranty association that receives any payments pursuant to this section agrees, upon depositing the payment in any account to its benefit, to return to the liquidator any amount of these payments that may be required to pay claims of secured creditors and claims falling within the priority classes of claims established in Section 443.301(a), (b), or (c). No bond may be required of any guaranty association.

(h) Nothing in this section affects the method by which a guaranty association determines the association's statutory coverage obligations.

(i) Without the consent of the affected guaranty associations

or an order of the receivership court, the liquidator may not offset the amount to be dispersed to any guaranty association by the amount of any specific deposit or any other statutory deposit or asset of the insolvent insurer held in that state unless the association has actually received the deposit.

Added by Acts 2005, 79th Leg., Ch. 995 (H.B. 2157), Sec. 1, eff. September 1, 2005.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.303 by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(a)(1), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(11), eff. September 1, 2007.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.303 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(a)(1), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(11), eff. September 1, 2007.

Acts 2011, 82nd Leg., R.S., Ch. 193 (S.B. 1433), Sec. 11, eff. September 1, 2011.

Sec. 443.304. UNCLAIMED AND WITHHELD FUNDS. (a) If any funds of the receivership estate remain unclaimed after the final distribution under Section 443.302, the funds must be placed in a segregated unclaimed funds account held by the commissioner. If the owner of any of the unclaimed funds presents proof of ownership satisfactory to the commissioner before the second anniversary of the date of the termination of the delinquency proceeding, the commissioner shall remit the funds to the owner. The interest earned on funds held in the unclaimed funds account may be used to pay any administrative costs related to the handling or return of unclaimed funds.

(b) If any amounts held in the unclaimed funds account remain unclaimed on or after the second anniversary of the date of the termination of the delinquency proceeding, the commissioner may file a motion for an order directing the disposition of the funds in the court in which the delinquency proceeding was pending. Any costs

incurred in connection with the motion may be paid from the unclaimed funds account. The motion shall identify the name of the insurer, the names and last known addresses of the persons entitled to the unclaimed funds, if known, and the amount of the funds. Notice of the motion shall be given as directed by the court. Upon a finding by the court that the funds have not been claimed before the second anniversary of the date of the termination of the delinquency proceeding, the court shall order that any claims for unclaimed funds and any interest earned on the unclaimed funds that has not been expended under Subsection (a) are abandoned and that the funds must be disbursed under one of the following methods:

(1) the amounts may be deposited in the general receivership expense account under Subsection (c);

(2) the amounts may be transferred to the comptroller, and deposited into the general revenue fund; or

(3) the amounts may be used to reopen the receivership in accordance with Section 443.353 and be distributed to the known claimants with approved claims.

(c) The commissioner may establish an account for the following purposes:

(1) to pay general expenses related to the administration of receiverships; and

(2) to advance funds to any receivership that does not have sufficient cash to pay its operating expenses.

(d) Any advance to a receivership under Subsection (c)(2) may be treated as a claim under Section 443.301 as agreed at the time the advance is made or, in the absence of an agreement, in the priority determined to be appropriate by the court.

(e) If the commissioner determines at any time that the funds in the account exceed the amount required, the commissioner may transfer the funds or any part of the funds to the comptroller, and the transferred funds must be deposited into the general revenue fund.

Added by Acts 2005, 79th Leg., Ch. 995 (H.B. [2157](#)), Sec. 1, eff. September 1, 2005.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.304 by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 3B.004(a)(1), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(mm), eff. September 1, 2007.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.304 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(a)(1), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(mm), eff. September 1, 2007.

SUBCHAPTER H. DISCHARGE

Sec. 443.351. CONDITION ON RELEASE FROM DELINQUENCY PROCEEDINGS. Until all payments of or on account of the insurer's contractual obligations by all guaranty associations, along with all expenses of the obligations and interest on all the payments and expenses, are repaid to the guaranty associations, unless otherwise provided in a plan approved by the guaranty association, an insurer that is subject to any formal delinquency proceedings may not:

(1) solicit or accept new business or request or accept the restoration of any suspended or revoked license or certificate of authority;

(2) be returned to the control of its shareholders or private management; or

(3) have any of its assets returned to the control of its shareholders or private management.

Added by Acts 2005, 79th Leg., Ch. 995 (H.B. 2157), Sec. 1, eff. September 1, 2005.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.351 by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(a)(1), eff. September 1, 2007.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.351 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(a)(1), eff. September 1, 2007.

Sec. 443.352. TERMINATION OF LIQUIDATION PROCEEDINGS. When all property justifying the expense of collection and distribution has been collected and distributed under this chapter, the liquidator shall apply to the receivership court for an order discharging the

liquidator and terminating the proceeding. The receivership court may grant the application and make any other orders, including orders to transfer any remaining funds that are uneconomic to distribute, or pursuant to Section 443.302(c), assign any assets that remain unliquidated, including claims and causes of action, as may be deemed appropriate.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(nn), eff. September 1, 2007.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.352 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(a)(1), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(nn), eff. September 1, 2007.

Sec. 443.353. REOPENING RECEIVERSHIP. After the liquidation proceeding has been terminated and the liquidator discharged, the commissioner or other interested party may at any time petition the court to reopen the delinquency proceeding for good cause, including the discovery of additional property. If the court is satisfied that there is justification for reopening, it shall so order.

Added by Acts 2005, 79th Leg., Ch. 995 (H.B. 2157), Sec. 1, eff. September 1, 2005.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.353 by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(a)(1), eff. September 1, 2007.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.353 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(a)(1), eff. September 1, 2007.

Sec. 443.354. DISPOSITION OF RECORDS DURING AND AFTER TERMINATION OF RECEIVERSHIP. (a) When it appears to the receiver that the records of the insurer in receivership are no longer useful, the receiver may recommend to the receivership court and the receivership court shall direct what records should be destroyed.

(b) If the receiver determines that any records should be

maintained after the closing of the delinquency proceeding, the receiver may reserve property from the receivership estate for the maintenance of the records, and any amounts so retained are administrative expenses of the estate under Section 443.301(a). Any records retained pursuant to this subsection must be transferred to the custody of the commissioner, and the commissioner may retain or dispose of the records as appropriate, at the commissioner's discretion. Any records of a delinquent insurer that are transferred to the commissioner may not be considered records of the department for any purposes, and Chapter 552, Government Code, does not apply to those records.

Added by Acts 2005, 79th Leg., Ch. 995 (H.B. 2157), Sec. 1, eff. September 1, 2005.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.354 by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(a)(1), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(oo), eff. September 1, 2007.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.354 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(a)(1), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(oo), eff. September 1, 2007.

Sec. 443.355. EXTERNAL AUDIT OF THE RECEIVER'S BOOKS. (a) The receivership court may, as it deems desirable, order audits to be made of the books of the receiver relating to any receivership established under this chapter. A report of each audit shall be filed with the commissioner and with the receivership court.

(b) The books, records, and other documents of the receivership must be made available to the auditor at any time without notice.

(c) The expense of each audit shall be considered a cost of administration of the receivership.

Added by Acts 2005, 79th Leg., Ch. 995 (H.B. 2157), Sec. 1, eff. September 1, 2005.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.355 by

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(a)(1), eff. September 1, 2007.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.355 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(a)(1), eff. September 1, 2007.

SUBCHAPTER I. INTERSTATE RELATIONS

Sec. 443.401. ANCILLARY CONSERVATION OF FOREIGN INSURERS. (a) The commissioner may initiate an action against a foreign insurer pursuant to Section 443.051 on any of the grounds stated in that section or on the basis that:

- (1) any of the foreign insurer's property has been sequestered, garnished, or seized by official action in its domiciliary state or in any other state;
- (2) the foreign insurer's certificate of authority to do business in this state has been revoked or was never issued and there are residents of this state with unpaid claims or in-force policies; or
- (3) initiation of the action is necessary to enforce a stay under Section 462.309, 463.404, or 2602.259.

(b) If a domiciliary receiver has been appointed, the commissioner may initiate an action against a foreign insurer under Subsection (a)(1) or (a)(2) only with the consent of the domiciliary receiver.

(c) An order entered pursuant to this section must appoint the commissioner as conservator. The conservator's title to assets must be limited to the insurer's property and records located in this state.

(d) Notwithstanding Section 443.201(c), the conservator shall hold and conserve the assets located in this state until the commissioner in the insurer's domiciliary state is appointed its receiver or until an order terminating conservation is entered under Subsection (g). Once a domiciliary receiver is appointed, the conservator shall turn over to the domiciliary receiver all property subject to an order under this section.

(e) The conservator may liquidate property of the insurer as necessary to cover the costs incurred in the initiation or administration of a proceeding under this section.

(f) The court in which an action under this section is pending

may issue a finding of insolvency or an ancillary liquidation order. The court may enter an ancillary liquidation order only for the limited purposes of:

(1) liquidating assets in this state to pay costs under Subsection (e); or

(2) activating relevant laws applicable to guaranty associations to pay valid claims that are not being paid by the insurer.

(g) The conservator may at any time petition the receivership court for an order terminating an order entered under this section.

Added by Acts 2005, 79th Leg., Ch. 995 (H.B. 2157), Sec. 1, eff. September 1, 2005.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.401 by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(a)(1), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(pp), eff. September 1, 2007.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.401 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(a)(1), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(pp), eff. September 1, 2007.

Sec. 443.402. DOMICILIARY RECEIVERS APPOINTED IN OTHER STATES.

(a) A domiciliary receiver appointed in another state is vested by operation of law with title to, and may summarily take possession of, all property and records of the insurer in this state.

Notwithstanding any other provision of law regarding special deposits, special deposits held in this state shall be, upon the entry of an order of liquidation with a finding of insolvency, distributed to the guaranty associations in this state as early access payments subject to Section 443.303, in relation to the lines of business for which the special deposits were made. The holder of any special deposit shall account to the domiciliary receiver for all distributions from the special deposit at the time of the distribution. The statutory provisions of another state and all

orders entered by courts of competent jurisdiction in relation to the appointment of a domiciliary receiver of an insurer and any related proceedings in another state must be given full faith and credit in this state. For purposes of this section, "another state" means any state other than this state. This state shall treat any other state than this state as a reciprocal state.

(b) Upon appointment of a domiciliary receiver in another state, the commissioner shall, unless otherwise agreed by the receiver, immediately transfer title to and possession of all property of the insurer under the commissioner's control, including all statutory general or special deposits, to the receiver.

(c) Except as provided in Subsection (a), the domiciliary receiver shall handle special deposits and special deposit claims in accordance with federal law and the statutes pursuant to which the special deposits are required. All amounts in excess of the estimated amount necessary to administer the special deposit and pay the unpaid special deposit claims are deemed general assets of the estate. If there is a deficiency in any special deposit so that the claims secured by the special deposit are not fully discharged from the deposit, the claimants may share in the general assets of the insurer to the extent of the deficiency at the same priority as other claimants in their class of priority under Section 443.301, but the sharing must be deferred until the other claimants of their class have been paid percentages of their claims equal to the percentage paid from the special deposit. The intent of this provision is to equalize to this extent the advantage gained by the security provided by the special deposits.

Added by Acts 2005, 79th Leg., Ch. 995 (H.B. 2157), Sec. 1, eff. September 1, 2005.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.402 by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(a)(1), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(qq), eff. September 1, 2007.

Redesignated from Insurance Code - Not Codified, Art/Sec 21A.402 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(a)(1), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(qq), eff. September 1, 2007.

CHAPTER 444. AGENCY CONTRACTS WITH CERTAIN INSURERS

Sec. 444.001. REQUIRED CONTRACT PROVISION. An agency contract entered into on or after August 27, 1973, by an insurer writing fire and casualty insurance in this state must contain, or shall be construed to contain, the following provision:

Notwithstanding any other provision of this contract, the obligation of the agent to remit written premiums to the insurer shall be changed on the commencement of a delinquency proceeding as defined by Chapter 443, Insurance Code, as amended. After the commencement of the delinquency proceeding, the obligation of the agent to remit premiums is limited to premiums earned before the cancellation date of insurance policies stated in the order of a court of competent jurisdiction under Chapter 443, Insurance Code, canceling the policies. The agent does not owe and may not be required to remit to the insurer or to the receiver any premiums that are unearned as of the cancellation date stated in the order.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(rr), eff. September 1, 2007.

Redesignated from Insurance Code, Section 442.801 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(a)(2), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(rr), eff. September 1, 2007.

Sec. 444.002. DISPOSITION OF PREMIUMS. (a) On or after the cancellation date of insurance policies as stated in the court's order canceling the policies, the agent shall promptly account to the receiver for:

(1) all unearned premiums to be returned to the insured or the replacement coverage to be obtained for the insured; and

(2) the earned premiums to be paid to the receiver.

(b) The agent shall:

(1) promptly return to an insured who paid the premiums any unearned premiums in the possession of the agent on the cancellation date of the policy; or

(2) with the approval of the insured, use the unearned premiums to purchase new coverage for the insured with a different insurer.

(c) The agent shall promptly remit to the receiver any earned premiums in the possession of the agent.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Redesignated from Insurance Code, Section 442.802 by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(a)(2), eff. September 1, 2007.

Redesignated from Insurance Code, Section 442.802 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(a)(2), eff. September 1, 2007.

Sec. 444.003. EFFECT OF CHAPTER ON ACTION BY RECEIVER AGAINST AGENT. This chapter does not prejudice a cause of action by the receiver against an agent to recover:

(1) unearned premiums that were not returned to policyholders; or

(2) earned premiums that were not promptly remitted to the receiver.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(ss), eff. September 1, 2007.

Redesignated from Insurance Code, Section 442.803 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(a)(2), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(ss), eff. September 1, 2007.

Sec. 444.004. AGENT NOT RECEIVER'S AGENT. This chapter does not render the agent an agent of the receiver for earned or unearned premiums.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.004(tt), eff. September 1, 2007.

Redesignated from Insurance Code, Section 442.804 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(a)(2), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.004(tt), eff. September 1, 2007.

SUBTITLE D. GUARANTY ASSOCIATIONS

CHAPTER 461. GENERAL PROVISIONS

Sec. 461.001. APPLICABILITY OF CHAPTER. (a) Except as provided by Subsection (b), this chapter applies to an insurance policy, contract, certificate, evidence of coverage, or application delivered or issued for delivery in this state that is not covered by an insurance guaranty fund or other solvency protection arrangement authorized by this code.

(b) This chapter does not apply to:

- (1) a fidelity, surety, or guaranty bond; or
- (2) marine insurance as defined by Section 1807.001.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 461.002. DISCLOSURE OF GUARANTY FUND NONPARTICIPATION.

(a) Each insurance policy, contract, certificate, evidence of coverage, or application subject to this chapter must include a statement that, if the insurer is unable to fulfill the insurer's contractual obligation under the policy, contract, certificate, or evidence of coverage, the insurer is not covered by an insurance guaranty fund or other solvency protection arrangement.

(b) The statement must be in 10-point type and affixed to the first page of the insurance policy, contract, certificate, evidence of coverage, or application.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 461.003. FORM OF STATEMENT; PROHIBITION. (a) The commissioner by rule shall promulgate the statement that an insurer must use to comply with this chapter.

(b) An insurer may not include in an insurance policy, contract, certificate, evidence of coverage, or application a statement that does not conform to the appropriate statement prescribed by the commissioner.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

CHAPTER 462. TEXAS PROPERTY AND CASUALTY INSURANCE GUARANTY ASSOCIATION

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 462.001. SHORT TITLE. This chapter may be cited as the Texas Property and Casualty Insurance Guaranty Act.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 462.002. PURPOSES. The purposes of this chapter are to:

- (1) provide a mechanism for the payment of covered claims under certain insurance policies to avoid excessive delay in payment;
- (2) avoid financial loss to claimants or policyholders because of an insurer's impairment;
- (3) assist in the detection and prevention of insurer insolvencies; and
- (4) provide an association to assess the cost of that protection among insurers.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 462.003. CONSTRUCTION. This chapter shall be liberally construed to implement the purposes of this chapter described by Section 462.002, which shall be used to aid and guide interpretation of this chapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 462.004. GENERAL DEFINITIONS. In this chapter:

(1) "Affiliate" means a person who, directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with an impaired insurer on December 31 of the year preceding the date the insurer becomes an impaired insurer.

(2) "Association" means the Texas Property and Casualty Insurance Guaranty Association.

(3) "Board" means the board of directors of the association.

(4) "Claimant" means an insured making a first-party claim or a person instituting a liability claim.

(5) "Impaired insurer" means a member insurer that is subject to a final, nonappealable order of liquidation that includes a finding of insolvency issued by a court of competent jurisdiction in this state or in the insurer's state of domicile.

(6) "Member insurer" means an insurer, including a stock insurance company, a mutual insurance company, a Lloyd's plan, a reciprocal or interinsurance exchange, and a county mutual insurance company, that:

(A) writes any kind of insurance to which this chapter applies under Sections 462.007 and 462.008, including reciprocal or interinsurance exchange contracts; and

(B) holds a certificate of authority to engage in the business of insurance in this state.

(7) "Person" means an individual, corporation, partnership, association, or voluntary organization.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 343 (S.B. 1063), Sec. 1, eff. September 1, 2019.

Sec. 462.005. DESCRIPTION OF CONTROL. (a) For purposes of this chapter, control is the power to direct, or cause the direction

of, the management and policies of a person, other than power that results from an official position with the person or a corporate office held by the person. The power may be possessed directly or indirectly by any means, including through the ownership of voting securities or by contract, other than a commercial contract for goods or nonmanagement services.

(b) A person is presumed to control another person if the person directly or indirectly owns, controls, holds with the power to vote, or holds proxies representing 10 percent or more of the voting securities of the other person. This presumption may be rebutted by a showing that the person does not in fact control the other person.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 462.006. NET DIRECT WRITTEN PREMIUMS. (a) Except as provided by Subsection (b) and subject to Subsection (c), in this chapter, "net direct written premiums" means direct premiums written in this state on insurance policies to which this chapter applies, less return premiums on those policies and dividends paid or credited to policyholders on that direct business.

(b) Subject to Subsection (c), for assessing the workers' compensation line of business, the term "net direct written premiums" includes the modified annual premium before the application of a deductible premium credit, less return premiums on those policies and dividends paid or credited to policyholders on that direct business.

(c) The term "net direct written premiums" does not include premiums on contracts between insurers or reinsurers.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 462.007. APPLICABILITY IN GENERAL; EXCEPTIONS. (a) Except as provided by Subsection (b), this chapter applies to each kind of direct insurance.

(b) Except as provided by Subchapter F, this chapter does not apply to:

- (1) life, annuity, health, or disability insurance;
- (2) mortgage guaranty, financial guaranty, or other kinds

of insurance offering protection against investment risks;

(3) a fidelity or surety bond, or any other bonding obligation;

(4) credit insurance, vendors' single-interest insurance, collateral protection insurance, or similar insurance protecting a creditor's interest arising out of a creditor-debtor transaction;

(5) insurance of warranties or service contracts;

(6) title insurance;

(7) ocean marine insurance;

(8) a transaction or combination of transactions between a person, including an affiliate of the person, and an insurer, including an affiliate of the insurer, that involves the transfer of investment or credit risk unaccompanied by the transfer of insurance risk, including transactions, except for workers' compensation insurance, involving captive insurers, policies in which deductible or self-insured retention is substantially equal in amount to the limit of the liability under the policy, and transactions in which the insured retains a substantial portion of the risk; or

(9) insurance provided by or guaranteed by government.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. [2017](#)), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 3B.005(a), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. [3167](#)), Sec. 9.005(a), eff. September 1, 2007.

Sec. 462.008. APPLICABILITY TO TEXAS MUTUAL INSURANCE COMPANY.

(a) This chapter applies to insurance written through the Texas Mutual Insurance Company only as provided by this section.

(b) This chapter applies to the Texas Mutual Insurance Company on a prospective basis on and after January 1, 2000. The Texas Mutual Insurance Company is only liable for assessments for a claim with a date of injury that occurs on or after January 1, 2000. The association, with respect to an insolvency of the Texas Mutual Insurance Company, is only liable for a claim with a date of injury that occurs on or after January 1, 2000.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. [2017](#)), Sec. 1, eff. April

1, 2007.

Sec. 462.009. APPLICABILITY TO FORMER TEXAS WORKERS' COMPENSATION INSURANCE FACILITY AND SUCCESSOR. (a) Notwithstanding any other provision of this chapter, this chapter applies to each insurance policy issued under Article 5.76 or 5.76-2, as those articles existed before their repeal.

(b) Notwithstanding any other provision of this chapter, the stock insurance company that resulted from the transfer of the former Texas workers' compensation insurance facility is considered an impaired insurer for purposes of this chapter if any action described by Section 462.004(5) is taken with respect to the company.

(c) A claim under an insurance policy described by Subsection (a) is a covered claim for purposes of this chapter if the claim is a covered claim for purposes of Sections 462.201-462.203, 462.205-462.210, 462.213, 462.214, and 462.305 without regard to whether the stock insurance company described by Subsection (b):

(1) issued or assumed the policy; or

(2) was authorized to engage in business in this state at the time:

(A) the policy was written; or

(B) the company became an impaired insurer.

(d) If a conflict exists between this section and any other statute relating to the former Texas workers' compensation insurance facility or the association, this section controls.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 462.010. CONFLICT WITH OTHER LAWS. (a) Except as provided by Subsection (b), if this chapter conflicts with another statute relating to the association, this chapter controls.

(b) This section does not apply to a conflict between this chapter and:

(1) Subtitle A, Title 5, Labor Code, except as described by Subsection (c); or

(2) Subtitle E, Title 10.

(c) This chapter controls with respect to subrogation rights of

an insurance carrier under Chapter 417, Labor Code, against an impaired insurer's insured or the association.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 462.011. IMMUNITY IN GENERAL. (a) Liability does not exist and a cause of action does not arise against any of the following persons for any good faith act or omission in performing the person's powers and duties under this chapter:

- (1) the commissioner or the commissioner's representative;
- (2) the association or the association's agent or employee;
- (3) a member insurer;
- (4) the board;
- (5) the receiver; or
- (6) a special deputy receiver or the special deputy receiver's agent or employee.

(b) The attorney general shall defend any action to which this section applies that is brought against the commissioner or the commissioner's representative, the association or the association's agent or employee, a member insurer or the insurer's agent or employee, a board member, or a special deputy receiver or the special deputy receiver's agent or employee, including an action instituted after the defendant's service with the association, commissioner, or department has terminated. This subsection does not require the attorney general to defend a person with respect to an issue other than the applicability or effect of the immunity created by Subsection (a). The attorney general is not required to defend the association or the association's agent or employee, a member insurer or the member insurer's agent or employee, a board member, or a special deputy receiver or the special deputy receiver's agent or employee against an action regarding the disposition of a claim filed with the association under this chapter or any issue other than the applicability or effect of the immunity created by Subsection (a). The association may contract with the attorney general under Chapter 771, Government Code, for legal services not covered by this subsection.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 462.012. IMMUNITY IN RELATION TO CERTAIN REPORTS AND RECOMMENDATIONS. Liability does not exist and a cause of action does not arise against any of the following persons for a statement made in good faith by the person in a report or recommendation made under Section 462.111 or 462.113:

- (1) the commissioner or the commissioner's representative;
- (2) the association or the association's agent or employee;
- (3) a member insurer; or
- (4) the board.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 462.013. IMMUNITY IN RELATION TO CERTAIN NEGOTIATIONS.

(a) Liability does not exist and a cause of action does not arise against any of the following persons for an act or omission in the performance of an activity related to the negotiations relating to the privatization of the former Texas workers' compensation facility:

- (1) the commissioner or the commissioner's representative;
- (2) the association or the association's agent or employee;
- (3) a member insurer; or
- (4) a board member.

(b) This section applies to each activity undertaken by a person described by Subsection (a), regardless of the date of the act or omission.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 462.014. RULES. The commissioner shall adopt reasonable rules as necessary to implement and supplement this chapter and this chapter's purposes.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 462.015. INFORMATION PROVIDED BY OR TO COMMISSIONER. (a) The commissioner shall notify the association of the existence of an impaired insurer not later than the third day after the date the commissioner gives notice of the designation of impairment. The association is entitled to a copy of any complaint seeking an order of receivership with a finding of insolvency against a member insurer at the time the complaint is filed with a court.

(b) On the board's request, the commissioner shall provide the association with a statement of the net direct written premiums of each member insurer.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 462.016. PENALTY FOR FAILURE TO PAY ASSESSMENTS OR COMPLY WITH PLAN OF OPERATION. (a) The commissioner shall suspend or revoke, after notice and hearing, the certificate of authority to engage in the business of insurance in this state of a member insurer that:

(1) fails to pay an assessment at the time the assessment is due; or

(2) otherwise fails to comply with the plan of operation.

(b) As an alternative to action under Subsection (a), the commissioner may assess a fine on a member insurer that fails to pay an assessment at the time the assessment is due. The fine may not exceed the lesser of:

(1) five percent of the unpaid assessment per month; or

(2) \$100 per month.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 462.017. APPEALS AND OTHER ACTIONS. (a) A final action or order of the commissioner under this chapter is subject to judicial review by a court.

(b) Venue in a suit by or against the commissioner or association relating to an action or ruling of the commissioner or association under this chapter is in Travis County. The commissioner or association is not required to give an appeal bond in an appeal of

a cause of action arising under this chapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.008(a), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.008(a), eff. September 1, 2007.

SUBCHAPTER B. GOVERNANCE OF ASSOCIATION

Sec. 462.051. ASSOCIATION AS LEGAL ENTITY; MEMBERSHIP. (a) The Texas Property and Casualty Insurance Guaranty Association is a nonprofit unincorporated legal entity.

(b) The association is composed of all member insurers. A member insurer must remain a member of the association as a condition of engaging in the business of insurance in this state.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 462.052. BOARD OF DIRECTORS. (a) The association's powers are exercised through a board of directors consisting of nine individuals.

(b) Member insurers shall select five insurance industry board members, subject to the approval of the commissioner. In approving selections to the board, the commissioner shall consider whether all member insurers are fairly represented.

(c) Four board members must be public representatives appointed by the commissioner.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 462.053. ELIGIBILITY TO SERVE AS PUBLIC REPRESENTATIVE. A board member who is a public representative may not be:

(1) an officer, director, or employee of an insurer, insurance agency, agent, broker, adjuster, or any other business

entity regulated by the department;

(2) a person required to register with the Texas Ethics Commission under Chapter 305, Government Code, in connection with the person's representation of clients in the field of insurance; or

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

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 462.054. ELIGIBILITY TO SERVE AS INDUSTRY REPRESENTATIVE. To be eligible to serve as an insurance industry board member, an individual must be a full-time employee of a member insurer.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 462.055. TERM; VACANCY. (a) A board member serves a term established by the plan of operation.

(b) The remaining board members, by majority vote, shall fill a vacancy on the board for the unexpired term of a director who serves as an insurance industry board member, subject to the commissioner's approval. The commissioner shall appoint a director to fill a vacancy on the board for the unexpired term of a director who serves as a public representative.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 343 (S.B. 1063), Sec. 2, eff. September 1, 2019.

Sec. 462.056. REIMBURSEMENT OF BOARD MEMBERS. A board member may be reimbursed from the assets of the association for expenses the board member incurs as a board member.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 462.057. FINANCIAL STATEMENT OF BOARD MEMBER. Each board member shall file with the Texas Ethics Commission a financial statement as provided by Subchapter B, Chapter 572, Government Code.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 462.058. CONFLICT OF INTEREST. (a) A director of the association or a member insurer or other entity represented by the director may not receive money or another valuable thing directly, indirectly, or through any substantial interest in any other corporation, firm, or business unit for negotiating, procuring, participating in, recommending, or aiding in a reinsurance agreement, merger, or other transaction, including the purchase, sale, or exchange of assets, insurance policies, or property made by the association or the supervisor, conservator, or receiver on behalf of an impaired insurer.

(b) The director, member insurer, or entity may not be pecuniarily or contractually interested, as principal, coprincipal, agent, or beneficiary, directly, indirectly, or through any substantial interest in any other corporation, firm, or business unit, in the reinsurance agreement, merger, purchase, sale, exchange, or other transaction.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 462.059. MEETING BY CONFERENCE CALL. (a) Notwithstanding Chapter 551, Government Code, the board may hold an open meeting by telephone conference call. A meeting held by telephone conference call:

(1) must be audible to the public at the location specified in the notice described by Subsection (c); and

(2) must allow two-way audio communication during the entire meeting between the members of the board attending a meeting authorized by this section.

(a-1) If the two-way audio communication required under

Subsection (a) is disrupted during a meeting so that a quorum of the board is no longer able to participate, the meeting may not continue until the two-way audio communication is reestablished.

(b) The meeting is subject to the notice requirements that apply to other meetings of the board of directors.

(c) The notice of the meeting must specify the location of the meeting, and each part of the meeting that is required to be open to the public must be audible to the public at that location. The association must make an audio recording of the meeting. The recording of the open portion of the meeting must be posted publicly to the association's Internet website.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 343 (S.B. 1063), Sec. 3, eff. September 1, 2019.

SUBCHAPTER C. GENERAL POWERS AND DUTIES OF ASSOCIATION

Sec. 462.101. GENERAL POWERS AND DUTIES. (a) The association may:

(1) employ or retain persons as necessary to handle claims and perform other duties of the association;

(2) borrow money necessary to implement this chapter in accordance with the plan of operation;

(3) sue or be sued;

(4) negotiate and enter into a contract as necessary to implement this chapter; and

(5) perform other acts as necessary or proper to implement this chapter.

(b) A contract authorized by Subsection (a)(4) includes a lump-sum or structured compromise and settlement agreement with a claimant who has a claim for medical or indemnity benefits for a period of three years or more, other than a settlement or lump-sum payment in violation of Subtitle A, Title 5, Labor Code.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 462.102. ASSOCIATION NOT IN PLACE OF IMPAIRED INSURER. In performing the association's statutory obligations under this chapter, the association is not considered:

- (1) to be engaged in the business of insurance;
- (2) to have assumed or succeeded to a liability of the impaired insurer; or
- (3) to otherwise stand in the place of the impaired insurer for any purpose, including for the purpose of determining whether the association is subject to personal jurisdiction of the courts of another state.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 462.103. PLAN OF OPERATION. (a) The association shall perform the association's functions under a plan of operation necessary or suitable to ensure the fair, reasonable, and equitable administration of the association. The plan of operation must:

- (1) be submitted to and approved in writing by the commissioner;
- (2) establish:
 - (A) procedures under which the powers and duties of the association are performed;
 - (B) procedures for handling assets of the association;
 - (C) the amount and method of reimbursing board members;
 - (D) acceptable forms of proof of covered claims;
 - (E) regular places and times for board meetings;
 - (F) procedures for records to be kept of each financial transaction of the association, the association's agents, and the board; and
 - (G) procedures under which selections for the board are submitted to the commissioner;
- (3) provide:
 - (A) for the establishment of a claims filing procedure that includes:
 - (i) notice by the association to claimants;
 - (ii) procedures for filing claims seeking recovery from the association; and
 - (iii) a procedure for appealing the denial of

claims by the association; and

(B) that a member insurer aggrieved by a final action or decision of the association may appeal to the commissioner not later than the 30th day after the date of the action or decision; and

(4) contain additional provisions necessary or proper for the execution of the association's powers and duties.

(b) The association shall submit to the commissioner any amendment to the plan of operation necessary or suitable to ensure the fair, reasonable, and equitable administration of the association. The amendment takes effect on the commissioner's written approval.

(c) If the association does not submit a suitable amendment to the plan of operation, the commissioner after notice and hearing shall adopt reasonable rules as necessary or advisable to implement this chapter. A rule continues in effect until modified by the commissioner or superseded by an amendment submitted by the association and approved by the commissioner.

(d) Each member insurer shall comply with the plan of operation.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 462.104. NOTICE TO INSUREDS. (a) The commissioner may require that the association notify an impaired insurer's insureds and any other interested parties of:

(1) the designation of impairment; and

(2) the insureds' and other parties' rights under this chapter.

(b) The association shall give notice as the commissioner directs under this section. The association shall mail the notice to the last known address, if available. If sufficient information for notification by mail is not available, notice by publication in a newspaper of general circulation is sufficient notice.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 462.105. ACCOUNTS. For purposes of administration and

assessment, the association is divided into:

- (1) the workers' compensation insurance account;
- (2) the automobile insurance account; and
- (3) the account for all other lines of insurance to which this chapter applies.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 462.106. ADMINISTRATIVE EXPENSES. (a) The association may use money in the administrative account to pay administrative costs and other general expenses of the association.

(b) The association may transfer income from investment of the association's money to the administrative account.

(c) On notification by the association of the amount of any additional money needed for the administrative account, the association shall assess member insurers in the manner provided by Sections 462.159-462.168 for that money. The commissioner shall consider the net direct written premiums collected in this state for all lines of business covered by this chapter. An assessment for administrative expenses incurred by a supervisor or conservator appointed by the commissioner or a court-appointed receiver for a nonmember of the association or unauthorized insurer operating in this state may not exceed \$1 million each calendar year.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 462.107. EXAMINATION OF ASSOCIATION. Not later than April 30 of each year, the association shall submit an audited financial statement for the preceding calendar year to the state auditor in a form approved by the state auditor's office.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 462.108. DEPOSIT OF MONEY. The board may deposit the money the association collects into the Texas Treasury Safekeeping

Trust Company in accordance with procedures established by the comptroller. The comptroller shall account to the association for the deposited money separately from all other money.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 462.109. DELEGATION OF POWERS AND DUTIES. (a) Except as provided by Subsection (b), the plan of operation may provide that, on approval of the board and the commissioner, the association may delegate by contract any or all powers or duties of the association to a corporation or other organization that:

(1) performs or will perform in two or more states functions similar to those of the association or the association's equivalent; and

(2) provides protection not substantially less favorable and effective than that provided by this chapter.

(b) The association may not delegate a power or duty under Section 462.101(a)(2), 462.151, 462.154, 462.155, or 462.302(d) under this section.

(c) The association shall:

(1) reimburse the corporation or other organization as a servicing facility would be reimbursed; and

(2) pay the corporation or other organization for the performance of any other functions of the association.

(d) A contract entered into under this section is subject to the performance standards imposed under Section 442.112.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 462.110. EXEMPTION FROM CERTAIN FEES AND TAXES. The association is exempt from payment of all fees and of all taxes levied by this state or a subdivision of this state, except taxes levied on real or personal property.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 462.111. ACCESS TO RECORDS OF MEMBER INSURER IN RECEIVERSHIP; ACTUARIAL AND OPERATIONAL ANALYSIS. (a) The association shall have access to the books and records of a member insurer in receivership to determine the extent of the impact on the association if the member becomes impaired.

(b) The association may:

- (1) perform or cause to be performed an actuarial and operational analysis of the member insurer; and
- (2) prepare a report on matters relating to the impact or potential impact on the association in the event of impairment.

(c) A report prepared under Subsection (b) is not a public document.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 462.112. BOARD ACCESS TO RECORDS OF IMPAIRED INSURER. The receiver or statutory successor of an impaired insurer covered by this chapter shall give the board or the board's representative:

- (1) access to the insurer's records as necessary for the board to perform the board's functions under this chapter relating to covered claims; and
- (2) copies of those records on the board's request and at the board's expense.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 462.1121. ACTION TO OBTAIN INFORMATION CONCERNING INSURER IN RECEIVERSHIP AUTHORIZED. (a) The association may bring an action against any third-party administrator, agent, attorney, or other representative of an insurer for which a receiver has been appointed to obtain custody and control of all information, including files, records, and electronic data, related to the insurer that is appropriate or necessary for the association, or a similar association in other states, to carry out its duties under this chapter or a similar law of another state. The association has the absolute right to obtain information under this section through emergency equitable relief, regardless of where the information is

physically located.

(b) In bringing an action under this section, the association is not subject to any defense, possessory lien or other type of lien, or other legal or equitable ground for refusal to surrender the information that may be asserted against the receiver of the insurer.

(c) The association is entitled to an award of reasonable attorney's fees and costs incurred by the association in any action to obtain information under this section.

(d) The rights granted to the association under this section do not affect the receiver's title to information, and information obtained under this section remains the property of the receiver while in the custody of the association.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.007(b), eff. September 1, 2007.

Added by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.007(b), eff. September 1, 2007.

Sec. 462.113. BOARD REPORT ON CONCLUSION OF INSOLVENCY. On the conclusion of the insolvency of a domestic insurer with respect to which the association was obligated to pay covered claims, the board may:

- (1) prepare a report on the history and causes of the insolvency, based on information available to the association; and
- (2) submit the report to the commissioner.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 462.114. DUTY OF RECEIVER. The receiver shall periodically submit a list of claims to the association or similar organization in another state.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

SUBCHAPTER D. ASSESSMENTS IN GENERAL

Sec. 462.151. MAKING OF ASSESSMENT; AMOUNT. (a) The

association shall assess member insurers the amount necessary to pay:

(1) the association's obligations under Section 462.302 and the expenses of handling covered claims subsequent to an insolvency; and

(2) other expenses authorized by this chapter.

(b) The assessment of each member insurer must be in the proportion that the net direct written premiums of the insurer for the calendar year preceding the assessment bear to the net direct written premiums of all member insurers for that year.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 462.152. MAXIMUM TOTAL ASSESSMENT. (a) The total assessment of a member insurer in a year may not exceed an amount equal to two percent of the insurer's net direct written premiums for the calendar year preceding the assessment.

(b) If the maximum assessment and the association's other assets are insufficient in a year to make all necessary payments, the money available shall be prorated and the association shall pay the unpaid portion as soon as money becomes available.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 462.153. REFUND OF CONTRIBUTION. The association may refund to the member insurers in proportion to the contribution of each member insurer to the association the amount by which the association's assets exceed the association's liabilities, if at the end of a calendar year the board finds that the assets of the association exceed the liabilities of the association as estimated by the board for the next year.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 462.154. NOTICE OF ASSESSMENT. The association shall notify a member insurer of an assessment not later than the 30th day

before the date the assessment is due.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 462.155. DEFERMENT. (a) The association may defer wholly or partly an assessment of a member insurer that would cause the insurer's financial statement to show amounts of capital or surplus less than the minimum amounts required for a certificate of authority in any jurisdiction in which the insurer is authorized to engage in the business of insurance.

(b) The member insurer shall pay the deferred assessment at the time payment will not reduce capital or surplus below required minimums. The payment shall be refunded to or credited against future assessments of any member insurer receiving a larger assessment because of the deferment, as elected by that insurer.

(c) During a period of deferment, the member insurer may not pay a dividend to shareholders or policyholders.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 462.156. USE OF ASSESSMENTS. (a) The amounts provided under assessments made under this chapter supplement the marshalling of assets by the receiver under Chapter 442 to make payments on the impaired insurer's behalf.

(b) This section does not require the receiver to exhaust the assets of the impaired insurer before an assessment is made or before money derived from an assessment may be used to pay covered claims.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 462.157. TAX CREDIT. (a) An insurer is entitled to a credit against the insurer's premium tax under Chapter 221 for the total amount of an assessment paid by the insurer under this chapter.

(b) The tax credit may be taken at a rate of 10 percent each year for 10 successive years after the date of assessment. At the

option of the insurer, the tax credit may be taken over an additional number of years.

(c) The balance of a tax credit not claimed in a particular year may be reflected in the books and records of the insurer as an admitted asset of the insurer for all purposes, including exhibition in an annual statement under Section 862.001.

(d) Available credit against premium tax allowed under this section may be transferred or assigned among insurers if:

- (1) a merger, acquisition, or total assumption of reinsurance among the insurers occurs; or
- (2) the commissioner by order approves the transfer or assignment.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 462.158. ADVANCE AS LOAN. Money advanced by the association under this chapter is considered a special fund loan to the impaired insurer for payment of covered claims and does not become an asset of the impaired insurer. The loan is repayable to the extent money from the impaired insurer is available.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 462.159. ESTIMATE OF ADDITIONAL MONEY NEEDED ON IMPAIRMENT OF INSURER. (a) If the commissioner determines that an insurer has become an impaired insurer, the association shall promptly estimate the amount of additional money, by lines of business, needed to supplement the immediately available assets of the impaired insurer to pay covered claims.

(b) The board shall make additional money available as the actual need arises for each impaired insurer.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 462.160. ASSESSMENT FOR ADDITIONAL MONEY FOR ACCOUNTS. If

the board determines that additional money is needed in any of the three accounts described by Section 462.105, the board shall make assessments as needed to produce the necessary money.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 462.161. AMOUNT OF ASSESSMENT; PRORATION OF PAYMENT. (a) The association, in determining the proportionate amount to be paid by individual insurers under an assessment under Section 462.160, shall consider the lines of business written by the impaired insurer and shall assess individual insurers in proportion to the ratio that the total net direct written premiums collected in this state by the insurer for those lines of business bears to the total net direct written premiums collected by all insurers, other than impaired insurers, in this state for those lines of business.

(b) The association shall determine the total net direct written premiums of an individual insurer and of all insurers in the state from the insurers' annual statements for the year preceding assessment.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 462.162. MAXIMUM ASSESSMENT OF INSURER; ADDITIONAL ASSESSMENT AUTHORITY UNDER CERTAIN CIRCUMSTANCES. (a) Except as otherwise provided by this section, assessments under Section 462.160 during a calendar year may not exceed two percent of each insurer's net direct written premiums for the preceding calendar year in the lines of business for which the assessments are made.

(b) In the event of a natural disaster or other catastrophe, the association may apply to the governor, in the manner prescribed by the plan of operation, for authority to assess each member insurer that writes insurance coverage, other than automobile insurance coverage or workers' compensation insurance coverage, an additional amount not to exceed two percent of the insurer's net direct written premiums for the preceding calendar year.

(c) If the maximum assessment in a calendar year does not provide an amount sufficient for payment of covered claims of

impaired insurers, the association may make assessments in successive calendar years.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 462.163. PAYMENT OF ASSESSMENT. An insurer shall pay the amount of an assessment under Section 462.160 or 462.162(b) to the association not later than the 30th day after the date the association gives notice of the assessment.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 462.164. PARTICIPATION RECEIPTS. (a) On receipt from a member insurer of payment of an assessment or partial assessment under Section 462.160 or 462.162(b), the association shall provide the insurer with a participation receipt. A participation receipt creates liability against the account described by Section 462.105 for the line or lines of business for which the assessment was made.

(b) The account from which an advance is made to an impaired insurer for the payment of covered claims is a general creditor of the impaired insurer for the money advanced. With reference to the remaining balance of an advance not used to pay covered claims, the claim of the account has preference over other general creditors.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 462.165. ACCOUNTING; REPORTS; REFUND. (a) The association, with respect to an impaired insurer, shall adopt accounting procedures that reflect the use of all money and shall make a final report of the use of the money to the commissioner. The final report must state any remaining balance from the money advanced to an impaired insurer for the payment of covered claims.

(b) The association shall make interim accounting reports as required by the commissioner or requested by the conservator.

(c) As soon as practicable after completion of the final

report, the association shall refund by line of business the remaining balance of those advances to the association's accounts.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 462.166. USE OF EXCESS MONEY IN ACCOUNT. (a) If the association determines that money in the account described by Section 462.164(b) for a line of business exceeds the amount reasonably necessary for efficient future operation under this chapter, the association shall, after deducting any premium tax credit taken under Section 462.157, return the excess money pro rata to the holders of participation receipts:

- (1) on which an outstanding balance exists; and
- (2) that were issued for an assessment on the same line of business as the line for which the excess money is found to exist.

(b) The association shall transfer an excess amount that exists in the account described by Section 462.164(b) to the comptroller to be deposited to the credit of the general revenue fund if:

- (1) after a distribution under this section the association finds that an excess amount still exists; or
- (2) participation receipts on which there is an outstanding balance do not exist.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 462.167. COLLECTION OF ASSESSMENTS. (a) The commissioner may collect an assessment on behalf of the association through a suit brought for that purpose.

(b) Venue for a suit under this section is in Travis County.

(c) Either party to the suit may appeal to an appellate court. The appeal is at once returnable to the appellate court. The appeal has precedence in the appellate court over all causes of a different character pending before the court.

(d) The commissioner is not required to give an appeal bond in any cause of action arising under this section.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April

1, 2007.

Sec. 462.168. EXEMPTION FOR IMPAIRED INSURER. An impaired insurer is exempt from assessment from the date the insurer is designated an impaired insurer until the date the commissioner determines that the insurer is no longer an impaired insurer.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

SUBCHAPTER E. COVERED CLAIMS; CLAIMANTS

Sec. 462.201. COVERED CLAIMS IN GENERAL. A claim is a covered claim if:

- (1) the claim is an unpaid claim;
- (2) the claim is made under an insurance policy to which this chapter applies that is:
 - (A) issued by an insurer authorized to engage in business in this state; or
 - (B) assumed by an insurer authorized to engage in business in this state that issues an assumption certificate to the insured;
- (3) the claim arises out of the policy and is within the coverage and applicable limits of the policy;
- (4) the insurer that issued the policy or assumed the policy under an assumption certificate issued to the insured is an impaired insurer; and
- (5) the claim:
 - (A) is made by a liability claimant or insured who is a resident of this state at the time of the insured event; or
 - (B) is a first-party claim for damage to property that is permanently located in this state.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 462.202. CLAIM FOR UNEARNED PREMIUMS. (a) A claim for unearned premiums is a covered claim. A covered claim for unearned premiums may not exceed \$25,000.

(b) With respect to a covered claim for unearned premiums, a person has a covered claim under this chapter if the person is a resident of this state at the time:

- (1) the policy is issued; or
- (2) the insurer is determined to be an impaired insurer.

(c) A person has a covered claim under this chapter if the person holds a valid assignment of a covered claim for unearned premiums under Subsections (a) and (b).

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1188 (S.B. 1227), Sec. 1, eff. June 19, 2015.

Sec. 462.203. CERTAIN EXPENSES OF RECEIVERSHIP OR CONSERVATORSHIP ESTATE COVERED. An administration expense incurred in processing or paying a claim against a receivership or conservatorship estate is a covered claim if the impaired insurer has insufficient assets to pay the expenses of administering the estate.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 462.204. AFFILIATE MAY NOT BE CLAIMANT. A person who is an affiliate of an impaired insurer may not be a claimant of the insurer.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 462.205. DETERMINATION OF RESIDENCE OF ENTITIES. A corporation or other entity that is not an individual is considered to be a resident of the state in which the entity's principal place of business is located.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 462.206. CLAIMS NOT COVERED: PREMIUM UNDER RETROSPECTIVE RATING PLAN. An amount sought as a return of premium under a retrospective rating plan is not a covered claim.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 462.207. CLAIMS NOT COVERED: AMOUNTS DUE CERTAIN ENTITIES.

(a) Any amount directly or indirectly due any reinsurer, insurer, self-insurer, insurance pool, or underwriting association, as a subrogation recovery, reinsurance recovery, contribution, or indemnification, or otherwise, is not a covered claim.

(b) An impaired insurer's insured is not liable, and the reinsurer, insurer, self-insurer, insurance pool, or underwriting association is not entitled to sue or continue a suit against the insured, for a subrogation recovery, reinsurance recovery, contribution, indemnification, or any other claim asserted directly or indirectly by a reinsurer, insurer, self-insurer, insurance pool, or underwriting association to the extent of the applicable liability limits of the insurance policy written and issued to the insured by the insolvent insurer.

(c) The association is entitled to recover the association's costs, expenses, and reasonable attorney's fees incurred in defending the association or an impaired insurer's insured against a claim brought in violation of this subsection by a reinsurer, insurer, self-insurer, insurance pool, or underwriting association, on that entity's own behalf or on behalf of the entity's insured, after the date on which the entity is provided notice by the association or otherwise of the provisions of this section applicable to the entity's suit.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.006(a), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.006(a), eff. September 1, 2007.

Acts 2019, 86th Leg., R.S., Ch. 343 (S.B. 1063), Sec. 4, eff. September 1, 2019.

Sec. 462.208. CLAIMS NOT COVERED: SUPPLEMENTARY PAYMENT OBLIGATIONS. A supplementary payment obligation, including an adjustment fee or expense, attorney's fee or expense, court cost, interest or penalty, or interest or bond premium, incurred before an insurer is determined to be an impaired insurer is not a covered claim.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 462.209. CLAIMS NOT COVERED: PREJUDGMENT OR POSTJUDGMENT INTEREST. Prejudgment or postjudgment interest that accrues after an insurer is determined to be an impaired insurer is not a covered claim.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 462.210. CLAIMS NOT COVERED: CERTAIN DAMAGES. A claim against the insured, insurer, guaranty association, receiver, special deputy receiver, or commissioner for recovery of punitive, exemplary, extracontractual, or bad-faith damages awarded in a court judgment against an insured or insurer is not a covered claim.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 462.211. CLAIMS NOT COVERED: LATE FILED CLAIMS. (a) Notwithstanding any other provision of this chapter or any other law to the contrary, and subject to Subsection (b), a claim that is filed with the association on a date that is later than 18 months after the date of the order of liquidation or that is unknown and unreported as of the date is not a covered claim.

(b) This section does not apply to a claim for workers'

compensation benefits governed by Title 5, Labor Code, and the applicable rules of the commissioner of workers' compensation.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.007(a), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.007(a), eff. September 1, 2007.

Sec. 462.212. NET WORTH EXCLUSION. (a) Except for a workers' compensation claim governed by Title 5, Labor Code, a covered claim does not include, and the association is not liable for, any claim arising from an insurance policy of any insured whose net worth on December 31 of the year preceding the date the insurer becomes an impaired insurer exceeds \$50 million.

(b) For purposes of this section, an insured's net worth includes the aggregate net worth of the insured and of the insured's parent, subsidiary, and affiliated companies computed on a consolidated basis.

(c) This section does not apply:

(1) to third-party claims against an insured that has:

(A) applied for or consented to the appointment of a receiver, trustee, or liquidator for all or a substantial part of the insurer's assets;

(B) filed a voluntary petition in bankruptcy; or

(C) filed a petition or an answer seeking a reorganization or arrangement with creditors or to take advantage of any insolvency law; or

(2) if an order, judgment, or decree is entered by a court of competent jurisdiction, on the application of a creditor, adjudicating the insured bankrupt or insolvent or approving a petition seeking reorganization of the insured or of all or a substantial part of its assets.

(d) In an instance described by Subsection (c), the association is entitled to assert a claim in the bankruptcy or receivership proceeding to recover the amount of any covered claim and costs of defense paid on behalf of the insured. A court shall award the

association the association's costs, expenses, and reasonable attorney's fees incurred in seeking recovery under this section.

(e) The association may establish procedures for requesting financial information from an insured on a confidential basis for the purpose of applying sections concerning the net worth of insureds, subject to any information requested under this subsection being shared with any other association similar to the association and with the liquidator for the impaired insurer on the same confidential basis. If the insured refuses to provide the requested financial information, the association may deem the net worth of the insured to be in excess of \$50 million at the relevant time.

(f) In any lawsuit contesting the applicability of Section 462.308 or this section when the insured has declined to provide financial information requested by the association, the insured bears the burden of proof concerning its net worth at the relevant time and shall pay the association the association's costs, expenses, and reasonable attorney's fees incurred in attempting to obtain the insured's financial information.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.010(a), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.010(a), eff. September 1, 2007.

Acts 2019, 86th Leg., R.S., Ch. 343 (S.B. 1063), Sec. 5, eff. September 1, 2019.

Sec. 462.213. AMOUNT OF INDIVIDUAL COVERED CLAIM; LIMIT. (a) Except as provided by Subsection (b) and Section 462.252, an individual covered claim may not exceed \$300,000.

(b) The association shall pay the full amount of a covered claim arising out of a workers' compensation claim made under a workers' compensation insurance policy.

(c) For purposes of this section, an individual covered claim includes any derivative claims by more than one person that arise from the same occurrence. The claims shall be considered collectively as a single claim under this chapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 462.214. CERTAIN SHAREHOLDERS' CLAIMS: LIMIT. Notwithstanding any other provision of this chapter, the association's liability for shareholder derivative actions or other claims for economic loss incurred by a claimant in the claimant's capacity as a shareholder under an insurance policy placed in force on or after January 1, 1992, is limited to \$300,000 for each policy, including defense costs, regardless of the number of claimants under each policy.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

SUBCHAPTER F. NONDUPLICATION OF RECOVERY

Sec. 462.251. EXHAUSTION OF RIGHTS UNDER OTHER POLICY REQUIRED.

(a) Any person who has a claim under an insurance policy, other than an impaired insurer's policy, and whose claim arises from the same facts, injury, or loss giving rise to a claim against an impaired insurer or the insurer's insured, must first exhaust the person's rights under the insurance policy, including:

(1) a claim for benefits under a workers' compensation insurance policy or a claim for indemnity or medical benefits under a health, disability, uninsured motorist, personal injury protection, medical payment, liability, or other insurance policy; and

(2) the right to defense under the insurance policy.

(b) Subsection (a) applies without regard to whether the insurance policy is issued by a member insurer.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 462.252. REDUCTION IN AMOUNT OF COVERED CLAIM FOR OTHER POLICY. (a) Except as provided by Subsection (b), an amount payable as a covered claim under this chapter is reduced by the full applicable limits of another insurance policy described by Section 462.251, and the association shall receive a full credit in the

amount of the full applicable limits of the other policy.

(b) A covered claim for workers' compensation benefits is subject to reduction only by a third-party liability recovery under Section 417.002, Labor Code.

(c) Subject to Section 462.255, the maximum amount payable by the association is the damages incurred by the claimant, less the association's credit or offset under this section, except that the association's liability may not exceed the lesser of:

(1) \$300,000; or

(2) the limits of the insurance policy under which the claim is made.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 462.253. EFFECT ON INSURED OF REDUCTION IN AMOUNT OF COVERED CLAIM. To the extent that the association's obligation is reduced by the application of Sections 462.251 and 462.252, the liability of the person insured by the impaired insurer's policy for the claim is reduced in the same amount.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 462.254. RECOVERY FROM MORE THAN ONE GUARANTY ASSOCIATION.

(a) Except as provided by Subsections (b) and (c), a person who has a claim that may be recovered from more than one insurance guaranty association or the equivalent shall seek recovery first from the association of the insured's residence.

(b) A claimant shall seek recovery of a first-party claim for damage to property with a permanent location first from the association of the location of the property.

(c) A claimant shall seek recovery of a workers' compensation claim first from the association of the claimant's residence.

(d) The association has a credit or offset against the benefits under this chapter in the amount of the claimant's recovery under this section.

(e) Subject to Section 462.255, the maximum amount payable by the association is the amount of damages incurred by the claimant,

less the credit or offset, except that the association's liability may not exceed \$300,000.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 462.255. CERTAIN CLAIMS SUBJECT TO LIEN OR SUBROGATION; LIMIT ON TOTAL RECOVERY. (a) Notwithstanding Sections 462.252(c) and 462.254(e), if a claimant is seeking recovery of insurance policy benefits that, had the impaired insurer not been insolvent, would be subject to lien or subrogation by any other insurer, including a workers' compensation insurer or health insurer, regardless of whether the other insurer is impaired, the association's credit or offset is deducted from the lesser of the damages incurred by the claimant or the limits of the policy under which the claim is made.

(b) A claimant's recovery under this chapter may not result in a total recovery to the claimant that is greater than the recovery that would have resulted had the impaired insurer not been insolvent.

(c) Subject to Sections 462.201-462.203, 462.205-462.210, 462.213, 462.214, and 462.305 of this code and Title 5, Labor Code, a claim for workers' compensation benefits under this chapter may not result in a recovery to the claimant that is less than the recovery that would have resulted had the impaired insurer not been insolvent.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

SUBCHAPTER G. ASSOCIATION POWERS AND DUTIES RELATING TO COVERED CLAIMS

Sec. 462.301. GENERAL POWERS AND DUTIES OF ASSOCIATION IN CONNECTION WITH PAYMENT OF COVERED CLAIMS. (a) The association shall investigate and adjust, compromise, settle, and pay covered claims to the extent of the association's obligation and deny all other claims.

(b) The association may review a settlement, release, or judgment to which an impaired insurer or the impaired insurer's insured was a party to determine the extent to which the settlement, release, or judgment may be properly contested.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 462.302. PAYMENT OF COVERED CLAIMS. (a) The association shall pay covered claims that exist before the designation of impairment or that arise:

(1) not later than the 30th day after the date of the designation of impairment;

(2) before the insurance policy expiration date, if that date is not later than the 30th day after the date of the designation of impairment; or

(3) before the insured replaces the insurance policy or causes the policy's cancellation, if the insured does so not later than the 30th day after the date of the designation of impairment.

(b) The association satisfies the obligation to pay a covered claim by paying the claimant the full amount of a covered claim for benefits.

(c) The association's liability is limited to the payment of covered claims. The association is not liable for any other claim or damages against the insured, an impaired insurer, the association, the receiver, the special deputy receiver, the commissioner, or the liquidator, including a claim for:

(1) recovery of attorney's fees, prejudgment or postjudgment interest, or penalties;

(2) extracontractual damages, multiple damages, or exemplary damages; or

(3) any other amount sought in connection with the assertion or prosecution of a claim, without regard to whether the claim is a covered claim, by or on behalf of:

(A) an insured or claimant; or

(B) a provider of goods or services retained by an insured or claimant.

(d) The association shall pay claims in the order the association considers reasonable, including paying as claims are received from the claimants or in groups or categories of claims.

(e) This section does not exclude the payment of workers' compensation benefits or other liabilities or penalties authorized by Title 5, Labor Code, arising from the association's processing and paying workers' compensation benefits after the designation of

impairment.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 462.303. CERTAIN DETERMINATIONS NOT BINDING. (a) The association is not bound by:

(1) a judgment taken before the designation of impairment in which an insured under a liability insurance policy or the insurer failed to exhaust all appeals;

(2) a judgment taken by default or consent against an insured or the impaired insurer; or

(3) a judgment, settlement, or release entered into by the insured or the impaired insurer.

(b) A judgment, settlement, or release described by Subsection (a) is not evidence of liability or of damages in connection with a claim brought against the association, an impaired insurer's insured, or another party under this chapter.

(c) The association is entitled to recover the association's costs, expenses, and reasonable attorney's fees incurred in contesting a claim based on a judgment, settlement, or release described by Subsection (a) on the association's behalf or on behalf of an impaired insurer's insured after the date on which the party asserting the claim is provided notice by the association or otherwise of the provisions of this section applicable to the judgment, settlement, or release.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 343 (S.B. 1063), Sec. 6, eff. September 1, 2019.

Sec. 462.304. SERVICING FACILITY. (a) The association shall handle claims through:

(1) the association's employees or contract claims adjusters; or

(2) subject to the approval of the commissioner, one or more insurers designated as a servicing facility under a servicing

agreement or loss portfolio transfer agreement.

(b) A member insurer may decline designation as a servicing facility.

(c) The association shall reimburse a servicing facility for obligations of the association paid by the facility and expenses incurred by the facility in handling claims for the association. The association shall reimburse a servicing facility under this subsection in a manner that is consistent with the applicable servicing agreement or loss portfolio agreement.

(d) The commissioner may revoke the designation of a servicing facility if the commissioner finds that servicing facility is handling claims unsatisfactorily.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 343 (S.B. 1063), Sec. 7, eff. September 1, 2019.

Sec. 462.305. LIMITATION OF ASSOCIATION'S LIABILITY. The association is not liable to an insured or liability claimant for the association's failure to settle a liability claim within the limits of a covered claim under this chapter. A claim described by this section for failure to settle a liability claim is not a covered claim.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 462.306. DISCHARGE OF POLICY OBLIGATION. (a) The association shall discharge an impaired insurer's policy obligations, including the duty to defend insureds under a liability insurance policy, to the extent that the policy obligation is a covered claim under this chapter.

(b) In performing the association's statutory obligations, the association may also enforce a duty imposed on the insured or beneficiary under the terms of an insurance policy within the scope of this chapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 462.307. ASSIGNMENT OF RIGHTS. (a) A person recovering under this chapter assigns to the association the person's rights:

(1) under the insurance policy; and
(2) to recover for the occurrence that is the basis of the claim under this chapter under an insurance policy issued by an unimpaired insurer to the extent of the person's recovery from the association.

(b) The association may pursue a claim to which the association is subrogated under Subsection (a) in the association's own name or in the name of the person recovering under this chapter.

(c) An insured or claimant seeking the protection of this chapter shall cooperate with the association to the same extent as that person would have been required to cooperate with the impaired insurer.

(d) Except as provided by Section 462.308 or 462.212, the association does not have a cause of action against the impaired insurer's insured for money the association has paid, other than a cause of action that the impaired insurer would have had if the money had been paid by the impaired insurer.

(e) In the case of an impaired insurer operating on a plan with assessment liability, the payment of a claim of the association does not reduce the liability of the insured to the receiver or statutory successor for an unpaid assessment.

(f) To the extent the association has a right to recover proceeds from the sale of salvage property related to a covered claim, the association's right to recover the proceeds may not be reduced in the amount of any pre-impairment costs, fees, or expenses related to the salvage property that are not part of a covered claim under Subchapter E. A person or entity in possession of salvage property subject to the association's right of recovery may not seek recovery from the association for any pre-impairment costs, fees, or expenses related to the salvage property that are not a covered claim under Subchapter E.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 343 (S.B. 1063), Sec. 8, eff. September 1, 2019.

Sec. 462.308. RECOVERY FROM CERTAIN PERSONS. (a) The association is entitled to recover:

(1) the amount of a covered claim and the cost of defense paid on behalf of a person:

(A) who is an affiliate of the impaired insurer; and

(B) whose liability obligations to other persons are satisfied wholly or partly by payment made under this chapter; and

(2) the amount of a covered claim for workers' compensation insurance benefits and the costs of administration and defense of the claim paid under this chapter from an insured employer or any successor entity to the insured employer under state, federal, or international law whose net worth on December 31 of the year preceding the date the insurer becomes an impaired insurer exceeds \$50 million.

(b) The association is not entitled to recover under Subsection (a)(2) against an insured who is exempt from federal income tax under Section 501(a), Internal Revenue Code of 1986, by being described by Section 501(c)(3) of that code.

(c) For purposes of Subsection (a)(2), an insured's net worth is deemed to include the aggregate net worth of the insured and of the insured's parent, subsidiary, and affiliated companies computed on a consolidated basis.

(d) A court shall award the association the association's costs, expenses, and reasonable attorney's fees incurred in seeking recovery under this section.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.009(a), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.009(a), eff. September 1, 2007.

Acts 2019, 86th Leg., R.S., Ch. 343 (S.B. 1063), Sec. 9, eff. September 1, 2019.

Sec. 462.309. STAY OF PROCEEDINGS; CERTAIN DECISIONS NOT BINDING. (a) To permit the association to properly defend a pending cause of action, a proceeding in which an impaired insurer is a party or is obligated to defend a party in a court in this state, other than a proceeding directly related to the receivership or instituted by the receiver, is stayed for:

(1) a six-month period beginning on the later of the date of the designation of impairment or the date an ancillary proceeding is brought in this state; and

(2) a subsequent period as determined by the court, if any.

(b) The stay applies to each party to the proceeding and the proceeding is stayed for all purposes.

(c) A deadline imposed under the Texas Rules of Civil Procedure or the Texas Rules of Appellate Procedure is tolled during the stay. Statutes of limitation or repose are not tolled during the stay, and any action filed during the stay is stayed upon the filing of the action.

(d) The court in which the delinquency proceeding is pending has exclusive jurisdiction regarding the application, enforcement, and extension of the stay and may issue an injunction or another similar order to enforce the stay.

(e) The commissioner may bring an ancillary conservation proceeding under Section 443.401 for the purpose of determining the application, enforcement, and extension of the stay to an impaired insurer that is not domiciled in this state.

(f) With respect to a covered claim arising from a judgment, order, decision, verdict, or finding based on the default of an impaired insurer or an impaired insurer's failure to defend the insured, the association, on the association's own behalf or on behalf of an insured and on application, shall be entitled to:

(1) have the court or administrator that made the judgment, order, decision, verdict, or finding set aside the judgment, order, decision, verdict, or finding; and

(2) defend the claim on the merits.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.011(a), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.011(a), eff. September 1, 2007.

Sec. 462.310. SETTLEMENT BY ASSOCIATION BINDING; PRIORITY OF CLAIM AND EXPENSES. (a) The settlement of a covered claim by the association or a similar organization in another state binds the receiver or statutory successor of an impaired insurer.

(b) The court having jurisdiction shall give the covered claim the same priority against assets of the impaired insurer that the claim would have had in the absence of this chapter.

(c) The expenses of the association or a similar organization in another state in handling claims have the same priority as the receiver's expenses.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 462.311. REPORT TO RECEIVER. The association shall periodically file with the receiver of an impaired insurer a statement of covered claims paid by the association and an estimate of claims anticipated against the association. The statement preserves the rights of the association against the assets of the impaired insurer.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

SUBCHAPTER H. RELEASE FROM RECEIVERSHIP

Sec. 462.351. ISSUANCE OF POLICIES AFTER RELEASE FROM RECEIVERSHIP. (a) Except as provided by Subsection (b), an impaired insurer placed in receivership for which money has been advanced under this chapter may not be authorized, on release from receivership, to issue new or renewal insurance policies until the insurer repays the advances to the association.

(b) On application of the association and after hearing, the commissioner may permit the insurer to issue new insurance policies

in accordance with the insurer's plan of operation for repayment of advances.

(c) The commissioner, in approving the plan of operation, may place restrictions on the issuance of new or renewal insurance policies as the commissioner considers necessary to implement the plan.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

CHAPTER 463. TEXAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION
SUBCHAPTER A. GENERAL PROVISIONS

Sec. 463.001. SHORT TITLE. This chapter may be cited as the Texas Life and Health Insurance Guaranty Association Act.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.012(b), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.012(b), eff. September 1, 2007.

Acts 2011, 82nd Leg., R.S., Ch. 14 (S.B. 567), Sec. 2, eff. September 1, 2011.

Sec. 463.002. PURPOSE. The purpose of this chapter is to protect, subject to certain limitations, a person specified by Section 463.201 against failure in the performance of a contractual obligation under a life, accident, health, or annuity policy, plan, or contract with respect to which this chapter provides coverage as determined under Subchapter E, because of the impairment or insolvency of the member insurer that issued the policy, plan, or contract.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 432 (S.B. 1153), Sec. 1, eff. September 1, 2019.

Sec. 463.003. GENERAL DEFINITIONS. In this chapter:

(1) "Association" means the Texas Life and Health Insurance Guaranty Association.

(1-a) "Benefit plan" means a specific employee, union, or association of natural persons benefit plan.

(2) "Board" means the board of directors of the association.

(3) "Contractual obligation" means an obligation under a policy or contract or certificate under a group policy or contract, or part of a policy or contract or certificate, for which coverage is provided under Subchapter E.

(4) "Covered policy" or "covered contract" means a policy or contract, or portion of a policy or contract, including a health maintenance organization contract, with respect to which this chapter provides coverage as determined under Subchapter E.

(4-a) "Enrollee" means an individual who is enrolled in a health maintenance organization contract with respect to which this chapter provides coverage as determined under Subchapter E. For purposes of this chapter, an enrollee is considered to be an insured.

(4-b) "Health benefit plan" means a hospital and medical expense incurred policy or certificate, health maintenance organization enrollee contract, or any other similar health contract. The term does not include:

- (A) accident-only insurance;
- (B) credit insurance;
- (C) dental-only insurance;
- (D) vision-only insurance;
- (E) Medicare supplement insurance;
- (F) long-term care coverage or benefits, home health care coverage or benefits, community-based care coverage or benefits, or any combination of those coverages or benefits;
- (G) disability income insurance;
- (H) coverage for on-site medical clinics; or
- (I) specified disease, hospital confinement indemnity, or limited benefit health insurance coverage if the types of coverage do not provide coordination of benefits and are provided under separate policies or certificates.

(5) "Impaired insurer" means a member insurer that is

designated an "impaired insurer" by the commissioner and is:

(A) placed by a court in this state or another state under an order of supervision, liquidation, rehabilitation, or conservation;

(B) placed under an order of liquidation or rehabilitation under Chapter 443; or

(C) placed under an order of supervision or conservation by the commissioner under Chapter 441.

(5-a) "Insurance" includes health benefit plan coverage.

(6) "Insolvent insurer" means a member insurer that has been placed under an order of liquidation with a finding of insolvency by a court in this state or another state.

(6-a) "Insurer" includes a health maintenance organization.

(7) "Member insurer" means an insurer that is required to participate in the association under Section 463.052.

(7-a) "Owner" means the owner of a policy or contract and "policyholder," "policy owner," and "contract owner" mean the person who is identified as the legal owner under the terms of the policy or contract or who is otherwise vested with legal title to the policy or contract through a valid assignment completed in accordance with the terms of the policy or contract and is properly recorded as the owner on the books of the member insurer. The terms "owner," "contract owner," "policyholder," and "policy owner" do not include persons with a mere beneficial interest in a policy or contract.

(8) "Person" means an individual, corporation, limited liability company, partnership, association, governmental body or entity, or voluntary organization.

(8-a) "Plan sponsor" means:

(A) the employer in the case of a benefit plan established or maintained by a single employer;

(B) the employee organization in the case of a benefit plan established or maintained by an employee organization; or

(C) in a case of a benefit plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the benefit plan.

(9) "Premium" means an amount received on a covered policy, less any premium, consideration, or deposit returned on the policy,

and any dividend or experience credit on the policy. The term does not include:

(A) an amount received for a policy or contract or part of a policy or contract for which coverage is not provided under Section 463.202, except that assessable premiums may not be reduced because of:

(i) an interest limitation provided by Section 463.203(b)(3); or

(ii) a limitation provided by Section 463.204 with respect to a single individual, participant, annuitant, or policy or contract owner;

(B) premiums in excess of \$5 million on an unallocated annuity contract not issued under a governmental benefit plan established under Section 401, 403(b), or 457, Internal Revenue Code of 1986;

(C) premiums received from the state treasury or the United States treasury for insurance for which this state or the United States contracts to:

(i) provide welfare benefits to designated welfare recipients; or

(ii) implement:

(a) Title 2, Health and Safety Code;

(b) Title 2, Human Resources Code; or

(c) the Social Security Act (42 U.S.C. Section 301 et seq.); or

(D) premiums in excess of \$5 million with respect to multiple nongroup policies of life insurance owned by one owner, regardless of whether the policy owner is an individual, firm, corporation, or other person and regardless of whether the persons insured are officers, managers, employees, or other persons, regardless of the number of policies or contracts held by the owner.

(10) "Resident" means a person who resides in this state on the earlier of the date a member insurer becomes an impaired insurer or the date of entry of a court order that determines a member insurer to be an impaired insurer or the date of entry of a court order that determines a member insurer to be an insolvent insurer and to whom the member insurer owes a contractual obligation. For the purposes of this subdivision:

(A) a person is considered to be a resident of only one state;

(B) a person other than an individual is considered to be a resident of the state in which the person's principal place of business is located; and

(C) a United States citizen who is either a resident of a foreign country or a resident of a United States possession, territory, or protectorate that does not have an association similar to the association created by this chapter is considered a resident of the state of domicile of the insurer that issued the policy or contract.

(10-a) "Structured settlement annuity" means an annuity purchased to fund periodic payments for a plaintiff or other claimant in payment for or with respect to personal injury suffered by the plaintiff or other claimant.

(11) "Supplemental contract" means a written agreement for the distribution of policy or contract proceeds.

(12) "Unallocated annuity contract" means an annuity contract or group annuity certificate that is not issued to and owned by an individual, except to the extent of any annuity benefits guaranteed to an individual by an insurer under the contract or certificate.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.013(a), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.013(a), eff. September 1, 2007.

Acts 2011, 82nd Leg., R.S., Ch. 14 (S.B. 567), Sec. 3, eff. September 1, 2011.

Acts 2019, 86th Leg., R.S., Ch. 432 (S.B. 1153), Sec. 2, eff. September 1, 2019.

Sec. 463.0031. DEFINITION OF PRINCIPAL PLACE OF BUSINESS OF PLAN SPONSOR OR OTHER PERSON. (a) Except as otherwise provided by this section, in this chapter, the "principal place of business" of a plan sponsor or a person other than an individual means the single state in which the individuals who establish policy for the direction, control, and coordination of the operations of the plan

sponsor or person as a whole primarily exercise that function, as determined by the association in its reasonable judgment by considering the following factors:

- (1) the state in which the primary executive and administrative headquarters of the plan sponsor or person is located;
- (2) the state in which the principal office of the chief executive officer of the plan sponsor or person is located;
- (3) the state in which the board of directors, or similar governing person or persons, of the plan sponsor or person conduct the majority of their meetings;
- (4) the state in which the executive or management committee of the board of directors, or similar governing person or persons, of the plan sponsor or person conduct the majority of their meetings;
- (5) the state from which the management of the overall operations of the plan sponsor or person is directed; and
- (6) in the case of a benefit plan sponsored by affiliated companies comprising a consolidated corporation, the state in which the holding company or controlling affiliate has its principal place of business as determined using the factors described by Subdivisions (1)-(5).

(b) In the case of a plan sponsor, if more than 50 percent of the participants in the benefit plan are employed in a single state, that state is the principal place of business of the plan sponsor.

(c) The principal place of business of a plan sponsor of a benefit plan described in Section 463.003(8-a)(C) is the principal place of business of the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the benefit plan that, in lieu of a specific or clear designation of a principal place of business, shall be deemed to be the principal place of business of the employer or employee organization that has the largest investment in that benefit plan.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 3B.013(b), eff. September 1, 2007.

Added by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. [3167](#)), Sec. 9.013(b), eff. September 1, 2007.

Sec. 463.0032. USE OF TERMS POLICY AND CONTRACT. For purposes of this chapter, "policy" and "contract" have the same meaning.

Added by Acts 2019, 86th Leg., R.S., Ch. 432 (S.B. 1153), Sec. 3, eff. September 1, 2019.

Sec. 463.004. CONSTRUCTION. This chapter shall be liberally construed to implement the purpose of this chapter described by Section 463.002. Section 463.002 shall be used to aid and guide interpretation of this chapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 463.005. IMMUNITY. (a) The following persons are not liable, and a cause of action does not arise against any of the following persons, for a good faith act or omission in exercising powers and performing duties under this chapter:

- (1) the commissioner or the commissioner's representative;
- (2) the association or the association's agent or employee;
- (3) a member insurer or the insurer's agent or employee;
- (4) a board member;
- (5) the receiver; and
- (6) a special deputy receiver or the special deputy receiver's agent or employee.

(b) Immunity under Subsection (a) extends to participation in an organization of one or more state associations that have similar purposes and to a similar organization and the organization's agent or employee.

(c) The attorney general shall defend any action to which this section applies that is brought against the commissioner or the commissioner's representative, the association or the association's agent or employee, a member insurer or the insurer's agent or employee, a board member, or a special deputy receiver or the special deputy receiver's agent or employee, including an action brought after the defendant's service with the association, commissioner, or department has terminated. This subsection does not require the attorney general to defend a person with respect to an issue other than the applicability or effect of the immunity created by this

section. The attorney general is not required to defend the association or the association's agent or employee, a member insurer or the insurer's agent or employee, a board member, or a special deputy receiver or the special deputy receiver's agent or employee against an action regarding the disposition of a claim filed with the association under this chapter or any issue other than the applicability or effect of the immunity created by this section. The association may contract with the attorney general under Chapter 771, Government Code, for legal services not covered by this subsection.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 463.006. RULES. The commissioner shall adopt reasonable rules as necessary to carry out and supplement this chapter and the purposes of this chapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 463.007. CONSTRUCTION OF LONG-TERM CARE RIDER. For purposes of this chapter, benefits provided by a long-term care rider to a life insurance policy or annuity contract are considered to be the same type of benefits as the base life insurance policy or annuity contract.

Added by Acts 2019, 86th Leg., R.S., Ch. 432 (S.B. 1153), Sec. 3, eff. September 1, 2019.

SUBCHAPTER B. GOVERNANCE OF AND PARTICIPATION IN ASSOCIATION

Sec. 463.051. PURPOSE AND REGULATION OF ASSOCIATION. (a) The Texas Life and Health Insurance Guaranty Association is a nonprofit legal entity existing to pay benefits and continue coverage as provided by this chapter.

(b) The association is subject to the applicable provisions of this code and other insurance laws of this state and the immediate supervision of the commissioner. The commissioner may examine and regulate the association in the same manner as an insurer under this

code.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.014(a), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.014(a), eff. September 1, 2007.

Acts 2011, 82nd Leg., R.S., Ch. 14 (S.B. 567), Sec. 4, eff. September 1, 2011.

Sec. 463.052. REQUIRED PARTICIPATION IN ASSOCIATION. (a) As a condition of engaging in the business of insurance in this state, an insurer, including a mutual assessment company, a local mutual aid association, a statewide mutual assessment company, a stipulated premium company, and a health maintenance organization authorized to engage in business in this state, shall participate as a member of the association if the insurer holds a certificate of authority to engage in a kind of insurance business in this state with respect to which this chapter provides coverage as determined under Subchapter E. The requirement to participate applies regardless of whether the insurer's certificate of authority in this state is suspended, revoked, not renewed, or voluntarily withdrawn.

(b) The following do not participate as member insurers:

- (1) a fraternal benefit society;
- (2) a mandatory state pooling plan;
- (3) a reciprocal or interinsurance exchange;
- (4) an organization which has a certificate of authority or license limited to the issuance of charitable gift annuities, as defined by this code or rules adopted by the commissioner; and
- (5) an entity similar to an entity described by Subdivision (1), (2), (3), or (4).

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.013(c), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.013(c),

eff. September 1, 2007.

Acts 2019, 86th Leg., R.S., Ch. 432 (S.B. 1153), Sec. 4, eff. September 1, 2019.

Sec. 463.053. BOARD OF DIRECTORS. (a) The association's powers are exercised through a board of directors consisting of nine individuals appointed by the commissioner as provided by this section.

(b) The commissioner shall appoint three board members from officers or employees of the 50 member insurers having the largest total direct premium income according to the most recent financial statement on file on the date of appointment.

(c) To give fair representation to member insurers, the commissioner shall appoint two board members from member insurers other than insurers described by Subsection (b), considering the varying categories of premium income and geographical location.

(c-1) The commissioner shall consider, among other things, whether the directors appointed under Subsections (b) and (c) fairly represent the member insurers that are health maintenance organizations and life, health, and annuity insurers.

(d) The commissioner shall appoint four board members who are public representatives.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 432 (S.B. 1153), Sec. 5, eff. September 1, 2019.

Sec. 463.054. ELIGIBILITY TO SERVE AS PUBLIC REPRESENTATIVE. To be eligible to serve as a public representative, an individual may not:

(1) be an officer, director, or employee of an insurer, insurance agency, agent, broker, solicitor, adjuster, or other business entity regulated by the department;

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

(3) be related within the second degree by affinity or

consanguinity to a person described by Subdivision (1) or (2).

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 463.055. TERM; VACANCY. (a) Board members serve staggered six-year terms, with the terms of three members expiring each odd-numbered year. A member may be reappointed.

(b) A board member shall serve until a successor is appointed.

(c) If a board member who is an officer or employee of a member insurer ceases to be an officer or employee of the insurer, the member's office becomes vacant.

(d) The commissioner shall appoint an individual to fill a vacancy on the board for the unexpired term.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 463.056. COMPENSATION OF BOARD MEMBERS. A board member may not receive compensation from the association for the member's services but may be reimbursed from the association's assets for expenses incurred as a board member.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 463.057. FINANCIAL STATEMENT OF BOARD MEMBER. Each board member shall file with the Texas Ethics Commission a financial statement as provided by Subchapter B, Chapter 572, Government Code.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 463.058. CONFLICT OF INTEREST. (a) In this section, "transaction on behalf of an impaired insurer" includes a reinsurance agreement, transaction, merger, purchase, sale, contribution, or exchange of assets, insurance policies, or property made by the

association or a supervisor, conservator, or receiver on behalf of an impaired insurer.

(b) A board member may not:

(1) receive money or another thing of value for negotiating, procuring, participating in, recommending, or aiding a transaction on behalf of an impaired insurer; or

(2) as a principal, coprincipal, agent, or beneficiary, have a pecuniary interest in a transaction on behalf of an impaired insurer.

(c) For the purposes of this section, a board member is considered to receive a thing of value or have a pecuniary interest in a transaction on behalf of an impaired insurer regardless of whether the receipt or interest is direct, indirect, or through a substantial interest in a corporation, firm, or other business unit.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 463.059. MEETINGS BY TELEPHONE AND VIDEOCONFERENCE. (a) Notwithstanding Chapter 551, Government Code, or any other law, the board or a committee of the board may meet by telephone conference call, videoconference, or other similar telecommunication method. The board may use telephone conference call, videoconference, or other similar telecommunication method for establishing a quorum, voting, or any other meeting purpose in accordance with this section regardless of the subject matter discussed or considered by the board at the meeting.

(b) A meeting authorized by this section is subject to the notice requirements that apply to other meetings.

(c) The notice of a meeting authorized by this section must specify the location of the meeting.

(d) Each part of a meeting authorized by this section that must be open to the public must be audible to the public at the location specified by Subsection (c).

(e) Two-way audio communication must be available during the entire meeting between all members of the board or committee attending a meeting authorized by this section, and if the two-way audio communication is disrupted so that a quorum of the board or committee is no longer participating in the meeting, the meeting may

not continue until the two-way audio communication is reestablished.

(f) An audio or digital recording of a meeting authorized by this section must be made in accordance with the association's bylaws. The recording of the open portion of the meeting must be posted on the association's Internet website.

(g) A vote during a meeting authorized by this section must be taken in such a manner that the vote of each member is audible and may be verified as the vote of the member.

Added by Acts 2011, 82nd Leg., R.S., Ch. 14 (S.B. 567), Sec. 5, eff. September 1, 2011.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 432 (S.B. 1153), Sec. 6, eff. September 1, 2019.

SUBCHAPTER C. GENERAL POWERS AND DUTIES OF ASSOCIATION

Sec. 463.101. GENERAL POWERS AND DUTIES. (a) The association may:

- (1) enter into contracts as necessary or proper to carry out this chapter and the purposes of this chapter;
- (2) sue or be sued, including taking:
 - (A) necessary or proper legal action to:
 - (i) recover an unpaid assessment under Subchapter D; or
 - (ii) settle a claim or potential claim against the association; or
 - (B) necessary legal action to avoid payment of an improper claim;
- (3) borrow money to effect the purposes of this chapter;
- (4) exercise, for the purposes of this chapter and to the extent approved by the commissioner, the powers of a domestic life, accident, or health insurance company, a health maintenance organization, or a group hospital service corporation, except that the association may not issue an insurance policy or annuity contract other than to perform the association's obligations under this chapter;
- (5) unless prohibited by other law, implement or file for an actuarially justified rate or premium increase in accordance with the terms and conditions of a covered policy or contract;

(6) to further the association's purposes, exercise the association's powers, and perform the association's duties, join an organization of one or more state associations that have similar purposes;

(7) request information from a person seeking coverage from the association in determining its obligations under this chapter with respect to the person, and the person shall promptly comply with the request; and

(8) take any other necessary or appropriate action to discharge the association's duties and obligations under this chapter or to exercise the association's powers under this chapter.

(b) If not in default, a note or other evidence of indebtedness of the association is a legal investment for a domestic insurer and may be carried as an admitted asset.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.015(a), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.015(a), eff. September 1, 2007.

Acts 2019, 86th Leg., R.S., Ch. 432 (S.B. 1153), Sec. 7, eff. September 1, 2019.

Sec. 463.102. PLAN OF OPERATION; AMENDMENTS. (a) The association shall perform the association's functions under a plan of operation approved by the commissioner. The plan of operation must:

(1) establish:

(A) procedures for handling the assets of the association;

(B) the amount and method of reimbursing board members under Section 463.056;

(C) regular places and times for board meetings, including telephone conference calls;

(D) procedures for maintaining records of all financial transactions of the association, the association's agents, and the board; and

(E) additional procedures for assessments under

Subchapter D; and

(2) contain additional provisions necessary or proper for the execution of the association's powers and duties.

(b) The association may amend the plan of operation. An amendment must be approved by the commissioner and takes effect on:

(1) the date the commissioner approves the amendment; or

(2) the 60th day after the date the amendment is submitted to the commissioner for approval, if the commissioner does not approve or disapprove the amendment before the 60th day.

(c) Each member insurer shall comply with the plan of operation.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 432 (S.B. 1153), Sec. 8, eff. September 1, 2019.

Sec. 463.103. PERSONNEL. The association may employ or retain employees or contractors to handle the association's financial transactions and to perform other functions under this chapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 463.104. ASSOCIATION RECORDS. (a) The association shall maintain a record of each negotiation or meeting in which the association or the association's representative discusses the association's activities in carrying out the powers and duties under Section 463.101, 463.103, 463.109, or 463.111(c) or Subchapter F.

(b) A record under Subsection (a) may be made public only on:

(1) termination of a liquidation, rehabilitation, or conservation proceeding involving the impaired or insolvent insurer;

(2) termination of the impairment or insolvency of the insurer; or

(3) order of a court.

(c) This section does not limit the association's duty to report on the association's activities as required by Section 463.110.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 463.105. ACCOUNTS. For the purposes of administration and assessment, the association shall maintain:

- (1) an accident, health, and hospital services insurance account;
- (2) a life insurance account;
- (3) an annuity account; and
- (4) an administrative account.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 463.106. DELEGATION OF POWERS AND DUTIES. (a) The plan of operation may provide that, on approval of the board and the commissioner, a power or duty of the association is delegated to a corporation or other organization that:

- (1) performs in two or more states functions similar to those of the association or the association's equivalent; and
- (2) provides protection not substantially less favorable and effective than that provided by this chapter.

(b) A power or duty under Section 463.261(c) or Subchapter D, other than a duty under Section 463.161(c), may not be delegated under this section.

(c) The corporation or other organization to which a power or duty is delegated shall be:

- (1) reimbursed for a payment made on behalf of the association; and
- (2) paid for performing any other function of the association.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 463.107. EXEMPTION FROM TAXATION. The association is exempt from payment of all fees and all taxes levied by this state or a subdivision of this state, except taxes levied on property.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 463.108. DETECTION AND PREVENTION OF IMPAIRMENT AND INSOLVENCY. On a majority vote, the board:

- (1) may make recommendations to the commissioner for detecting and preventing insurer insolvencies; and
- (2) shall notify the commissioner of information indicating that a member insurer may be impaired or insolvent.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 463.109. ASSOCIATION APPEARANCE BEFORE COURT; INTERVENTION. (a) The association may appear before a court in this state with jurisdiction over an impaired or insolvent insurer concerning which the association is or may become obligated under this chapter. The association's right to appear applies to:

- (1) a proposal for reinsuring, reissuing, modifying, or guaranteeing the insurer's policies or contracts;
- (2) the determination of the insurer's policies or contracts and contractual obligations; and
- (3) any other matter germane to the association's powers and duties.

(b) The association may appear or intervene before a court in another state with jurisdiction over:

- (1) an impaired or insolvent insurer concerning which the association is or may become obligated; or
- (2) a third party against whom the association may have rights through subrogation of the insurer's policyholders or enrollees.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 432 (S.B. 1153), Sec. 9, eff. September 1, 2019.

Sec. 463.110. ANNUAL REPORT. Not later than the 120th day after the last day of each association fiscal year, the board shall submit to the commissioner:

(1) a financial report in a form approved by the commissioner; and

(2) a report of the association's activities during the preceding fiscal year.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 463.111. BOARD AND ASSOCIATION ADVICE AND ASSISTANCE. (a) On a majority vote, the board may report and make recommendations to the commissioner on any matter germane to:

(1) the solvency, liquidation, rehabilitation, or conservation of a member insurer; or

(2) the solvency of an insurer seeking to engage in the business of insurance in this state.

(b) A report or recommendation under Subsection (a) is not a public document, and Chapter 552, Government Code, does not apply to the report or recommendation until the insurer that is the subject of the report or recommendation is designated as impaired.

(c) On the commissioner's request, the association may assist and advise the commissioner concerning rehabilitation, payment of claims, continuation of coverage, or the performance of other contractual obligations of an impaired or insolvent insurer.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 463.112. BOARD ACCESS TO RECORDS. The receiver or statutory successor of an impaired insurer shall give the board or a representative of the board:

(1) access to the insurer's records as necessary for the board to carry out the board's functions under this chapter relating to covered claims; and

(2) copies of those records on the board's request and at the board's expense.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 463.113. BOARD REPORT AT CONCLUSION OF INSOLVENCY. (a) At the conclusion of an insurer insolvency in which the association was obligated to pay a covered claim, the board shall prepare and submit to the commissioner a report containing any information the board possesses concerning the history and causes of the insolvency.

(b) The board:

(1) shall cooperate with the boards of directors of guaranty associations in other states to prepare a report on the history and causes of the insolvency of a particular insurer; and

(2) may adopt by reference a report prepared by any of those associations.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 463.114. SUMMARY DOCUMENT; DISCLAIMER. (a) The association shall prepare a summary document describing the general purposes and limitations of this chapter and amend the document as necessary to comply with this chapter. The document must clearly and conspicuously contain on the document's face a disclaimer that:

(1) states the name and address of the association and department;

(2) warns the policy or contract holder that:

(A) the association may not cover the policy; or

(B) coverage, if available, is subject to substantial limitations and exclusions and requires continuous residence in this state;

(3) states that an insurer and the insurer's agent are prohibited by law from using the association's existence to sell, solicit, or induce the purchase of any kind of insurance;

(4) warns the policy or contract holder not to rely on association coverage in selecting an insurer; and

(5) provides other information the commissioner prescribes.

(b) The association shall submit the document to the commissioner for approval.

(c) At the expiration of the 60th day after approval of the document, a member insurer may not deliver a policy or contract with respect to which this chapter provides coverage as determined under Subchapter E to a policy, contract, or certificate holder or enrollee before a copy of the summary document is delivered to the policy, contract, or certificate holder or enrollee. The document must also be available on request of a policy, contract, or certificate holder or enrollee.

(d) The distribution, delivery, content, or interpretation of a summary document does not guarantee that a policy or contract or a policy, contract, or certificate holder or enrollee is provided coverage by this chapter if a member insurer becomes impaired or insolvent. Failure to receive the document does not give an insured or policy, contract, or certificate holder or enrollee any rights greater than those provided by this chapter.

(e) An insurer or agent may not deliver a policy or contract described by Section 463.202 that is excluded from the coverage provided by this chapter by Section 463.203 unless the insurer or agent, either before or in conjunction with delivery, gives the policy, contract, or certificate holder or enrollee a separate written notice clearly and conspicuously disclosing that the policy or contract is not covered by the association.

(f) The commissioner shall specify by rule the form and content of the disclaimer required by Subsection (a) and the notice required by Subsection (e).

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 432 (S.B. 1153), Sec. 10, eff. September 1, 2019.

SUBCHAPTER D. ASSESSMENTS

Sec. 463.151. MAKING AND PAYMENT OF ASSESSMENT. (a) The association shall assess member insurers, separately for each account under Section 463.105, in the amounts and at the times the board determines necessary to provide money for the association to exercise the association's powers, perform the association's duties, and carry out the purposes of this chapter. The association may not authorize

and call an assessment to meet the requirements of the association with respect to an impaired or insolvent insurer until the assessment is necessary to carry out the purposes of this chapter. The board shall classify assessments under Section 463.152 and determine the amount of assessments with reasonable accuracy, recognizing that exact determinations may not always be possible.

(a-1) The association shall notify each member insurer of its anticipated pro rata share of an authorized assessment not yet called not later than the 180th day after the date the assessment is authorized.

(b) An assessment is due on the date the association specifies, which may not be earlier than the 30th day after the date the association gives written notice of the assessment to member insurers. Interest accrues on an unpaid amount at a rate of 10 percent beginning on the due date.

(c) An insurer whose certificate of authority to engage in business in this state is revoked or surrendered remains liable for any unpaid assessment made before the date of the revocation or surrender.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.016(a), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.016(a), eff. September 1, 2007.

Sec. 463.152. CLASSES OF ASSESSMENTS. (a) Assessments are classified as Class A or Class B assessments.

(b) Class A assessments are authorized and called to pay:

(1) the association's administrative costs;

(2) administrative expenses that:

(A) are properly incurred under this chapter; and

(B) relate to an unauthorized insurer or to an entity

that is not a member insurer; and

(3) other general expenses not related to a particular impaired or insolvent insurer.

(c) Class B assessments are authorized and called to the extent

necessary for the association to carry out the association's powers and duties under Sections 463.101, 463.103, 463.109, and 463.111(c) and Subchapter F with regard to an impaired or insolvent insurer.

(d) For purposes of this section, an assessment is authorized at the time a resolution by the board is passed under which an assessment will be called immediately or in the future from member insurers for a specified amount and an assessment is called at the time a notice has been issued by the association to member insurers requiring that an authorized assessment be paid within a period stated in the notice. An authorized assessment becomes a called assessment at the time notice is mailed by the association to member insurers.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.016(b), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.016(b), eff. September 1, 2007.

Sec. 463.153. AMOUNT OF ASSESSMENTS. (a) The board shall determine the amount of a Class A assessment for each account under Section 463.105, considering with respect to member insurers one or more of the following as shown by annual statements for the year preceding the date of the assessment:

- (1) annual premium receipts;
- (2) admitted assets; or
- (3) insurance in force.

(b) Class B assessments on a member insurer for each account under Section 463.105 shall be authorized and called in the proportion that the premiums received on business in this state by the member insurer on policies or contracts covered by each account for the three most recent calendar years for which information is available preceding the year in which the impaired or insolvent member insurer became impaired or insolvent bear to premiums received on business in this state for those calendar years by all assessed member insurers. Except for assessments related to long-term care insurance as described by Subsection (b-1), the amount of a Class B

assessment shall be allocated among the separate accounts in accordance with an allocation formula that may be based on:

(1) the premiums or reserves of the impaired or insolvent insurer; or

(2) any other standard deemed by the board in the board's sole discretion as being fair and reasonable under the circumstances.

(b-1) The amount of a Class B assessment for long-term care insurance written by an impaired or insolvent member insurer shall be allocated according to a methodology included in the plan of operation and approved by the commissioner. The methodology must provide for 50 percent of the assessment to be allocated to accident and health member insurers and 50 percent to be allocated to life and annuity member insurers. This subsection does not apply to a rider to a member insurer's life insurance policy or annuity contract that provides long-term care benefits.

(c) The total amount of assessments on a member insurer for each account under Section 463.105 may not in one calendar year exceed two percent of the insurer's average annual premiums on the policies covered by the account during the three calendar years preceding the year in which the impaired or insolvent member insurer became an impaired or insolvent insurer. If two or more assessments are authorized in a calendar year with respect to member insurers that become impaired or insolvent in different calendar years, the average annual premiums for purposes of the aggregate assessment percentage limitation described by this subsection shall be equal to the higher of the three-year average annual premiums for the applicable subaccount or account as computed in accordance with this section. If the maximum assessment and the other assets of the association do not provide in a year an amount sufficient to carry out the association's responsibilities, the association shall make necessary additional assessments as soon as this chapter permits.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.016(c), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.016(c), eff. September 1, 2007.

Acts 2011, 82nd Leg., R.S., Ch. 14 (S.B. 567), Sec. 6, eff.

September 1, 2011.

Acts 2019, 86th Leg., R.S., Ch. 432 (S.B. 1153), Sec. 11, eff. September 1, 2019.

Sec. 463.154. DEFERMENT. The association may wholly or partly defer an assessment on a member insurer if the association believes payment of the assessment would endanger the ability of the insurer to fulfill the insurer's contractual obligations. The amount of the assessment that is deferred may be assessed against the other member insurers in a manner consistent with this subchapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 432 (S.B. 1153), Sec. 12, eff. September 1, 2019.

Sec. 463.155. DEPOSIT OF ASSESSMENTS. The association may deposit assessments into the Texas Treasury Safekeeping Trust Company in accordance with procedures established by the comptroller. The comptroller shall account to the association for the deposited money separately from all other money.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 463.156. CERTIFICATE OF CONTRIBUTION. The association shall issue to each member insurer that pays a Class B assessment a certificate of contribution, in a form the commissioner prescribes, for the amount paid. All outstanding certificates are of equal priority regardless of the amount of the assessment paid or the date the certificate is issued.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 463.157. REFUNDS. (a) The board may refund to member

insurers the amount by which the association's assets, including any net realized gains and income from investments, exceed the amount the board determines is necessary to carry out the association's obligations regarding that amount during the next year.

(b) A refund must be made:

(1) by an equitable method established in the plan of operation; and

(2) in proportion to the contribution of each member insurer.

(c) The board may retain a reasonable amount to provide for the association's continuing expenses and for future losses if refunds are impractical.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 463.158. USE OF ASSESSMENTS. Money from assessments supplements the marshalling of an impaired insurer's assets to make payments on the insurer's behalf.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 463.159. FAILURE TO PAY; COLLECTION BY COMMISSIONER. On failure of a member insurer to pay an assessment when due, the commissioner may either:

(1) suspend or revoke, after notice and hearing, the insurer's certificate of authority to engage in the business of insurance in this state; or

(2) levy a forfeiture in an amount not less than \$100 each month or more than five percent of the unpaid assessment each month.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 463.160. PREMIUM TAX CREDIT FOR CLASS A ASSESSMENT. The amount of a Class A assessment paid by a member insurer in each taxable year shall be allowed as a credit on the amount of premium

taxes due.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2011, 82nd Leg., 1st C.S., Ch. 4 (S.B. 1), Sec. 2.06, eff. September 28, 2011.

Sec. 463.161. PREMIUM TAX CREDIT FOR CLASS B ASSESSMENT. (a) A member insurer is entitled to show as an admitted asset a certificate of contribution in the form the commissioner approves under Section 463.156. Unless the commissioner requires a longer period, the certificate may be shown at:

(1) for the calendar year of issuance, an amount equal to the certificate's original face value approved by the commissioner; and

(2) beginning with the year following the calendar year of issuance, an amount equal to the certificate's original face value, reduced by 20 percent a year for each year after the year of issuance, for a period of five years.

(b) An amount written off during a calendar year under Subsection (a) shall be allowed as a credit against the member insurer's premium tax owed for business engaged in during that year. The insurer is not required to write off in a single year an amount that exceeds the amount of premium tax owed for the business described by this subsection.

(c) The association shall pay to the commissioner, and the commissioner shall deliver to the comptroller for deposit to the credit of the general revenue fund, any amount owed as a refund from the association under Section 463.157 that was written off and used for a tax credit under this section.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.017(a), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.017(a), eff. September 1, 2007.

Sec. 463.162. ASSIGNMENT OR TRANSFER OF CREDIT. (a) A member insurer may assign or transfer a credit against premium tax to another member insurer if:

- (1) an acquisition, merger, or total assumption of reinsurance occurs between the insurers; or
- (2) the commissioner by order approves the assignment or transfer.

(b) Not later than the later of November 1 or the 60th day after the date of the assignment or transfer, each member insurer shall:

- (1) report the assignment or transfer to the comptroller on a form the comptroller prescribes; and
- (2) include with the report any documents from the commissioner that show approval of the assignment or transfer.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 463.163. INSURED'S LIABILITY UNDER ASSESSMENT PLAN. This chapter does not reduce the liability for unpaid assessments of the insureds of an impaired or insolvent insurer operating under a plan with assessment liability.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

SUBCHAPTER E. COVERAGE PROVIDED BY ASSOCIATION

Sec. 463.201. PERSONS COVERED. (a) Subject to Subsections (b) and (c), this chapter provides coverage for a policy or contract described by Section 463.202 to a person who is:

- (1) a person, other than a certificate holder under a group policy or contract who is not a resident, who is a beneficiary, assignee, or payee, including a health care provider who renders services covered under a health insurance policy or certificate, of a person described by Subdivision (2);
- (2) a person who is an owner of or certificate holder or enrollee under a policy or contract specified by Section 463.202, other than an unallocated annuity contract or structured settlement annuity, and who is:

- (A) a resident; or
- (B) not a resident, but only under all of the following

conditions:

- (i) the member insurers that issued the policies or contracts are domiciled in this state;

- (ii) the state in which the person resides has an association similar to the association; and

- (iii) the person is not eligible for coverage by an association in any other state because the insurer or health maintenance organization was not licensed in the state at the time specified in that state's guaranty association law;

- (3) a person who is the owner of an unallocated annuity contract issued to or in connection with:

- (A) a benefit plan whose plan sponsor has the sponsor's principal place of business in this state; or

- (B) a government lottery, if the owner is a resident;

or

- (4) a person who is the payee under a structured settlement annuity, or beneficiary of the payee if the payee is deceased, if:

- (A) the payee is a resident, regardless of where the contract owner resides;

- (B) the payee is not a resident, the contract owner of the structured settlement annuity is a resident, and the payee is not eligible for coverage by the association in the state in which the payee resides; or

- (C) the payee and the contract owner are not residents, the insurer that issued the structured settlement annuity is domiciled in this state, the state in which the contract owner resides has an association similar to the association, and neither the payee or, if applicable, the payee's beneficiary, nor the contract owner is eligible for coverage by the association in the state in which the payee or contract owner resides.

(b) This chapter does not provide coverage to:

- (1) a person who is a payee or the beneficiary of a payee with respect to a contract the owner of which is a resident of this state, if the payee or the payee's beneficiary is afforded any coverage by the association of another state;

- (2) a person otherwise described by Subsection (a)(3), if any coverage is provided by the association of another state to that person; or

(3) a person who acquires rights to receive payments through a structured settlement factoring transaction as defined by Section 5891(c)(3)(A), Internal Revenue Code of 1986 (26 U.S.C. Section 5891(c)(3)(A)), regardless of whether the transaction occurred before, on, or after the date that section became effective.

(c) This chapter is intended to provide coverage to persons who are residents of this state, and in those limited circumstances as described in this chapter, to nonresidents. In order to avoid duplicate coverage, if a person who would otherwise receive coverage under this chapter is provided coverage under the laws of any other state, the person may not be provided coverage under this chapter. In determining the application of the provisions of this subsection in situations in which a person could be covered by the association of more than one state, whether as an owner, payee, enrollee, beneficiary, or assignee, this chapter shall be construed in conjunction with other state laws to result in coverage by only one association.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.018(a), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.018(a), eff. September 1, 2007.

Acts 2019, 86th Leg., R.S., Ch. 432 (S.B. 1153), Sec. 12, eff. September 1, 2019.

Sec. 463.202. POLICIES AND CONTRACTS COVERED. (a) Except as limited by this chapter, the coverage provided by this chapter to a person specified by Section 463.201, subject to Sections 463.201(b) and (c), applies with respect to the following policies and contracts issued by a member insurer:

- (1) a direct, nongroup life, health, accident, annuity, or supplemental policy or contract, including a health maintenance organization contract or certificate;
- (2) a certificate under a direct group policy or contract;
- (3) a group hospital service contract; and
- (4) an unallocated annuity contract.

(b) The coverage provided by this chapter also applies with respect to all other insurance coverage written by the following entities authorized to engage in business in this state:

- (1) a mutual assessment company;
- (2) a local mutual aid association;
- (3) a statewide mutual assessment company; and
- (4) a stipulated premium company.

(c) For the purposes of this section, an annuity contract or a certificate under a group annuity contract includes:

- (1) a guaranteed investment contract;
- (2) a deposit administration contract;
- (3) an allocated or unallocated funding agreement;
- (4) a structured settlement annuity;
- (5) an annuity issued to or in connection with a government lottery; and
- (6) an immediate or deferred annuity contract.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. [2017](#)), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 3B.018(b), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. [3167](#)), Sec. 9.018(b), eff. September 1, 2007.

Acts 2019, 86th Leg., R.S., Ch. 432 (S.B. [1153](#)), Sec. 13, eff. September 1, 2019.

Sec. 463.203. POLICIES AND CONTRACTS EXCLUDED. (a) In this section, "Moody's Corporate Bond Yield Average" means the monthly average corporates as published by Moody's Investors Service, Inc., or any successor to that entity.

(b) This chapter does not provide coverage for:

- (1) any part of a policy or contract not guaranteed by the insurer or under which the risk is borne by the policy or contract owner;
- (2) a policy or contract of reinsurance, unless an assumption certificate has been issued;
- (3) any part of a policy or contract to the extent that the rate of interest on which that part is based:

(A) as averaged over the period of four years before the date the member insurer becomes impaired or insolvent under this chapter, whichever is earlier, exceeds a rate of interest determined by subtracting two percentage points from Moody's Corporate Bond Yield Average averaged for the same four-year period or for a lesser period if the policy or contract was issued less than four years before the date the member insurer becomes impaired or insolvent under this chapter, whichever is earlier; and

(B) on and after the date the member insurer becomes impaired or insolvent under this chapter, whichever is earlier, exceeds the rate of interest determined by subtracting three percentage points from Moody's Corporate Bond Yield Average as most recently available;

(4) a portion of a policy or contract issued to a plan or program of an employer, association, similar entity, or other person to provide life, health, or annuity benefits to the entity's employees, members, or others, to the extent that the plan or program is self-funded or uninsured, including benefits payable by an employer, association, or similar entity under:

(A) a multiple employer welfare arrangement as defined by Section 3, Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1002);

(B) a minimum premium group insurance plan;

(C) a stop-loss group insurance plan; or

(D) an administrative services-only contract;

(5) any part of a policy or contract to the extent that the part provides dividends, experience rating credits, or voting rights, or provides that fees or allowances be paid to any person, including the policy or contract owner, in connection with the service to or administration of the policy or contract;

(6) a policy or contract issued in this state by a member insurer at a time the insurer was not authorized to issue the policy or contract in this state;

(7) an unallocated annuity contract issued to or in connection with a benefit plan protected under the federal Pension Benefit Guaranty Corporation, regardless of whether the Pension Benefit Guaranty Corporation has not yet become liable to make any payments with respect to the benefit plan;

(8) any part of an unallocated annuity contract that is not issued to or in connection with a specific employee, a benefit plan

for a union or association of individuals, or a governmental lottery;

(9) any part of a financial guarantee, funding agreement, or guaranteed investment contract that:

(A) does not contain a mortality guarantee; and

(B) is not issued to or in connection with a specific employee, a benefit plan, or a governmental lottery;

(10) a part of a policy or contract to the extent that the assessments required by Subchapter D with respect to the policy or contract are preempted by federal or state law;

(11) a contractual agreement that established the member insurer's obligations to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by the benefit plan or the plan's trustee in a case in which neither the benefit plan sponsor nor its trustee is an affiliate of the member insurer;

(12) a part of a policy or contract to the extent the policy or contract provides for interest or other changes in value that are to be determined by the use of an index or external reference stated in the policy or contract, but that have not been credited to the policy or contract, or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer under this chapter, whichever date is earlier, subject to Subsection (c);

(13) a policy or contract providing a hospital, medical, prescription drug, or other health care benefit under 42 U.S.C. Sections 1395w-21 et seq. and 1395w-101 et seq. (Medicare Parts C and D), 42 U.S.C. Sections 1396-1396w-5 (Medicaid), or 42 U.S.C. Sections 1397aa-1397mm (State Children's Health Insurance Program) or a regulation adopted under those federal statutes; or

(14) structured settlement annuity benefits to which a payee or beneficiary has transferred the payee's or beneficiary's rights in a structured settlement factoring transaction as defined by Section 5891(c)(3)(A), Internal Revenue Code of 1986 (26 U.S.C. Section 5891(c)(3)(A)), regardless of whether the factoring transaction occurred before, on, or after the date that section became effective.

(b-1) The exclusion from coverage described by Subsection (b)(3) does not apply to any portion of a policy or contract, including a rider, that provides long-term care benefits or any other health insurance benefit.

(c) For purposes of determining the values that have been credited and are not subject to forfeiture as described by Subsection (b)(12), if a policy's or contract's interest or changes in value are credited less frequently than annually, the interest or change in value determined by using the procedures defined in the policy or contract is credited as if the contractual date of crediting interest or changing values is the earlier of the date of impairment or the date of insolvency, and is not subject to forfeiture.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.018(c), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.018(c), eff. September 1, 2007.

Acts 2011, 82nd Leg., R.S., Ch. 14 (S.B. 567), Sec. 7, eff. September 1, 2011.

Acts 2019, 86th Leg., R.S., Ch. 432 (S.B. 1153), Sec. 14, eff. September 1, 2019.

Sec. 463.204. OBLIGATIONS EXCLUDED. A contractual obligation does not include:

(1) death benefits in an amount in excess of \$300,000 or a net cash surrender or net cash withdrawal value in an amount in excess of \$100,000 under one or more life insurance policies on a single life;

(2) an amount in excess of:

(A) \$250,000 in the present value under one or more annuity contracts issued with respect to a single life under individual annuity policies or group annuity policies; or

(B) \$5 million in unallocated annuity contract benefits with respect to a single contract owner regardless of the number of those contracts;

(3) an amount in excess of the following amounts, including any net cash surrender or cash withdrawal values, under one or more accident, health, accident and health, or long-term care insurance policies on a single life:

(A) \$500,000 for health benefit plans;

(B) \$300,000 for disability income and long-term care insurance, as those terms are defined by this code or rules adopted by the commissioner; or

(C) \$200,000 for coverages that are not defined as health benefit plans, disability income, or long-term care insurance;

(4) an amount in excess of \$250,000 in present value annuity benefits, in the aggregate, including any net cash surrender and net cash withdrawal values, with respect to each individual participating in a governmental retirement benefit plan established under Section 401, 403(b), or 457, Internal Revenue Code of 1986 (26 U.S.C. Sections 401, 403(b), and 457), covered by an unallocated annuity contract or the beneficiary or beneficiaries of the individual if the individual is deceased;

(5) an amount in excess of \$250,000 in present value annuity benefits, in the aggregate, including any net cash surrender and net cash withdrawal values, with respect to each payee of a structured settlement annuity or the beneficiary or beneficiaries of the payee if the payee is deceased;

(6) aggregate benefits in an amount in excess of \$300,000 with respect to a single life, except with respect to:

(A) benefits paid under health benefit plans, described by Subdivision (3)(A), in which case the aggregate benefits are \$500,000; and

(B) benefits paid to one owner of multiple nongroup policies of life insurance, whether the policy owner is an individual, firm, corporation, or other person, and whether the persons insured are officers, managers, employees, or other persons, in which case the maximum benefits are \$5 million regardless of the number of policies and contracts held by the owner;

(7) an amount in excess of \$5 million in benefits, with respect to either one plan sponsor whose plans own directly or in trust one or more unallocated annuity contracts not included in Subdivision (4) irrespective of the number of contracts with respect to the contract owner or plan sponsor or one contract owner provided coverage under Section 463.201(a)(3)(B), except that, if one or more unallocated annuity contracts are covered contracts under this chapter and are owned by a trust or other entity for the benefit of two or more plan sponsors, coverage shall be afforded by the association if the largest interest in the trust or entity owning the contract or contracts is held by a plan sponsor whose principal place

of business is in this state, and in no event shall the association be obligated to cover more than \$5 million in benefits with respect to all these unallocated contracts;

(8) any contractual obligations of the insolvent or impaired insurer under a covered policy or contract that do not materially affect the economic value of economic benefits of the covered policy or contract; or

(9) punitive, exemplary, extracontractual, or bad faith damages, regardless of whether the damages are:

(A) agreed to or assumed by an insurer, insured, or covered person; or

(B) imposed by a court.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.013(d), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.013(d), eff. September 1, 2007.

Acts 2011, 82nd Leg., R.S., Ch. 14 (S.B. 567), Sec. 8, eff. September 1, 2011.

Acts 2019, 86th Leg., R.S., Ch. 432 (S.B. 1153), Sec. 15, eff. September 1, 2019.

Sec. 463.205. PROTECTION PROVIDED BY OTHER JURISDICTION. This chapter does not provide coverage for a resident with respect to an impaired or insolvent insurer domiciled in another jurisdiction if guaranty protection is provided to the resident by the law of that jurisdiction.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 463.206. ASSOCIATION DISCRETION IN MANNER OF PROVIDING BENEFITS. (a) The board shall have discretion and may exercise reasonable business judgment to determine the means by which the association is to provide the benefits of this chapter in an economical and efficient manner.

(b) If the association arranges or offers to provide the benefits of this chapter to a covered person under a plan or arrangement that fulfills the association's obligations under this chapter, the person is not entitled to benefits from the association in addition to or other than those provided under the plan or arrangement.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.015(b), eff. September 1, 2007.

Added by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.015(b), eff. September 1, 2007.

**SUBCHAPTER F. POWERS AND DUTIES OF ASSOCIATION RELATING
TO IMPAIRED OR INSOLVENT INSURER**

Sec. 463.251. IMPAIRED DOMESTIC INSURER. (a) This section applies only to a member insurer that is an impaired domestic insurer.

(b) With the commissioner's approval, the association may:

(1) guarantee, assume, reissue, or reinsure, or cause to be guaranteed, assumed, reissued, or reinsured, one or more of the insurer's policies or contracts;

(2) provide money, pledges, notes, guarantees, or other means proper to:

(A) implement Subdivision (1); and

(B) ensure payment of the insurer's contractual obligations until action is taken under Subdivision (1); or

(3) loan money to the insurer.

(c) In taking action under Subsection (b), the association may impose any condition that:

(1) does not impair the insurer's contractual obligations; and

(2) is approved by:

(A) the commissioner; and

(B) the insurer, except in a conservation or rehabilitation ordered by a court.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 432 (S.B. 1153), Sec. 16, eff.

September 1, 2019.

Sec. 463.252. IMPAIRED DOMESTIC, FOREIGN, OR ALIEN INSURER NOT PAYING CLAIMS. (a) This section applies only to a member insurer that:

- (1) is an impaired domestic, foreign, or alien insurer; and
- (2) is not timely paying claims.

(b) Subject to Subsection (d), the association shall:

(1) with respect to the insurer, take one or more actions that the association is authorized to take under Section 463.251 with respect to an impaired domestic insurer, subject to the conditions of that section; or

(2) provide substitute benefits instead of the insurer's contractual obligations as provided by Subsection (c).

(c) A policy or contract owner, certificate holder, or enrollee who claims emergency or hardship may petition for substitute benefits under standards the association proposes and the commissioner approves. Substitute benefits are available only for a health claim, periodic annuity benefit payment, death benefit, supplemental benefit, or cash withdrawal.

(d) The association is required to take action under this section only if:

(1) the laws of the insurer's state of domicile provide that, until all payments of or on account of the insurer's contractual obligations are made by all guaranty associations and all expenses of the associations and interest on those payments and expenses have been repaid to the associations or a plan of repayment by the insurer has been approved by the associations:

(A) the delinquency proceeding may not be dismissed;

(B) the insurer and the insurer's assets may not be returned to the control of the insurer's shareholders or private management; and

(C) the insurer may not solicit or accept new business or have any suspended or revoked certificate of authority restored;

(2) the insurer is a domestic insurer that has been placed under an order of rehabilitation by a court in this state; or

(3) the insurer is a foreign or alien insurer and:

(A) the insurer has been prohibited from soliciting or accepting new business in this state;

(B) the insurer's certificate of authority has been suspended or revoked in this state; and

(C) a petition for rehabilitation or liquidation has been filed in a court in the insurer's state of domicile by the insurance official of that state.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 432 (S.B. 1153), Sec. 17, eff. September 1, 2019.

Sec. 463.253. INSOLVENT INSURER. (a) This section applies only to a member insurer that is an insolvent insurer.

(b) The association shall provide money, pledges, guarantees, or other means reasonably necessary to discharge the insurer's duties and to:

(1) guarantee, assume, reissue, or reinsure, or cause to be guaranteed, assumed, reissued, or reinsured, the insurer's policies or contracts; or

(2) ensure payment of the insurer's contractual obligations.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 432 (S.B. 1153), Sec. 18, eff. September 1, 2019.

Sec. 463.254. LIFE OR HEALTH INSURANCE POLICIES OR CONTRACTS.

(a) This section applies only when the association is taking an action under Section 463.252(b)(2) or 463.253 with respect to a life or health insurance policy or contract.

(b) The association, in accordance with Subsections (c) and (d), as applicable, shall ensure payment of benefits identical to the benefits that would have been payable under the policy or contract of the insurer.

(c) For a group policy or contract, the association shall ensure payment of benefits under Subsection (b) for claims incurred

before the later of:

(1) the earlier of the next renewal date under the policy or contract or the 45th day after the date the association becomes obligated with respect to the policy or contract; or

(2) the 30th day after the date the association becomes obligated with respect to the policy or contract.

(d) For an individual policy, the association shall ensure payment of benefits under Subsection (b) for claims incurred before the later of:

(1) the earlier of the next renewal date under the policy, if any, or the first anniversary of the date the association becomes obligated with respect to the policy; or

(2) the 30th day after the date the association becomes obligated with respect to the policy.

(e) The association shall diligently attempt to provide each known insured, enrollee, or group policy or contract holder with notice before the 30th day before the date the benefits are terminated.

(f) As provided by Subsections (g)-(i), the association shall make substitute coverage available on an individual basis to:

(1) each known insured or enrollee under an individual policy, or the owner if other than the insured or enrollee; and

(2) each individual who:

(A) was formerly insured or enrolled under a group policy or contract; and

(B) is not eligible for replacement group coverage.

(g) Substitute coverage is available for an individual policy under Subsection (f) only if the insured, enrollee, or owner was entitled under law or the terminated policy to continue an individual policy in force until a specified age or for a specified period during which the insurer:

(1) was not entitled to unilaterally change a provision of the policy; or

(2) was entitled only to change a premium by class.

(h) Substitute coverage is available for a group policy or contract under Subsection (f) only if the formerly insured or enrolled individual was entitled under law or the terminated policy or contract to convert group coverage to individual coverage.

(i) To provide substitute coverage under Subsection (f), the association may offer to reissue the terminated coverage or issue an

alternative policy. The association shall offer the reissued or alternative policy without requiring evidence of insurability, at actuarially justified rates. The reissued or alternative policy may not provide for a waiting period or exclusion that would not have applied under the terminated policy. The association may reinsure a reissued or alternative policy.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 432 (S.B. 1153), Sec. 19, eff. September 1, 2019.

Sec. 463.255. POLICY OR CONTRACT WITH GUARANTEED INTEREST RATE. In taking an action under Section 463.252(b)(2) or 463.253 with respect to a policy or contract with a guaranteed minimum interest rate, the association shall ensure the payment or crediting of a rate of interest consistent with Section 463.203(b)(3).

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 463.256. ALTERNATIVE POLICY. (a) An alternative policy issued by the association must:

- (1) be approved by the commissioner;
- (2) provide coverage of a kind that the association determines is similar to the coverage of the policy issued by the impaired or insolvent insurer;
- (3) contain at least the minimum provisions required by the statutes of this state; and
- (4) provide benefits that are not unreasonable in relation to the premium charged.

(b) The association shall set the premium according to a table of rates the association adopts. The premium:

- (1) must reflect:
 - (A) the amount of insurance provided; and
 - (B) each insured's or enrollee's age and class of risk;

and

- (2) may not reflect any change in an insured's or

enrollee's health occurring after the original policy was most recently underwritten.

(c) The association may adopt various kinds of alternative policies to issue at a later date without regard to any particular impairment or insolvency.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 432 (S.B. 1153), Sec. 20, eff. September 1, 2019.

Sec. 463.257. IMPOSITION OF LIEN OR MORATORIUM. To carry out the association's duties under this chapter and with the court's approval, the association may:

(1) impose a permanent policy or contract lien in connection with any guarantee, assumption, or reinsurance agreement if the association determines that:

(A) the amounts that may be assessed under this chapter are insufficient to ensure full and prompt performance of the association's duties under this chapter; or

(B) adverse economic or financial conditions affecting member insurers make imposition of the lien in the public interest; or

(2) in addition to any contractual provision for deferral of cash or policy loan value, impose a temporary moratorium or lien on payment of cash values and policy loans or the exercise of any other right to withdraw money held in connection with a policy or contract.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 463.258. PREMIUM FOR REISSUANCE OF TERMINATED COVERAGE. If the association reissues terminated coverage at a premium different from the terminated policy's premium, the premium must:

(1) reflect the amount of insurance provided and the insured's or enrollee's age and class of risk; and

(2) be approved by the commissioner or a court.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 432 (S.B. 1153), Sec. 21, eff. September 1, 2019.

Sec. 463.259. PREMIUM DUE DURING RECEIVERSHIP. After a court enters an order of receivership with respect to an impaired or insolvent insurer, a premium due for coverage issued by the insurer is owned by and is payable at the direction of the association. The association is liable for an unearned premium owed to a policy or contract owner that arises after the court enters the order.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.015(c), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.015(c), eff. September 1, 2007.

Sec. 463.260. LIMITS ON AND TERMINATION OF ASSOCIATION OBLIGATION. (a) The association is not liable for benefits that exceed the contractual obligations for which the insurer is liable or would have been liable if not impaired or insolvent. The association has no obligation to provide benefits outside the express written terms of the policy or contract, including:

- (1) claims based on marketing materials;
- (2) claims based on side letters, riders, or other documents that were issued without meeting applicable policy form filing or approval requirements;
- (3) claims based on misrepresentation of or regarding policy benefits;
- (4) extracontractual claims; or
- (5) claims for penalties or consequential or incidental damages.

(b) The association's obligations with respect to coverage under a policy of an impaired or insolvent insurer or under a

reissued or alternative policy terminate on the date the coverage or policy is replaced by another similar policy by the policyholder, the contract owner, the insured, the enrollee, or the association.

(c) If a premium is not paid before the 32nd day after the date the premium is due under a guaranteed, assumed, alternative, or reissued policy or contract or substitute coverage, the association's obligations under the policy, contract, or coverage terminate, except with respect to a claim incurred or any net cash surrender value due as provided by this chapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.018(d), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.018(d), eff. September 1, 2007.

Acts 2019, 86th Leg., R.S., Ch. 432 (S.B. 1153), Sec. 22, eff. September 1, 2019.

Sec. 463.261. ASSIGNMENT OF RIGHTS. (a) A person receiving a benefit under this chapter, including a payment of or on account of a contractual obligation, continuation of coverage, or provision of substitute or alternative coverage, is considered to have assigned to the association the rights under, and any cause of action relating to, the covered policy to the extent of the benefit received. The association may require a payee, policy or contract owner, beneficiary, insured, enrollee, or annuitant to assign the person's rights and cause of action to the association as a condition of receiving a right or benefit under this chapter.

(b) The association's subrogation rights under Subsection (a) have the same priority against the assets of the impaired or insolvent insurer as that held by the person entitled to receive a benefit under this chapter.

(c) The association has all common law rights of subrogation and any other equitable or legal remedy that would have been available to the impaired or insolvent insurer or holder, beneficiary, enrollee, or payee of a policy or contract with respect to the policy or contract.

(d) The rights of the association under Subsection (c) include, in the case of a structured settlement annuity, any rights of the owner, beneficiary, or payee of the annuity, to the extent of benefits received under this chapter, against any person originally or by succession responsible for the losses arising from the personal injury relating to the annuity or payment for the annuity, other than a person responsible solely by reason of serving as an assignee in respect of a qualified assignment under Section 130, Internal Revenue Code of 1986 (26 U.S.C. Section 130).

(e) If a provision of this section is invalid or ineffective with respect to any person or claim for any reason, the amount payable by the association with respect to the related covered obligations is reduced by the amount realized by any other person with respect to the person or claim that is attributable to the policies, or portion of the policies, covered by the association. If the association has provided benefits with respect to a covered obligation and a person recovers amounts as to which the association has rights described in this section, the person shall pay to the association the portion of the recovery attributable to the policies, or portion of the policies, covered by the association.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. [2017](#)), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 3B.015(d), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. [3167](#)), Sec. 9.015(d), eff. September 1, 2007.

Acts 2019, 86th Leg., R.S., Ch. 432 (S.B. [1153](#)), Sec. 23, eff. September 1, 2019.

Sec. 463.262. EFFECT OF SUBROGATION AND ASSIGNMENT OF RIGHTS AND AVAILABLE ASSETS ON ASSOCIATION OBLIGATION. (a) The limitations set forth in this chapter are limitations on the benefits for which the association is obligated before taking into account either the association's subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer attributable to covered policies.

(b) The costs of the association's obligations under this

chapter may be met by the use of assets attributable to covered policies or reimbursed to the association pursuant to the association's subrogation and assignment rights.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.018(e), eff. September 1, 2007.

Added by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.018(e), eff. September 1, 2007.

Sec. 463.263. DEPOSIT TO BE PAID TO ASSOCIATION. (a) A deposit in this state, held under law or required by the commissioner for the benefit of creditors, including policy owners, that is not turned over to the domiciliary receiver on the entry of a final order of liquidation or order approving a rehabilitation plan of an insurer domiciled in this state or a reciprocal state in accordance with Section 443.402 shall be promptly paid to the association.

(b) The association is entitled to retain a portion of any amount paid to the association under this section equal to the percentage determined by dividing the aggregate amount of policy owners' claims related to that insolvency for which the association has provided statutory benefits by the aggregate amount of all policy owners' claims in this state related to that insolvency and shall remit to the domiciliary receiver the amount paid to the association less the amount retained under this section.

(c) The amount paid to the association under this section, less the amount retained by the association under this section, is treated as a distribution of estate assets under Section 443.303 or the similar law of the state of domicile of the impaired or insolvent insurer.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.015(e), eff. September 1, 2007.

Added by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.015(e), eff. September 1, 2007.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 14 (S.B. 567), Sec. 9, eff. September 1, 2011.

Sec. 463.264. REINSURANCE. (a) The association may elect to

succeed to the rights of an insolvent insurer under a contract of reinsurance to which the insolvent insurer is a party to the extent:

(1) of the contractual obligations of the covered policies for which the association may become obligated; and

(2) that the reinsurance contract provides coverage for losses occurring after the association is obligated to provide coverage.

(b) As a condition to making an election under Subsection (a), the association shall pay all unpaid premiums due under the reinsurance contract to which Subsection (a) refers for coverage relating to a period before and after the date the association is obligated to provide coverage.

Added by Acts 2011, 82nd Leg., R.S., Ch. 14 (S.B. 567), Sec. 10, eff. September 1, 2011.

SUBCHAPTER G. OPERATION OF IMPAIRED OR INSOLVENT INSURER

Sec. 463.301. ISSUANCE OR RENEWAL OF POLICIES FOLLOWING CONSERVATORSHIP OR RECEIVERSHIP. (a) If an assessment has been made under this chapter for the insurer or guaranty fees have been provided for the insurer, an impaired insurer placed in conservatorship or receivership may not issue a new or renewal insurance policy on release from the conservatorship or receivership until the insurer has repaid in full the amount of guaranty fees provided by the association.

(b) Notwithstanding Subsection (a), on application of the association and after hearing, the commissioner may permit the insurer to issue new policies as provided by a plan of operation by the insurer for repayment. In approving the plan, the commissioner may restrict the issuance of new or renewal policies as necessary to implement the plan.

(c) The commissioner shall give 10 days' notice of the hearing to the association. The association and the member insurers that paid assessments in relation to the impaired insurer are entitled to appear at and participate in the hearing.

(d) Money recovered against an impaired insurer under this section shall be repaid to the member insurers that paid assessments in relation to the impaired insurer on return of the member insurers' certificates of contribution.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 463.302. DISTRIBUTIONS TO SHAREHOLDERS AND AFFILIATES.

(a) An impaired or insolvent insurer may not make a distribution to shareholders until the association has recovered the total amount of valid claims for money spent in carrying out the association's powers and performing the association's duties under Section 463.101, 463.103, 463.109, or 463.111(c) or Subchapter F with respect to that insurer, plus interest on that amount.

(b) Except as otherwise provided by this section, a receiver appointed under an order of receivership for an insurer domiciled in this state may recover on behalf of the insurer from an affiliate that controlled the insurer the amount of any distribution, other than a stock dividend the insurer paid on the insurer's capital stock, made during the five years preceding the date of the petition for liquidation or rehabilitation.

(c) A person who was an affiliate that controlled the insurer when a distribution described by Subsection (b) was paid is liable for the amount of the distribution received. A person who was an affiliate that controlled the insurer when the distribution was declared is liable for the amount of the distribution the affiliate would have received if the distribution had been paid immediately. Two or more persons liable for the same distribution are jointly and severally liable. If a person liable under this subsection is insolvent, all of the affiliates that controlled the insolvent person when the distribution was paid are jointly and severally liable for any resulting deficiency in the amount recovered from the insolvent person.

(d) The maximum amount recoverable under Subsections (b) and (c) is the amount needed in excess of all other available assets of the impaired or insolvent insurer to pay the insurer's contractual obligations.

(e) The receiver may not recover a distribution to shareholders under Subsection (b) if the insurer shows that, at the time the distribution was paid, the distribution was lawful and reasonable and that the insurer did not know and could not reasonably have known that the distribution might adversely affect the ability of the insurer to fulfill the insurer's contractual obligations.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.019(a), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.019(a), eff. September 1, 2007.

Sec. 463.303. ASSETS ATTRIBUTABLE TO COVERED POLICIES. (a) For the purposes of this section, assets attributable to covered policies are the proportion of the assets that the reserves that should have been established for the covered policies bear to the reserves that should have been established for all insurance policies written by the impaired or insolvent insurer.

(b) To carry out the association's obligations under this chapter, the association is considered a creditor of the impaired or insolvent insurer to the extent of assets attributable to covered policies, less any amount to which the association is entitled as subrogee under Section 463.261.

(c) Assets of the impaired or insolvent insurer attributable to covered policies shall be used to continue all covered policies and pay all contractual obligations of the impaired or insolvent insurer as required by this chapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 463.304. DISTRIBUTION OF OWNERSHIP RIGHTS OF IMPAIRED OR INSOLVENT INSURER. In making an equitable distribution of the ownership rights of an impaired or insolvent insurer before the termination of a receivership, the court:

(1) shall consider the welfare of the policyholders, contract owners, certificate holders, and enrollees of the continuing or successor insurer; and

(2) may consider the contributions of the respective parties, including the association, the shareholders, policyholders, contract owners, certificate holders, and enrollees of the impaired or insolvent insurer, and any other party with a bona fide interest.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.019(b), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.019(b), eff. September 1, 2007.

Acts 2019, 86th Leg., R.S., Ch. 432 (S.B. 1153), Sec. 24, eff. September 1, 2019.

SUBCHAPTER H. POWERS AND DUTIES OF COMMISSIONER AND DEPARTMENT

Sec. 463.351. NOTICE OF COMMISSIONER ACTIONS. (a) The commissioner shall:

(1) notify the insurance officials of all the other states, territories of the United States, and the District of Columbia by mail not later than the 30th day after the date the commissioner:

(A) revokes or suspends a member insurer's certificate of authority; or

(B) issues a formal order requiring a member insurer to:

(i) restrict the insurer's premium writing;

(ii) withdraw from this state;

(iii) reinsure all or part of the insurer's business;

(iv) obtain additional contributions to surplus; or

(v) increase capital, surplus, or another account for the security of policyholders, contract owners, or creditors;

(2) report to the board when the commissioner:

(A) takes an action described by Subdivision (1) or receives from another insurance official a report indicating that a similar action has been taken in another state; or

(B) has reasonable cause to believe from a completed or continuing examination that a member insurer may be impaired or insolvent; and

(3) provide to the board the National Association of Insurance Commissioners Insurance Regulatory Information System ratios and listings of insurers not included in those ratios.

(b) A report under Subsection (a)(2)(A) must contain all significant details of the action taken or report received.

(c) The board may use information described by this section to carry out the board's duties under this chapter. The board shall keep a report made under this section and the contents of the report confidential until the commissioner or other lawful authority makes the report and the contents public.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 432 (S.B. 1153), Sec. 25, eff. September 1, 2019.

Sec. 463.352. ADVICE FROM BOARD. The commissioner may seek the board's advice and recommendations on a matter affecting the commissioner's duties regarding the financial condition of:

- (1) a member insurer; or
- (2) an insurer applying for a certificate of authority to engage in the business of insurance in this state.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 463.353. EXAMINATION. (a) The board by majority vote may request the commissioner to order an examination of a member insurer that the board in good faith believes may be impaired or insolvent. The commissioner shall keep the request on file. The request is open for public inspection before release of the examination report to the public.

(b) Not later than the 30th day after the date the commissioner receives the request, the commissioner shall begin the examination. The examination may be conducted:

- (1) as a National Association of Insurance Commissioners examination; or
- (2) by a person the commissioner designates.

(c) The association shall pay the cost of the examination.

(d) The commissioner shall notify the board when the examination is completed. The examination report shall be treated in the same manner as other examination reports. The report may not be released to the board before the report is released to the public,

except that the commissioner may comply with Section 463.351.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 463.354. DEMAND TO CURE IMPAIRMENT. (a) When an impairment is declared and the amount of the impairment is determined, the commissioner shall serve a demand on the impaired insurer to cure the impairment within a reasonable time.

(b) Notice of the demand under Subsection (a) to the impaired insurer constitutes notice to any shareholders of the insurer.

(c) Failure of the impaired insurer to comply promptly with the demand does not excuse the association from exercising the association's powers and performing the association's duties under this chapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 463.355. FAILURE TO COMPLY WITH PLAN OF OPERATION. On failure of a member insurer to comply with the plan of operation, the commissioner may suspend or revoke, after notice and hearing, the insurer's certificate of authority to engage in the business of insurance in this state.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 463.356. ASSUMPTION OF POWERS AND DUTIES OF ASSOCIATION. The commissioner may assume the powers and duties of the association under this chapter with respect to impaired or insolvent insurers if the association does not within a reasonable period act as provided by:

- (1) Section 463.252(b)(2);
- (2) Section 463.253; and
- (3) Section 463.254.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April

1, 2007.

Sec. 463.357. NOTIFICATION OF EFFECT OF CHAPTER. The commissioner, as receiver of an impaired insurer, may notify all interested persons of the effect of this chapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 463.358. STATEMENT OF PREMIUMS. On request, the commissioner shall provide the association with a statement of the premiums in this state and any other appropriate state for each member insurer.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

SUBCHAPTER I. APPEALS AND OTHER ACTIONS

Sec. 463.401. APPEAL TO COMMISSIONER. (a) Not later than the 60th day after the date of a final action of the association or the board, a member insurer may appeal the action to the commissioner.

(b) A member insurer appealing an assessment shall pay the assessment to the association. The association may use the money to meet the association's obligations while the appeal is pending. If the appeal on the assessment is upheld, the association shall return to the insurer the amount paid in error or in excess of the amount the commissioner determines the insurer was obligated to pay.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 463.402. VENUE. Venue for an action against the association under this chapter is in Travis County.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 463.403. APPEAL BOND. The association is not required to give an appeal bond in an appeal of a cause of action under this chapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 463.404. STAY OF PROCEEDINGS; CERTAIN DECISIONS NOT BINDING. (a) To permit the receiver or association to properly defend a pending cause of action, a proceeding in which an impaired insurer is a party or is obligated to defend a party in a court in this state, other than a proceeding directly related to the receivership or brought by the receiver, is stayed for:

(1) a six-month period beginning on the later of the date the insurer is designated as impaired or the date an ancillary proceeding is brought in this state; and

(2) any subsequent period as determined by the court.

(b) If a covered claim arises from a judgment, order, verdict, finding, or other decision based on the default of an impaired insurer or the insurer's failure to defend an insured, the association on the association's behalf or on behalf of the insured may apply to the court or administrator that made the decision to have the decision set aside and is entitled to defend the claim on the merits.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

SUBCHAPTER J. PROHIBITED PRACTICES

Sec. 463.451. PROHIBITED USE OF PROTECTION PROVIDED BY CHAPTER.

(a) A person may not make, publish, disseminate, circulate, or place before the public, or directly or indirectly cause to be made, published, disseminated, circulated, or placed before the public, a written or oral advertisement, announcement, or statement that uses the existence of the association to sell, solicit, or induce the purchase of a kind of insurance with respect to which this chapter provides coverage.

(b) This section applies to an advertisement, announcement, or statement made, published, disseminated, circulated, or placed before

the public:

- (1) in a newspaper, magazine, or other publication;
- (2) in a notice, circular, pamphlet, letter, or poster;
- (3) over a radio or television station; or
- (4) in any other manner.

(c) Except as provided by Section 463.114, the use by a person of the protection provided by this chapter in the sale of insurance is unfair competition and an unfair practice under Chapter 541.

(d) This section does not apply to the association or any other entity that does not sell or solicit insurance.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

CHAPTER 464. UNAUTHORIZED INSURANCE GUARANTY FUND ACT
SUBCHAPTER A. GENERAL PROVISIONS

Sec. 464.001. SHORT TITLE. This chapter may be cited as the Unauthorized Insurance Guaranty Fund Act.

Added by Acts 2009, 81st Leg., R.S., Ch. 1026 (H.B. 4339), Sec. 1, eff. June 19, 2009.

Sec. 464.002. CONSTRUCTION AND PURPOSE. (a) The purpose of this chapter is to alleviate the financial hardship imposed on persons who are harmed by the sale of unauthorized insurance in this state. Persons who suffer damages as a result of unpaid claims on policies issued by unauthorized insurers in this state are not covered under guaranty acts, which provide protection to persons with claims against authorized insurers. The legislature finds that it is appropriate to provide additional remedies to these persons.

(b) The commissioner's powers under this Act shall be liberally construed to support the purpose stated in Subsection (a).

(c) This chapter does not limit the powers granted the commissioner under other provisions of law. The powers and authority of the commissioner under this chapter are cumulative and are in addition to all other powers and authority that are available to the commissioner.

Added by Acts 2009, 81st Leg., R.S., Ch. 1026 (H.B. 4339), Sec. 1,

eff. June 19, 2009.

Sec. 464.003. DEFINITIONS. In this chapter:

(1) "Delinquency proceeding" has the meaning assigned by Section 443.004.

(2) "Fund" means the unauthorized insurance guaranty fund.

(3) "Fund account" means the account established for the deposit of money held by the fund.

(4) "Policy claim" means an obligation incurred under a contract or policy of insurance issued by an unauthorized insurer as described by Chapter 101. The term does not include claims under reinsurance contracts or claims of other creditors.

(5) "Receiver" means the receiver of an unauthorized insurer in a delinquency proceeding, including the commissioner when acting in that capacity, or a special deputy receiver.

(6) "Unauthorized insurer" has the meaning assigned by Section 443.004.

Added by Acts 2009, 81st Leg., R.S., Ch. 1026 (H.B. 4339), Sec. 1, eff. June 19, 2009.

Sec. 464.004. APPLICABILITY. This chapter applies to a delinquency proceeding under Chapter 443 of an unauthorized insurer.

Added by Acts 2009, 81st Leg., R.S., Ch. 1026 (H.B. 4339), Sec. 1, eff. June 19, 2009.

Sec. 464.005. IMMUNITY. Liability does not exist and a cause of action does not arise against the commissioner or an agent, employee, or representative of the commissioner for any good faith act or omission in performing the commissioner's, or the agent's, employee's, or representative's powers and duties under this chapter.

Added by Acts 2009, 81st Leg., R.S., Ch. 1026 (H.B. 4339), Sec. 1, eff. June 19, 2009.

Sec. 464.006. EXEMPTION FROM CERTAIN FEES AND TAXES. The fund

is exempt from payment of all fees and taxes levied by this state or a political subdivision of this state.

Added by Acts 2009, 81st Leg., R.S., Ch. 1026 (H.B. 4339), Sec. 1, eff. June 19, 2009.

Sec. 464.007. RULES. The commissioner may adopt rules as necessary to implement this chapter.

Added by Acts 2009, 81st Leg., R.S., Ch. 1026 (H.B. 4339), Sec. 1, eff. June 19, 2009.

SUBCHAPTER B. FUND

Sec. 464.051. CREATION OF UNAUTHORIZED INSURANCE GUARANTY FUND. The unauthorized insurance guaranty fund is established.

Added by Acts 2009, 81st Leg., R.S., Ch. 1026 (H.B. 4339), Sec. 1, eff. June 19, 2009.

Sec. 464.052. DEPOSIT OF FUNDS. (a) The fund account shall be established with the Texas Treasury Safekeeping Trust Company in accordance with procedures adopted by the comptroller. The comptroller shall account for the deposited money separately from all other money.

(b) The commissioner may identify collected penalties to be deposited into the fund account from:

(1) administrative penalties assessed by the commissioner for violations of Chapter 101 or penalties under Section 861.702, including amounts collected through state warrant holds;

(2) civil penalties assessed under Chapter 101 when the commissioner is the party requesting penalties;

(3) administrative penalties assessed by the commissioner against a person holding a certificate of authority, license, registration, or other authorization to engage in the business of insurance that is issued or recognized by the commissioner for engaging in conduct outside the scope of the person's certificate, license, registration, or authorization;

(4) administrative penalties assessed by the commissioner

against a person holding a certificate of authority, license, registration, or authorization issued or recognized by the commissioner for using unapproved forms, rates, or advertisements if the forms, rates, or advertisements are required to be approved by the commissioner before being used in this state; and

(5) forfeitures of bonds issued under Section 101.353 or 101.354.

(c) In determining the amounts to be deposited into the fund account, the commissioner shall consider:

(1) the amount existing in the fund account;

(2) the anticipated penalties described by Subsection (b) that have been or may be collected;

(3) the estimated assets, administrative expenses, and claims of any unauthorized insurers subject to a delinquency proceeding; and

(4) any anticipated delinquency proceedings of unauthorized insurers.

(d) If the commissioner determines that the amounts on deposit in the fund account exceed the amount required to pay administrative expenses and claims of existing and anticipated delinquency proceedings of unauthorized insurers, the commissioner may transfer the excess amount from the fund to the comptroller for deposit into the general revenue fund.

(e) The commissioner shall notify the comptroller of the existence of money under Subsection (c) to be credited to the fund account. The commissioner must enter an order to transfer amounts from the fund account.

Added by Acts 2009, 81st Leg., R.S., Ch. 1026 (H.B. 4339), Sec. 1, eff. June 19, 2009.

Sec. 464.053. ADVANCE OF FUNDS. (a) In the event of a delinquency proceeding of an unauthorized insurer, the commissioner may advance funds from the fund account if the assets of the unauthorized insurer are insufficient to pay administrative expenses or policy claims. The commissioner shall hold the funds in a separate account. Funds advanced under this section are available to supplement the assets of the unauthorized insurer, and do not become property of the unauthorized insurer or the receivership estate.

(b) In determining an amount to be advanced, the commissioner shall consider:

(1) the amount existing in the fund, and any estimated future amounts to be deposited in the fund;

(2) the assets of the unauthorized insurer that are anticipated to be available to pay administrative expenses and claims;

(3) the projected administrative expenses and claims in the delinquency proceeding; and

(4) the projected administrative expenses and claims in other existing and anticipated delinquency proceedings of unauthorized insurers.

Added by Acts 2009, 81st Leg., R.S., Ch. 1026 (H.B. 4339), Sec. 1, eff. June 19, 2009.

Sec. 464.054. USE OF FUNDS. (a) An amount advanced under Section 464.053 may be used to supplement the assets of an unauthorized insurer to pay administrative expenses and policy claims that are approved by:

(1) the commissioner in a proceeding under Section 443.051; or

(2) the receiver in a proceeding under Section 443.052.

(b) For the purposes of Section 443.301(b), approved policy claims under this chapter shall be classified as Class 2 claims.

(c) The commissioner or receiver, as applicable, is not required to make distributions from the assets of the unauthorized insurer before using amounts advanced under Section 464.053. Any payment of a policy claim made under Subsection (a) shall be treated as a distribution under Section 443.302. If approved policy claims cannot be paid in full from the funds advanced under Section 464.053 and the assets of the unauthorized insurer available for distribution, the claims shall be paid on a pro rata basis in the manner described in Section 443.301.

(d) Amounts advanced that are not needed to pay administrative expenses or policy claims shall be returned to the fund account. On a final distribution under Section 443.302 or the termination of a delinquency proceeding, any funds of the unauthorized insurer remaining after the payment in full of administrative expenses and

policy claims shall be used to repay the advance, up to the amount of the advance.

(e) A person who has a policy claim may receive funds deposited or advanced under this chapter only in accordance with this section.

Added by Acts 2009, 81st Leg., R.S., Ch. 1026 (H.B. 4339), Sec. 1, eff. June 19, 2009.

SUBTITLE E. REQUIREMENTS OF OTHER JURISDICTIONS

CHAPTER 481. VOLUNTARY DEPOSITS

Sec. 481.001. DEPOSIT WITH COMPTROLLER. (a) An insurer organized and engaged in business under this code that is required by another state, country, or province as a condition of engaging in an insurance business in that state, country, or province to make or maintain a deposit with an officer of any state, country, or province may, at the insurer's discretion, voluntarily deposit with the comptroller cash or securities in an amount that is sufficient to satisfy the conditions of the other state, country, or province.

(b) Any securities deposited must be approved by the commissioner as being of a type and character in which the insurer is authorized by law to invest.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 481.002. APPLICABILITY OF CHAPTER TO CERTAIN DEPOSITS. A voluntary deposit held by the comptroller or the department that was made by an insurer in this state before May 8, 1959, to gain admission to another state may, at the insurer's option, be considered to be held under this chapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 481.003. DUTIES OF COMPTROLLER. The comptroller shall receive a deposit made by an insurer as described by this chapter and hold it exclusively for the protection of all policyholders or creditors of the insurer, wherever they are located, or for the

protection of the insurer's policyholders or creditors in a particular state, country, or province, as designated by the insurer at the time the insurer makes the deposit.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 481.004. ACCESS TO DEPOSIT. In accordance with reasonable rules adopted by the comptroller and the commissioner, the proper officer of an insurer making a deposit as described by this chapter may at a reasonable time:

- (1) examine the deposit;
- (2) detach coupons from the securities; and
- (3) collect interest on the deposit.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 481.005. SITUS OF DEPOSIT FOR TAX PURPOSES. For purposes of state, county, or municipal taxation, the situs of deposited securities is the municipality and county in which the principal business office of the insurer making the deposit is fixed by the insurer's charter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 481.006. WITHDRAWAL OF DEPOSIT. (a) An insurer that makes a deposit as described by this chapter may, at the insurer's option, withdraw all or part of the deposit if:

- (1) the insurer first deposits with the comptroller other securities of like class as, and of an amount and value equal to, the securities proposed to be withdrawn; and
- (2) the withdrawal and substitution are approved by the commissioner.

(b) An insurer, without making a substitute deposit under Subsection (a), may not withdraw all or part of a deposit made as described by this chapter for the protection of the insurer's

policyholders or creditors in a particular state, country, or province that requires the deposit unless:

(1) the insurer files with the commissioner evidence that satisfies the commissioner that the insurer has withdrawn from business and does not have any unsecured liabilities outstanding or potential policyholder liabilities or obligations in the other state, country, or province; and

(2) the commissioner approves the withdrawal.

(c) An insurer, without making a substitute deposit under Subsection (a), may not withdraw all or part of a deposit made as described by this chapter for the protection of all of the insurer's policyholders or creditors, wherever they are located, unless:

(1) the insurer files with the commissioner evidence that satisfies the commissioner that the insurer does not have any unsecured liabilities outstanding or potential policy liabilities or obligations anywhere; and

(2) the commissioner approves the withdrawal.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 481.007. WITHDRAWAL OF DEPOSIT AFTER MERGER, CONSOLIDATION, OR TOTAL REINSURANCE. When two or more insurers that have two or more deposits made for identical purposes as described by this chapter or former Article 4739, Revised Statutes, merge, consolidate, or enter into a total reinsurance contract by which the ceding insurer is dissolved and the ceding insurer's assets and liabilities are acquired or assumed by the surviving insurer, the new, surviving, or reinsuring insurer may withdraw all of the deposits, except for the deposit of the greatest amount and value. The new, surviving, or reinsuring insurer must demonstrate that the deposits are duplicated and that the insurer is the owner of the deposits.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 481.008. RETURN OF DEPOSIT. An insurer that has made a deposit as described by this chapter or former Article 4739, Revised

Statutes, is entitled to a return of the deposit if the insurer applies for the return of the deposit and demonstrates to the commissioner that the deposit is no longer required under the laws of any state, country, or province in which the insurer sought or gained admission to engage in business based on a certificate of the deposit.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 481.009. DELIVERY OF DEPOSIT BY COMPTROLLER. On being provided a certified copy of the commissioner's order issued under Section 481.007 or 481.008, the comptroller shall release, transfer, and deliver the deposit to the owner of the deposit in accordance with the order.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

SUBTITLE F. REINSURANCE
CHAPTER 491. GENERAL REINSURANCE REQUIREMENTS
SUBCHAPTER A. REINSURANCE

Sec. 491.001. INAPPLICABILITY OF SUBCHAPTER. This subchapter does not apply to:

- (1) life insurance;
- (2) health insurance;
- (3) annuity contracts;
- (4) title insurance;
- (5) workers' compensation insurance;
- (6) employers' liability insurance coverage; or
- (7) any policy or kind of coverage for which the maximum possible loss to the insurer is not readily ascertainable on the policy's issuance.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 491.002. REINSURANCE PERMITTED. An insurer or reinsurer

authorized to engage in the business of insurance or reinsurance in this state may reinsure all or part of a single risk in another solvent insurer.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 491.003. RISK LIMITATION FOR DOMESTIC OR FOREIGN INSURER. An insurer incorporated under the laws of this state, another state, or the United States and authorized to engage in business in this state may not expose itself to a loss or hazard on a single risk in an amount that exceeds 10 percent of the insurer's surplus for policyholders unless the insurer reinsures the excess in another solvent insurer.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 491.004. RISK LIMITATION FOR ALIEN INSURER. An insurer incorporated under the laws of a jurisdiction other than this state, another state, or the United States and authorized to engage in business in this state may not, unless the insurer reinsures the excess in another solvent insurer, expose itself to a loss or hazard on a single risk in an amount that exceeds the sum of:

(1) 10 percent of the insurer's deposit with the statutory officer in the state through which the insurer is authorized to engage in business in the United States; and

(2) 10 percent of the other surplus for policyholders of the insurer's United States branch.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 491.005. COMPLIANCE WITH OTHER LAW. Reinsurance that is required or permitted by this subchapter must comply with Chapter 493.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April

1, 2007.

SUBCHAPTER B. COMPUTATION OF REINSURANCE RESERVE

Sec. 491.051. COMPUTATION OF RESERVE FOR INSURER WITH NO BASIS PRESCRIBED BY LAW. For an insurer engaged in the business of a kind of insurance in this state, for which no basis is prescribed by law, the department shall compute the reinsurance reserve on the basis prescribed by Section 862.102 for an insurer writing fire insurance.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 491.052. COMPUTATION OF REINSURANCE RESERVES FOR CERTAIN INSURERS. (a) On December 31 of each year, or as soon as practicable after that date, the department shall, in accordance with Section 491.051, compute the reinsurance reserve for all unexpired risks of each insurer organized under the laws of this state or engaged in the business of insurance in this state.

(b) This section does not apply to:

- (1) life insurance;
- (2) fire insurance;
- (3) marine insurance;
- (4) inland marine insurance;
- (5) lightning insurance; or
- (6) tornado insurance.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

CHAPTER 493. AUTHORIZED REINSURANCE; CREDIT AND ACCOUNTING

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 493.001. DEFINITIONS. In this chapter:

(1) "Assuming insurer" means an insurer that, under a reinsurance contract, incurs an obligation to a ceding insurer, the performance of which is contingent on the ceding insurer incurring liability or loss under the ceding insurer's insurance contract with a third person.

(2) "Qualified United States financial institution" means

an institution that:

(A) is organized or, in the case of a United States branch or agency office of a foreign banking organization, licensed, under the laws of the United States or any state of the United States; and

(B) is regulated, supervised, and examined by a federal or state authority that has regulatory authority over banks and trust companies.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 493.002. APPLICABILITY OF CHAPTER. (a) Except as provided by Subsection (a-1), this chapter applies to all insurers, including:

- (1) a stock or mutual property and casualty insurance company;
- (2) a Mexican casualty insurance company;
- (3) a Lloyd's plan;
- (4) a reciprocal or interinsurance exchange;
- (5) a nonprofit legal service corporation;
- (6) a county mutual insurance company;
- (7) a farm mutual insurance company;
- (8) a risk retention group;
- (9) any insurer writing a line of insurance regulated by Title 10;

(10) all life, health, and accident insurance companies regulated by the department, including:

- (A) a stock or mutual life, health, or accident insurance company;
- (B) a fraternal benefit society; and
- (C) a nonprofit hospital, medical, or dental service corporation, including a group hospital service corporation operating under Chapter 842; and

(11) a health maintenance organization operating under Chapter 843.

(a-1) A county mutual insurance company operating under Section 912.056(d) that does not directly or indirectly write or assume insurance in any manner in another state may not be allowed credit

under Section 493.1033 for reinsurance ceded to a reinsurer qualifying under Sections 493.1033 and 493.1034 and is not subject to Section 493.1039. This subsection does not prohibit a county mutual insurance company described by this subsection from ceding reinsurance to reinsurers qualifying under Sections 493.1033 and 493.1034 under other provisions of this chapter.

(b) Repealed by Acts 2017, 85th Leg., R.S., Ch. 594 (S.B. 1070), Sec. 2.12(2), eff. September 1, 2017.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 594 (S.B. 1070), Sec. 2.02, eff. September 1, 2017.

Acts 2017, 85th Leg., R.S., Ch. 594 (S.B. 1070), Sec. 2.12(2), eff. September 1, 2017.

Sec. 493.003. RULES. The commissioner may adopt necessary and reasonable rules under this chapter to protect the public interest.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

SUBCHAPTER B. REINSURANCE

Sec. 493.051. REINSURANCE AUTHORIZED. (a) An insurer authorized to engage in the business of insurance in this state may reinsure, in any solvent assuming insurer, any risk or part of a risk that both insurers are authorized by law to assume.

(b) An insurer authorized to engage in business in this state may provide reinsurance under this chapter on any line of insurance in which the insurer is authorized to engage in this state.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 594 (S.B. 1070), Sec. 2.03, eff. September 1, 2017.

Sec. 493.052. LIMITATION ON REINSURANCE OF ENTIRE OUTSTANDING BUSINESS. (a) An insurer may not reinsure the insurer's entire outstanding business in an assuming insurer unless the assuming insurer is authorized to engage in the business of insurance in this state.

(b) Before the date of reinsurance:

(1) the reinsurance contract must be submitted to the commissioner; and

(2) the commissioner must approve the contract as fully protecting the interests of all policyholders.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 493.053. FILING OF REINSURANCE SCHEDULES. The commissioner shall require each insurer to file reinsurance schedules:

(1) when the insurer makes the insurer's annual report; and

(2) at other times as the commissioner directs.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 493.054. ACCOUNTING FOR REINSURANCE CONTRACTS. (a) An insurer shall account for reinsurance contracts and shall record the contracts in the insurer's financial statements in a manner that accurately reflects the effect of the contracts on the insurer's financial condition.

(b) A reinsurance contract may contain a provision allowing the offset of mutual debts and credits between the ceding insurer and the assuming insurer, whether arising out of one or more reinsurance contracts.

(c) The commissioner may adopt reasonable rules relating to:

(1) the accounting and financial statement requirements of this section and the treatment of reinsurance contracts between insurers, including minimum risk transfer standards, asset debits or credits, reinsurance debits or credits, and reserve debits or credits relating to the transfer of all or any part of an insurer's risks or liabilities by reinsurance contracts; and

(2) any contingencies arising from reinsurance contracts.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 493.055. LIMITATION ON RIGHTS AGAINST REINSURER. A person does not have a right against a reinsurer that is not specifically stated in:

- (1) the reinsurance contract; or
- (2) a specific agreement between the reinsurer and the

person.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

SUBCHAPTER C. CREDIT FOR REINSURANCE

Sec. 493.101. EXCLUSIVE PROCEDURE FOR TAKING CREDIT FOR REINSURANCE. A ceding insurer may take a credit for reinsurance, as an asset or as a deduction from liability, only as provided by this chapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 493.102. CREDIT FOR REINSURANCE GENERALLY. (a) A ceding insurer may be allowed credit for reinsurance ceded, as an asset or as a deduction from liability, only if the reinsurance is ceded to an assuming insurer that:

(1) is authorized to engage in the business of insurance or reinsurance in this state;

(2) is accredited as a reinsurer in this state, as provided by Section 493.103;

(3) subject to Subchapter D, maintains, in a qualified United States financial institution that has been granted the authority to operate with fiduciary powers, a trust fund to pay valid claims of:

(A) the assuming insurer's United States policyholders and ceding insurers; and

(B) the policyholders' and ceding insurers' assigns and successors in interest;

(4) is certified as a reinsurer in this state under Section 493.1033 and maintains adequate collateral as determined by the commissioner; or

(5) is an eligible assuming insurer under Section 493.108.

(b) Notwithstanding Subsection (a), a ceding insurer may be allowed credit for reinsurance ceded to an assuming insurer that does not meet the requirements of that subsection, but only with respect to the insurance of risks located in a jurisdiction in which the reinsurance is required by the jurisdiction's law, including regulations, to be ceded to an assuming insurer that does not meet the requirements of that subsection.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 594 (S.B. 1070), Sec. 2.04, eff. September 1, 2017.

Acts 2021, 87th Leg., R.S., Ch. 22 (H.B. 1689), Sec. 1, eff. January 1, 2022.

Sec. 493.103. ACCREDITED REINSURER. For purposes of Section 493.102(a)(2), an insurer is accredited as a reinsurer in this state if the insurer:

(1) submits to this state's jurisdiction;

(2) submits to this state's authority to examine the insurer's books and records;

(3) is domiciled and authorized to engage in the business of insurance or reinsurance in at least one state or, if the insurer is a United States branch of an alien assuming insurer, is entered through and authorized to engage in the business of insurance or reinsurance in at least one state;

(4) annually files with the department a copy of the annual statement the insurer files with the insurance department of the insurer's state of domicile; and

(5) maintains a surplus as regards policyholders in an amount of at least \$20 million.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April

1, 2007.

Sec. 493.1033. CREDIT ALLOWED FOR CERTAIN CERTIFIED REINSURERS.

(a) Credit shall be allowed when the reinsurance is ceded to an assuming insurer that:

(1) is certified by the commissioner as a reinsurer in this state; and

(2) secures its obligations in accordance with the requirements of this section and Sections 493.1034-493.1038.

(b) To be eligible for certification, the assuming insurer must:

(1) be domiciled and licensed to transact insurance or reinsurance in a jurisdiction listed as qualified on the list published by the commissioner under Section 493.1035;

(2) maintain minimum capital and surplus in an amount required by the commissioner by rule;

(3) maintain a financial strength rating from not fewer than two rating agencies determined to be acceptable in accordance with rules adopted by the commissioner;

(4) agree to submit to the jurisdiction of any court of competent jurisdiction in any state of the United States;

(5) appoint the commissioner as its agent for service of process in this state;

(6) provide security for 100 percent of the assuming insurer's liabilities for reinsurance ceded by United States ceding insurers if the assuming insurer resists enforcement of a final judgment of a court of the United States;

(7) meet application information filing requirements, as established by the commissioner by rule, for the initial application for certification and on an ongoing basis; and

(8) satisfy any other requirements for certification required by the commissioner by rule.

(c) In determining eligibility for certification under Subsection (b), the commissioner may defer to the certification granted and financial strength rating assigned by a National Association of Insurance Commissioners accredited jurisdiction.

(d) Credit for reinsurance under this section applies only to a reinsurance contract entered into or renewed on or after the effective date of the certification of the assuming insurer.

Added by Acts 2017, 85th Leg., R.S., Ch. 594 (S.B. 1070), Sec. 2.05, eff. September 1, 2017.

Sec. 493.1034. CERTAIN ASSOCIATIONS MAY BE CERTIFIED REINSURERS. (a) An association that includes incorporated and individual unincorporated underwriters may be a certified reinsurer under Section 493.1033. To be eligible for certification the association must satisfy the requirements of Section 493.1033 and this section.

(b) The association must satisfy minimum capital and surplus requirements through the capital and surplus equivalents, net of liabilities, of the association and its members that must include a joint central fund in an amount determined by the commissioner to provide adequate protection that may be applied to any unsatisfied obligation of the association or any of its members.

(c) The incorporated members of the association may not be engaged in any business other than underwriting and are subject to the same level of regulation and solvency control by the association's domiciliary regulator as are the unincorporated members.

(d) Not later than the 90th day after the date the association's financial statements are due to be filed with the association's domiciliary regulator, the association shall provide to the commissioner:

(1) an annual certification by the association's domiciliary regulator of the solvency of each underwriter member; or

(2) if a certification described by Subdivision (1) is unavailable, financial statements, prepared by independent public accountants, of each underwriter member of the association.

Added by Acts 2017, 85th Leg., R.S., Ch. 594 (S.B. 1070), Sec. 2.05, eff. September 1, 2017.

Sec. 493.1035. QUALIFIED JURISDICTIONS. (a) The commissioner shall develop and publish a list of qualified jurisdictions in one of which an assuming insurer must be licensed and domiciled in order to be considered for certification by the commissioner under Section 493.1033 as a certified reinsurer. In developing the list, the

commissioner shall consider the list of qualified jurisdictions published through the National Association of Insurance Commissioners committee process.

(b) In order to determine whether a jurisdiction of an assuming insurer located outside of the United States is eligible to be recognized as a qualified jurisdiction under Subsection (a), the commissioner shall evaluate the appropriateness and effectiveness of the reinsurance supervisory system of the jurisdiction, both initially and on an ongoing basis, and consider the rights, benefits, and extent of reciprocal recognition afforded by the jurisdiction to reinsurers licensed and domiciled in the United States.

(c) In order to be qualified a jurisdiction must agree in writing to share information and cooperate with the commissioner with respect to all certified reinsurers doing business in the jurisdiction.

(d) A jurisdiction may not be recognized as a qualified jurisdiction if the commissioner has determined that the jurisdiction does not adequately and promptly enforce final United States judgments and arbitration awards. Additional factors may be considered in the discretion of the commissioner.

(e) If the commissioner approves under this section a jurisdiction as qualified that does not appear on the list of qualified jurisdictions published through the National Association of Insurance Commissioners committee process, the commissioner shall provide documentation in accordance with rules adopted by the commissioner. The rules must include a requirement for a thoroughly documented justification of the approval.

(f) The commissioner shall include as a qualified jurisdiction under this section a United States jurisdiction that meets the requirements for accreditation under the National Association of Insurance Commissioners financial regulation standards and accreditation program.

(g) If a certified reinsurer's domiciliary jurisdiction ceases to be a qualified jurisdiction, the commissioner may suspend the reinsurer's certification indefinitely, instead of revoking the certification.

Added by Acts 2017, 85th Leg., R.S., Ch. 594 (S.B. [1070](#)), Sec. 2.05, eff. September 1, 2017.

Sec. 493.1036. REQUIREMENTS FOR CERTIFIED REINSURER. (a) The commissioner shall assign a rating to each certified reinsurer after giving due consideration to the financial strength ratings assigned by rating agencies recognized by the commissioner by rule.

(b) The commissioner shall publish a list of the ratings assigned under this section for all certified reinsurers.

(c) A certified reinsurer shall secure obligations assumed from ceding insurers domiciled in the United States in accordance with the rating assigned by the commissioner under Subsection (a) and with the amount of security required by the commissioner by rule.

(d) For a domestic ceding insurer to qualify for full financial statement credit for reinsurance ceded to a certified reinsurer, the certified reinsurer must maintain security:

(1) in a form acceptable to the commissioner and consistent with the insurance laws of this state; or

(2) in a multibeneficiary trust in accordance with Subchapter D, except as otherwise provided.

(e) If a certified reinsurer maintains a trust under Subchapter D to secure its obligations, and chooses to secure its obligations incurred as a certified reinsurer with a multibeneficiary trust, the certified reinsurer shall maintain separate trust accounts for the obligations incurred under reinsurance agreements the certified reinsurer issued or renewed with reduced security as permitted by this section or comparable laws of other United States jurisdictions and for its obligations subject to Subchapter D. It is a condition to the grant of certification under Section 493.1033 that the certified reinsurer has bound itself, by the language of the trust agreement and agreement with the insurance commissioner or other chief insurance regulatory official with principal regulatory oversight over each trust account, to fund, on termination of the trust account, out of the remaining surplus of the trust any deficiency of any other trust account described by this subsection.

(f) The minimum trustee surplus requirements provided in Subchapter D do not apply to a multibeneficiary trust described by this section, except that the trust shall maintain a minimum trustee surplus of \$10 million.

(g) With respect to obligations incurred by a certified reinsurer under this section, if the security is insufficient, the commissioner:

(1) shall reduce the allowable credit by an amount

proportionate to the deficiency; and

(2) may impose further reductions in allowable credit on finding that there is a material risk that the certified reinsurer's obligations will not be paid in full when due.

(h) For purposes of this section, a reinsurer whose certification has been revoked, suspended, or voluntarily surrendered or whose certification status has become inactive for any reason shall be treated as a reinsurer required to secure 100 percent of its obligations, except that if the commissioner continues to assign to the reinsurer a higher financial strength rating as permitted by this section, the security requirement does not apply to a reinsurer whose certification has been suspended or whose certification status has become inactive.

Added by Acts 2017, 85th Leg., R.S., Ch. 594 (S.B. 1070), Sec. 2.05, eff. September 1, 2017.

Sec. 493.1037. CERTIFICATION BY NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS. If an applicant for certification has been certified as a reinsurer in a National Association of Insurance Commissioners accredited jurisdiction:

(1) the commissioner may make a determination to defer to the accredited jurisdiction's certification and the financial strength rating assigned by that jurisdiction; and

(2) if the commissioner makes the determination authorized by Subdivision (1), the applicant shall be considered to be a certified reinsurer in this state.

Added by Acts 2017, 85th Leg., R.S., Ch. 594 (S.B. 1070), Sec. 2.05, eff. September 1, 2017.

Sec. 493.1038. SUSPENSION OR REVOCATION OF ACCREDITATION OR CERTIFICATION; INACTIVE STATUS. (a) A certified reinsurer that ceases to assume new business in this state may request to maintain its certification in inactive status to continue to qualify for a reduction in security for in-force business. An inactive certified reinsurer shall continue to comply with all applicable requirements of this section, and the commissioner shall assign a financial strength rating that takes into account, if relevant, the reasons the

reinsurer is not assuming new business.

(b) If an accredited or certified reinsurer ceases to meet the requirements for accreditation or certification, the commissioner may, after notice and opportunity for hearing, suspend or revoke the reinsurer's accreditation or certification. A suspension or revocation may not take effect until after the date of the commissioner's order on the hearing, unless:

(1) the reinsurer waives its right to hearing;

(2) the commissioner's order is based on regulatory action by the reinsurer's domiciliary jurisdiction or the voluntary surrender or termination of the reinsurer's eligibility to transact insurance or reinsurance business in its domiciliary jurisdiction or in the primary certifying state of the reinsurer under this section; or

(3) the commissioner finds that an emergency requires immediate action and a court of competent jurisdiction has not stayed the commissioner's action.

(c) While a reinsurer's accreditation or certification is suspended, a reinsurance contract issued or renewed after the effective date of the suspension does not qualify for credit except to the extent that the reinsurer's obligations under the contract are secured in accordance with Subchapter D.

(d) If a reinsurer's accreditation or certification is revoked, credit for reinsurance may not be granted after the effective date of the revocation except to the extent that the reinsurer's obligations under the contract are secured in accordance with Section 493.1036 or Subchapter D.

Added by Acts 2017, 85th Leg., R.S., Ch. 594 (S.B. 1070), Sec. 2.05, eff. September 1, 2017.

Sec. 493.1039. CONCENTRATION RISK. (a) A ceding insurer shall manage its reinsurance recoverable proportionate to its book of business. A domestic ceding insurer shall notify the commissioner not later than the 30th day after the date reinsurance recoverable from any single assuming insurer, or group of affiliated assuming insurers, exceeds or is likely to exceed 50 percent of the domestic ceding insurer's last reported surplus to policyholders. The notification shall demonstrate that the exposure is safely managed by

the domestic ceding insurer.

(b) A ceding insurer shall diversify its reinsurance program. A domestic ceding insurer shall notify the commissioner not later than the 30th day after the date the insurer cedes to any single assuming insurer, or group of affiliated assuming insurers, an amount that exceeds or is likely to exceed 20 percent of the ceding insurer's gross written premium in the prior calendar year. The notification shall demonstrate that the exposure is safely managed by the domestic ceding insurer.

Added by Acts 2017, 85th Leg., R.S., Ch. 594 (S.B. 1070), Sec. 2.05, eff. September 1, 2017.

Sec. 493.104. CREDIT FOR FUNDS SECURING REINSURANCE

OBLIGATIONS. (a) Subject to Subsection (b), any asset or deduction from liability for reinsurance ceded to an assuming insurer that does not meet the requirements of Section 493.102 shall be allowed in an amount that does not exceed the liabilities carried by the ceding insurer and in the amount of funds held by or on behalf of the ceding insurer under a reinsurance contract with the assuming insurer, including funds held in trust for the ceding insurer, as security for the payment of obligations under the contract.

(b) The funds held as security:

(1) must be held in the United States subject to withdrawal solely by and under the exclusive control of the ceding insurer or, in the case of a trust, held in a qualified United States financial institution that has been granted the authority to operate with fiduciary powers; and

(2) may be in the form of:

(A) cash;

(B) securities that are listed by the Securities Valuation Office of the National Association of Insurance Commissioners and qualify as admitted assets;

(C) subject to Section 493.105, a clean, irrevocable, unconditional letter of credit, issued or confirmed by a qualified United States financial institution that has been determined by the commissioner or the Securities Valuation Office of the National Association of Insurance Commissioners to meet the standards of financial condition and standing that are considered necessary and

appropriate to regulate the quality of financial institutions whose letters of credit will be acceptable to the commissioner; or

(D) another form of security acceptable to the commissioner.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 79 (S.B. 1093), Sec. 2, eff. September 1, 2015.

Sec. 493.105. ACCEPTABILITY OF CERTAIN LETTERS OF CREDIT. A letter of credit issued or confirmed by an institution that meets the standards prescribed by Section 493.104(b)(2)(C) as of the date the letter is issued or confirmed, but later fails to meet those standards, continues to be acceptable as security under Section 493.104 until the earliest of:

- (1) the letter's expiration;
- (2) the letter's extension, renewal, modification, or amendment after the date the institution fails to meet those standards; or
- (3) the expiration of the three-month period after the date the institution fails to meet those standards.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 493.106. CREDIT FOR REINSURANCE: DIRECT PAYMENT ON LIABILITY REQUIRED. (a) A ceding insurer may not be given credit for reinsurance ceded, as an asset or as a deduction from liability, in an accounting or financial statement unless the reinsurance is payable by the assuming insurer:

- (1) on the liability of the ceding insurer under the contracts reinsured, without diminution because of the ceding insurer's insolvency; and
- (2) directly to the ceding insurer or to the ceding insurer's domiciliary liquidator or receiver.

(b) Subsection (a)(2) does not apply if:

- (1) the reinsurance contract specifically provides that, if

the ceding insurer is insolvent, the reinsurance is payable to a payee other than one described by Subsection (a)(2); or

(2) the assuming insurer, with the direct insured's consent, has assumed the ceding insurer's policy obligations to the payee as the assuming insurer's direct obligations to the payee under the policy as a substitute for the ceding insurer's obligations.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 493.107. REQUEST FOR INFORMATION FROM ASSUMING INSURER.

(a) The commissioner may request that an assuming insurer not meeting the requirements of Section 493.102 file:

(1) financial statements certified and audited by an independent certified public accountant;

(2) a certified copy of the certificate or letter of authority from the domiciliary jurisdiction; and

(3) information on the principals and management of the assuming insurer.

(b) If an assuming insurer does not comply with a request under this section, the commissioner may issue a directive prohibiting all authorized insurers from taking credit for business ceded to the assuming insurer after the effective date of the directive.

(c) An unauthorized insurer that is included in the most recent quarterly listing published by the International Insurers Department of the National Association of Insurance Commissioners is considered to have complied with a request under this section.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 493.108. CREDIT ALLOWED FOR CERTAIN ELIGIBLE ASSUMING INSURERS. (a) Credit must be allowed when reinsurance is ceded to an assuming insurer that meets the conditions as required by this section.

(b) The assuming insurer must have its principal office or be domiciled in and be licensed in a reciprocal jurisdiction described by Subsection (c).

(c) In this section:

(1) "Reciprocal jurisdiction" means a jurisdiction that is:

(A) a jurisdiction located outside of the United States or, in the case of a covered agreement between the United States and European Union, a member state of the European Union, that is subject to an in-force covered agreement described by Subdivision (2) with the United States, each within its legal authority;

(B) a jurisdiction located in the United States that meets the requirements for accreditation under the National Association of Insurance Commissioners financial regulation standards and accreditation program; or

(C) a qualified jurisdiction, as determined by the commissioner under Section 493.1035, that is not otherwise described in Paragraph (A) or (B) and meets certain additional requirements, consistent with the in-force covered agreements as specified by the commissioner by rule.

(2) "Covered agreement" means an agreement that:

(A) is entered into under the Dodd-Frank Wall Street Reform and Consumer Protection Act (31 U.S.C. Sections 313-314);

(B) is in effect or in a period of provisional application; and

(C) addresses the elimination, under specified conditions, of collateral requirements as a condition for entering into a reinsurance agreement with a ceding insurer domiciled in this state or allowing the ceding insurer to recognize credit for reinsurance.

(d) The assuming insurer must have and maintain, on an ongoing basis, minimum capital and surplus, or its equivalent, calculated according to the methodology of the assuming insurer's domiciliary jurisdiction, in an amount required by the commissioner by rule. If the assuming insurer is an association, including incorporated and individual unincorporated underwriters, the assuming insurer must have and maintain, on an ongoing basis:

(1) minimum capital and surplus equivalents, net of liabilities, calculated according to the methodology of the assuming insurer's domiciliary jurisdiction; and

(2) a central fund containing a balance in an amount required by the commissioner by rule.

(e) The assuming insurer must have and maintain, on an ongoing basis, a minimum solvency or capital ratio, as applicable, required by the commissioner by rule. If the assuming insurer is an

association, including incorporated and individual unincorporated underwriters, the association must have and maintain, on an ongoing basis, a minimum solvency or capital ratio in the reciprocal jurisdiction where the assuming insurer has its principal office or is domiciled and is licensed.

(f) The assuming insurer must agree and provide adequate assurance to the commissioner in a form as required by the commissioner by rule, as follows:

(1) The assuming insurer must provide prompt written notice and explanation to the commissioner if:

(A) the assuming insurer no longer meets the minimum requirements under Subsection (d) or (e); or

(B) any regulatory action is taken against the assuming insurer for serious noncompliance with applicable law;

(2) The assuming insurer must consent in writing to the jurisdiction of this state's courts and to the appointment of the commissioner as agent for service of process. The commissioner may require that an assuming insurer also include the consent for service of process in each reinsurance agreement to which the assuming insurer is a party. Nothing in this section limits or in any way alters the capacity of parties to a reinsurance agreement to agree to alternative dispute resolution mechanisms except to the extent the agreement is unenforceable under applicable insolvency or delinquency laws;

(3) The assuming insurer must consent in writing to pay all final judgments, wherever enforcement is sought, obtained by a ceding insurer or its legal successor, that have been declared enforceable in the jurisdiction where the judgment was obtained;

(4) Each reinsurance agreement must require the assuming insurer to provide security in an amount equal to 100 percent of the assuming insurer's liabilities attributable to reinsurance ceded under the reinsurance agreement if the assuming insurer resists enforcement of:

(A) a final judgment that is enforceable under the law of the jurisdiction in which the judgment was obtained; or

(B) a properly enforceable arbitration award, whether obtained by the ceding insurer or its legal successor on behalf of the ceding insurer's receivership estate; and

(5) The assuming insurer must:

(A) confirm that the assuming insurer is not presently

participating in any solvent scheme of arrangement that involves this state's ceding insurers; and

(B) if the assuming insurer enters into a solvent scheme of arrangement, agree to notify the ceding insurer and the commissioner that the assuming insurer entered into the scheme of arrangement and provide security in an amount equal to 100 percent of the assuming insurer's liabilities to the ceding insurer. The security required by this paragraph must be in a form consistent with the provisions of this subchapter and required by the commissioner by rule.

(g) On request of the commissioner, the assuming insurer or its legal successor, on behalf of the assuming insurer and any legal predecessor of the assuming insurer, must provide to the commissioner documentation required by the commissioner by rule.

(h) The assuming insurer must maintain a practice of prompt payment of claims under reinsurance agreements in accordance with criteria established by the commissioner by rule.

(i) The assuming insurer's supervisory authority must annually confirm to the commissioner, as of the preceding December 31 or the annual date otherwise statutorily reported to the assuming insurer's reciprocal jurisdiction, that the assuming insurer complies with the requirements of Subsections (d) and (e).

(j) Nothing in this section prohibits an assuming insurer from voluntarily providing to the commissioner information related to this section.

(k) The commissioner shall timely develop and publish a list of reciprocal jurisdictions.

(l) The commissioner's list of reciprocal jurisdictions published under Subsection (k) must include any reciprocal jurisdiction described by Subsection (c)(1)(A) or (B). The commissioner shall consider any other reciprocal jurisdiction on the list of reciprocal jurisdictions published through the National Association of Insurance Commissioners committee process. The commissioner may, in accordance with criteria established by the commissioner by rule, approve a jurisdiction that does not appear on the list of reciprocal jurisdictions published through the National Association of Insurance Commissioners committee process to be placed on the list of reciprocal jurisdictions published under Subsection (k).

(m) The commissioner may remove a jurisdiction from the list of

reciprocal jurisdictions published under Subsection (k) if, in accordance with a process established by the commissioner by rule, the commissioner finds that the jurisdiction ceases to meet the requirements of a reciprocal jurisdiction under this section. Notwithstanding the authority to remove a jurisdiction, the commissioner may not remove from the list a reciprocal jurisdiction described by Subsection (c)(1)(A) or (B). If the commissioner removes a reciprocal jurisdiction from the list published under Subsection (k), credit for reinsurance ceded to an assuming insurer that has its principal office or is domiciled in the removed jurisdiction must be allowed if otherwise allowed under this subchapter.

(n) The commissioner shall timely develop and publish a list of assuming insurers that satisfy the conditions imposed by this section and to which cessions must be granted credit under Subsection (a). The commissioner may add an assuming insurer to the list developed and published under this subsection if a National Association of Insurance Commissioners' accredited jurisdiction has added the assuming insurer to the accredited jurisdiction's list of eligible assuming insurers or if, on initial eligibility, the assuming insurer submits to the commissioner the information required by Subsection (f) and complies with any additional requirements imposed by the commissioner by rule except to the extent that the additional requirements conflict with the applicable covered agreement.

(o) If the commissioner finds that an assuming insurer ceases to meet one or more of the requirements under this section, the commissioner may revoke or suspend the assuming insurer's eligibility under this section in accordance with procedures established by the commissioner by rule.

(p) If an assuming insurer's eligibility is suspended, no reinsurance agreement issued, amended, or renewed after the effective date of the suspension qualifies for credit during the period of suspension except to the extent that the assuming insurer's obligations under the agreement are secured in accordance with Section 493.104.

(q) If an assuming insurer's eligibility is revoked, no credit for reinsurance may be granted after the effective date of the revocation with respect to any reinsurance agreements entered into by the assuming insurer, including reinsurance agreements entered into before the date of revocation except to the extent that the assuming insurer's obligations under the contract are secured in a form

acceptable to the commissioner and consistent with the provisions of Section 493.104.

(r) If a ceding insurer is subject to rehabilitation, liquidation, or conservation, the ceding insurer or its representative may seek and, if found appropriate by the court in which the rehabilitation, liquidation, or conservation proceedings are pending, obtain an order requiring the assuming insurer to post security for all outstanding ceded liabilities.

(s) Nothing in this section limits or in any way alters the capacity of parties to a reinsurance agreement to agree on requirements for security or other terms in that reinsurance agreement, except as expressly prohibited by law.

(t) This section does not alter or impair a ceding insurer's right to take credit for reinsurance to the extent that credit is not available under this section if the reinsurance otherwise qualifies for credit under this subchapter.

(u) Nothing in this section authorizes an assuming insurer to withdraw or reduce the security provided under any reinsurance agreement except as permitted by the agreement.

(v) Nothing in this section limits or in any way alters the capacity of parties to any reinsurance agreement to renegotiate the agreement.

(w) This section applies only to:

(1) credit under a reinsurance agreement that is delivered, issued for delivery, or renewed on or after January 1, 2022; and
 (2) losses incurred and reserves reported on or after the later of:

(A) the date on which the assuming insurer has met all eligibility requirements under this section; and

(B) the effective date of the applicable reinsurance agreement, amendment, or renewal.

Added by Acts 2021, 87th Leg., R.S., Ch. 22 (H.B. 1689), Sec. 2, eff. January 1, 2022.

SUBCHAPTER D. REQUIREMENTS FOR TRUST CREDIT ALLOWANCE

Sec. 493.151. APPLICABILITY OF SUBCHAPTER. This subchapter applies to:

(1) a trust that is used to qualify for a reinsurance

credit under Section 493.102(a)(3) and as described by Sections 493.1036(e) and (f); and

(2) the assuming insurer that maintains the trust fund.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 594 (S.B. 1070), Sec. 2.06, eff. September 1, 2017.

Sec. 493.152. COMPOSITION OF TRUST. (a) If the assuming insurer is a single insurer, the trust must:

(1) consist of a trustee account representing the assuming insurer's liabilities attributable to business written in the United States; and

(2) include a trustee surplus of at least \$20 million, except after the assuming insurer has permanently discontinued underwriting new business secured by the trust for not less than three calendar years, the insurance commissioner or other chief insurance regulatory official with principal regulatory oversight over the trust may authorize a reduction in the required trustee surplus, but only after a finding, based on an assessment of the risk, that the new required surplus level is adequate for the protection of United States ceding insurers, policyholders, and claimants in light of reasonably foreseeable adverse loss development.

(a-1) The risk assessment described by Subsection (a)(2) may involve an actuarial review, including an independent analysis of reserves and cash flows, and must consider all material risk factors, including when applicable, the lines of business involved, the stability of the incurred loss estimates, and the effect of the surplus requirements on the assuming insurer's liquidity or solvency. The minimum required trustee surplus may not be reduced to an amount less than 30 percent of the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers.

(b) If the assuming insurer is a group of insurers that includes an unincorporated individual insurer:

(1) the trust must:

(A) consist of a trustee account representing the

group's liabilities attributable to business written in the United States; and

(B) include a trusteed surplus of at least \$100 million; and

(2) the group shall make available to the department an annual certification by the group's domiciliary regulator and its independent public accountants of each underwriter's solvency.

(c) If the assuming insurer is a group of incorporated insurers under common administration that has continuously engaged in the business of insurance for at least three years, is under the supervision of the Department of Trade and Industry of the United Kingdom, and has an aggregate policyholders' surplus of \$10 billion:

(1) the trust must:

(A) consist of a trusteed account representing the group's several liabilities attributable to business written in the United States under reinsurance contracts issued in the name of the group; and

(B) include a trusteed surplus of not less than \$100 million held jointly for the benefit of United States insurers that have ceded business to any member of the group; and

(2) each member of the group shall make available to the department an annual certification by the member's domiciliary regulator and its independent public accountants of each member's solvency.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 594 (S.B. 1070), Sec. 2.07, eff. September 1, 2017.

Sec. 493.153. FORM OF TRUST. (a) The trust must be established in a form approved by the commissioner or an insurance commissioner or other chief insurance regulatory official of another state who, under the trust instrument, has principal regulatory oversight over the trust.

(b) A copy of the trust instrument and any amendment to the trust instrument must be filed with the insurance commissioner or other chief insurance regulatory official of each state in which the

ceding insurer beneficiaries of the trust are domiciled.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 594 (S.B. 1070), Sec. 2.08, eff. September 1, 2017.

Sec. 493.154. TERMS OF TRUST. (a) The trust instrument must provide that contested claims are valid and enforceable on the final order of any court in the United States.

(b) The trust must vest legal title to the trust's assets in the trustees of the trust for:

(1) the trust's United States policyholders and ceding insurers; and

(2) the policyholders' and ceding insurers' assigns and successors in interest.

(c) The trust must remain in effect as long as the assuming insurer has outstanding obligations under a reinsurance contract subject to the trust.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 493.155. REPORTS AND CERTIFICATION. (a) Not later than February 28 of each year, the trustees of the trust shall:

(1) report to the department in writing, showing the balance of the trust and listing the trust's investments at the end of the preceding year; and

(2) certify the date of termination of the trust, if termination is planned, or certify that the trust will not expire before December 31 of the year of the report.

(b) To enable the commissioner to determine the sufficiency of the trust fund under Section 493.102(a)(3) and for purposes of Sections 493.1036(e) and (f), the assuming insurer shall report to the department not later than March 1 of each year information substantially the same as the information required to be reported by an authorized insurer on the National Association of Insurance Commissioners' Annual Statement form.

(c) Not later than February 28 of each year, if requested by a beneficiary of the trust fund, an assuming insurer that maintains a trust fund shall provide or make available to the assuming insurer's United States ceding insurers or those ceding insurers' assigns and successors in interest the following information:

(1) a copy of the trust instrument and any amendments to the trust instrument relating to the trust fund;

(2) a copy of the assuming insurer's annual and quarterly financial information, and the insurer's most recent audited financial statement provided to the commissioner, including any exhibits and schedules;

(3) any financial information provided to the department or commissioner by the assuming insurer, including any exhibits and schedules;

(4) a copy of any annual and quarterly financial information provided to the department or commissioner by the trustee of the trust fund maintained by the assuming insurer, including any exhibits and schedules; and

(5) a copy of the information required to be reported by the trustee under Subsection (a).

(d) If requested by a ceding insurer, the assuming insurer shall provide, in addition to the information under Subsection (c), a certification that:

(1) discloses the financial information provided to the commissioner relating to reinsurance liabilities attributable to the ceding insurer; and

(2) certifies that the amount of security held in trust on behalf of the ceding insurer is at least equal to those amounts as reflected in the report to the department under Subsection (a).

(e) The assuming insurer shall also provide, if requested by the ceding insurer, a certification that the trust, in aggregate:

(1) consists of sufficient assets to support the assuming insurer's trust obligations under applicable state laws and regulations; and

(2) includes a trusteed surplus of at least \$20 million.

(f) An assuming insurer may decline to release trade secrets or commercially sensitive information to a ceding insurer.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 594 (S.B. 1070), Sec. 2.09, eff. September 1, 2017.

Sec. 493.156. CERTAIN TRUSTEED ASSUMING INSURERS: REQUIREMENTS FOR REINSURANCE CONTRACT. (a) A ceding insurer may not be allowed credit under Section 493.102(a)(3) for reinsurance ceded to an assuming insurer that is not authorized, accredited, or certified to engage in the business of insurance or reinsurance in this state unless the assuming insurer agrees in the reinsurance contract:

(1) that, if the assuming insurer fails to perform the assuming insurer's obligations under the reinsurance contract, the assuming insurer, at the request of the ceding insurer, will:

(A) submit to the jurisdiction of a court in any state of the United States;

(B) comply with all requirements necessary to give the court jurisdiction; and

(C) abide by the final decision of that court or, if the court's decision is appealed, of the appellate court; and

(2) to designate the commissioner or an attorney as an agent for service of process in any action, suit, or proceeding instituted by or on behalf of the ceding insurer.

(b) This section is not intended to conflict with or override a provision in a reinsurance contract that requires the parties to arbitrate the parties' disputes.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 594 (S.B. 1070), Sec. 2.10, eff. September 1, 2017.

Sec. 493.1561. CERTAIN TRUSTEED ASSUMING REINSURERS; REQUIREMENTS FOR TRUST AGREEMENT. (a) In this section, "commissioner" means the insurance commissioner or other chief insurance regulatory official with principal regulatory oversight over the trust.

(b) If the assuming insurer does not meet the requirements of

Section 493.102(a)(1) or (2), the credit permitted by Section 493.102(a)(3) or (4) may not be allowed unless the assuming insurer agrees in the trust agreement that:

(1) notwithstanding any other provisions in the trust agreement, the trustee shall comply with an order of the commissioner or a court ordering the trustee to transfer to the commissioner all assets of the trust fund if:

(A) the trust fund is inadequate because the trust fund contains an amount that is less than the amount required by this subchapter; or

(B) the grantor of the trust has been declared insolvent or placed into receivership, rehabilitation, or liquidation or a similar proceeding under the laws of the grantor's domiciliary state or country;

(2) claims in a proceeding described by Subdivision (1)(B) must be filed with the commissioner;

(3) the commissioner shall value the claims described by Subdivision (2) and distribute the assets of the trust under the laws of the trust's domiciliary state applicable to the liquidation of a domestic insurance company;

(4) if the commissioner determines that all or part of the trust assets are unnecessary to satisfy the claims of the grantor's ceding insurers domiciled in the United States, the commissioner shall return those unnecessary assets to the trustee for distribution in accordance with the trust agreement; and

(5) the grantor waives any right available under federal or state law that is inconsistent with this section.

Added by Acts 2017, 85th Leg., R.S., Ch. 594 (S.B. 1070), Sec. 2.11, eff. September 1, 2017.

Sec. 493.157. EXAMINATION OF TRUST AND ASSUMING INSURER. The trust and the assuming insurer are subject to examination as determined by the commissioner.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

CHAPTER 494. REINSURANCE OF AIRCRAFT AND SPACE EQUIPMENT RISKS

Sec. 494.001. DEFINITIONS. In this chapter:

(1) "Aircraft" means an object that is capable of:

(A) moving through the atmosphere, regardless of whether the object is powered or tethered; and

(B) lifting the weight of the object and an additional payload.

(2) "Space equipment" means a spacecraft, satellite, rocket, or other manmade object that may be:

(A) launched from earth into orbit around a celestial body or for space travel; or

(B) placed into orbit around a celestial body.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 494.002. AUTHORITY TO REINSURE. (a) A domestic insurance company as defined by Section 841.001, alone or together with another insurer, may reinsure any liability, property, casualty, collision, personal injury, death, or other risk relating to, arising from, or incident to the manufacture, ownership, custody, or operation of an aircraft or any space equipment, subject to any just and reasonable limitation imposed by the commissioner.

(b) A limitation imposed by the commissioner must be consistent with the purposes of this chapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

Sec. 494.003. REQUIREMENT FOR CEDING INSURER. To enter into a reinsurance agreement under this chapter, the ceding insurer must be authorized to engage in business in this state.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 1, eff. April 1, 2007.

TITLE 5. PROTECTION OF CONSUMER INTERESTS
SUBTITLE A. PUBLIC INSURANCE COUNSEL
CHAPTER 501. OFFICE OF PUBLIC INSURANCE COUNSEL

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 501.001. DEFINITION. In this chapter, "office" means the office of public insurance counsel.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 501.002. OFFICE OF PUBLIC INSURANCE COUNSEL. The independent office of public insurance counsel represents the interests of insurance consumers in this state.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 501.003. SUNSET PROVISION. The office is subject to Chapter 325, Government Code (Texas Sunset Act). Unless continued in existence as provided by that chapter, the office is abolished September 1, 2029.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 1227 (H.B. 1116), Sec. 2.06, eff. September 1, 2005.

Acts 2009, 81st Leg., 1st C.S., Ch. 2 (S.B. 2), Sec. 1.07, eff. July 10, 2009.

Acts 2011, 82nd Leg., R.S., Ch. 1231 (S.B. 647), Sec. 1, eff. September 1, 2011.

Acts 2021, 87th Leg., R.S., Ch. 850 (S.B. 713), Sec. 2.02, eff. June 16, 2021.

Acts 2023, 88th Leg., R.S., Ch. 941 (S.B. 1659), Sec. 1.14, eff. June 18, 2023.

Sec. 501.004. PUBLIC INTEREST INFORMATION. (a) The office shall prepare information of public interest describing the functions of the office.

(b) The office shall make the information available to the public and appropriate state agencies.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 501.005. ACCESS TO PROGRAMS AND FACILITIES. (a) The office shall prepare and maintain a written plan that describes how a person who does not speak English can be provided reasonable access to the office's programs.

(b) The office shall comply with federal and state laws for program and facility accessibility.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

SUBCHAPTER B. PUBLIC COUNSEL

Sec. 501.051. APPOINTMENT; TERM. (a) The governor, with the advice and consent of the senate, shall appoint a public counsel to serve as the executive director of the office. The public counsel serves a two-year term that expires on February 1 of each odd-numbered year.

(b) The governor shall appoint the public counsel without regard to the race, color, disability, sex, religion, age, or national origin of the appointee.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 501.052. QUALIFICATIONS. To be eligible to serve as public counsel, a person must:

- (1) be licensed to practice law in this state;
- (2) have demonstrated a strong commitment to and involvement in efforts to safeguard the rights of the public; and
- (3) possess the knowledge and experience necessary to practice effectively in insurance proceedings.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 501.053. BUSINESS INTEREST; SERVICE AS PUBLIC COUNSEL. A person is not eligible for appointment as public counsel if the person or the person's spouse:

- (1) is employed by or participates in the management of a business entity or other organization regulated by or receiving funds from the department;
- (2) owns or controls, directly or indirectly, more than a

10 percent interest in a business entity or other organization regulated by or receiving funds from the department or the office; or

(3) uses or receives a substantial amount of tangible goods, services, or funds from the department or the office, other than compensation or reimbursement authorized by law for department or office membership, attendance, or expenses.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 501.054. LOBBYING ACTIVITIES. A person may not serve as public counsel or act as general counsel to the office if the person is required to register as a lobbyist under Chapter 305, Government Code, because of the person's activities for compensation related to the operation of the department or the office.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 501.055. GROUNDS FOR REMOVAL. (a) It is a ground for removal from office if the public counsel:

(1) does not have at the time of appointment or maintain during service as public counsel the qualifications required by Section 501.052;

(2) violates a prohibition established by Section 501.053, 501.054, 501.056, or 501.102; or

(3) cannot, because of illness or disability, discharge the public counsel's duties for a substantial part of the public counsel's term.

(b) The validity of an action of the office is not affected by the fact that the action is taken when a ground for removal of the public counsel exists.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 501.056. PROHIBITED REPRESENTATION OR EMPLOYMENT. A former public counsel may not represent any person or receive compensation for services rendered on behalf of any person regarding a case pending before the commissioner or department before the

second anniversary of the date the person ceases to serve as public counsel.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

SUBCHAPTER C. PERSONNEL

Sec. 501.101. OFFICE PERSONNEL. (a) The public counsel shall employ professional, technical, and other employees necessary to implement this chapter.

(b) Compensation for an employee shall be set under the General Appropriations Act as provided by the legislature.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 501.102. TRADE ASSOCIATIONS. (a) In this section, "trade association" means a nonprofit, cooperative, and voluntarily joined association of business or professional competitors designed to assist its members and its industry or profession in dealing with mutual business or professional problems and in promoting their common interest.

(b) A person may not serve as public counsel or be an employee of the office who is exempt from the state's position classification plan or is compensated at or above the amount prescribed by the General Appropriations Act for step 1, salary group A17, of the position classification salary schedule if the person is:

(1) an officer, employee, or paid consultant of a trade association in the field of insurance; or

(2) the spouse of an officer, manager, or paid consultant of a trade association in the field of insurance.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 501.103. CAREER LADDER PROGRAM; PERFORMANCE EVALUATIONS.

(a) The public counsel or the public counsel's designee shall develop an intra-agency career ladder program. The program must require intra-agency posting of all nonentry level positions concurrently with any public posting.

(b) The public counsel or the public counsel's designee shall

develop a system of annual performance evaluations. All merit pay for office employees must be based on the system established under this subsection.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 501.104. EQUAL EMPLOYMENT OPPORTUNITY POLICY; REPORT.

(a) The public counsel or the public counsel's designee shall prepare and maintain a written policy statement to ensure implementation of an equal employment opportunity program under which all personnel transactions are made without regard to race, color, disability, sex, religion, age, or national origin. The policy statement must include:

(1) personnel policies, including policies relating to recruitment, evaluation, selection, appointment, training, and promotion of personnel that are in compliance with the requirements of Chapter 21, Labor Code;

(2) a comprehensive analysis of the office workforce that meets federal and state guidelines;

(3) procedures by which a determination can be made about areas of significant underuse in the office workforce of all persons for whom federal or state guidelines encourage a more equitable balance; and

(4) reasonable methods to appropriately address those areas of significant underuse.

(b) A policy statement prepared under Subsection (a) must:

(1) cover an annual period;

(2) be updated at least annually;

(3) be reviewed by the Commission on Human Rights for compliance with Subsection (a)(1); and

(4) be filed with the governor.

(c) The governor shall deliver a biennial report to the legislature based on the information received under Subsection (b). The report may be made separately or as a part of other biennial reports to the legislature.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 501.105. QUALIFICATIONS AND STANDARDS OF CONDUCT. The

office shall provide to the public counsel and office employees, as often as necessary, information regarding their:

(1) qualifications for office or employment under this chapter; and

(2) responsibilities under applicable laws relating to standards of conduct for state officers or employees.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

SUBCHAPTER D. POWERS AND DUTIES

Sec. 501.151. POWERS AND DUTIES OF OFFICE. The office:

(1) may assess the impact of insurance rates, rules, and forms on insurance consumers in this state; and

(2) shall advocate in the office's own name positions determined by the public counsel to be most advantageous to a substantial number of insurance consumers.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 501.152. ADMINISTRATION OF OFFICE. The public counsel shall administer and enforce this chapter, including preparing and submitting to the legislature a budget for the office and approving expenditures for professional services, travel, per diem, and other actual and necessary expenses incurred in administering the office.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 501.153. AUTHORITY TO APPEAR, INTERVENE, OR INITIATE. The public counsel:

(1) may appear or intervene, as a party or otherwise, as a matter of right before the commissioner or department on behalf of insurance consumers, as a class, in matters involving:

(A) rates, rules, and forms affecting:

(i) property and casualty insurance;

(ii) title insurance;

(iii) credit life insurance;

(iv) credit accident and health insurance; or

(v) any other line of insurance for which the

commissioner or department promulgates, sets, adopts, or approves rates, rules, or forms;

(B) rules affecting life, health, or accident insurance; or

(C) withdrawal of approval of policy forms:

(i) in proceedings initiated by the department under Sections 1701.055 and 1701.057; or

(ii) if the public counsel presents persuasive evidence to the department that the forms do not comply with this code, a rule adopted under this code, or any other law;

(2) may initiate or intervene as a matter of right or otherwise appear in a judicial proceeding involving or arising from an action taken by an administrative agency in a proceeding in which the public counsel previously appeared under the authority granted by this chapter;

(3) may appear or intervene, as a party or otherwise, as a matter of right on behalf of insurance consumers as a class in any proceeding in which the public counsel determines that insurance consumers are in need of representation, except that the public counsel may not intervene in an enforcement or parens patriae proceeding brought by the attorney general; and

(4) may appear or intervene before the commissioner or department as a party or otherwise on behalf of small commercial insurance consumers, as a class, in a matter involving rates, rules, or forms affecting commercial insurance consumers, as a class, in any proceeding in which the public counsel determines that small commercial consumers are in need of representation.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 501.154. ACCESS TO INFORMATION. The public counsel:

(1) is entitled to the same access as a party, other than department staff, to department records available in a proceeding before the commissioner or department under the authority granted to the public counsel by this chapter; and

(2) is entitled to obtain discovery under Chapter 2001, Government Code, of any nonprivileged matter that is relevant to the subject matter involved in a proceeding or submission before the commissioner or department as authorized by this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 501.155. RECOMMENDATION OF LEGISLATION. The public counsel may recommend legislation to the legislature that the public counsel determines would positively affect the interests of insurance consumers.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 501.156. CONSUMER BILL OF RIGHTS. The public counsel shall submit to the department for adoption a consumer bill of rights appropriate to each personal line of insurance regulated by the department to be distributed on issuance of a policy by an insurer to each policyholder under department rules.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 501.157. PROHIBITED INTERVENTIONS OR APPEARANCES. The public counsel may not intervene or appear in:

(1) any proceeding or hearing before the commissioner or department, or any other proceeding, that relates to approval or consideration of an individual charter, license, certificate of authority, acquisition, merger, or examination; or

(2) any proceeding concerning the solvency of an individual insurer, a financial issue, a policy form, advertising, or another regulatory issue affecting an individual insurer or agent.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 501.158. CONFIDENTIALITY REQUIREMENTS. Confidentiality requirements applicable to examination reports under Sections 401.105 and 401.106 and to the commissioner under Section 441.201 apply to the public counsel.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 2D.001,

eff. April 1, 2009.

Sec. 501.159. COMMENTS ON CERTAIN INSURER FILINGS. (a) Notwithstanding this chapter, the office may submit written comments to the commissioner and otherwise participate regarding individual insurer filings made under Chapters 2251 and 2301 relating to insurance described by Subchapter B, Chapter 2301.

(b) The commissioner may adopt reasonable and necessary rules to implement this section.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 14, eff. April 1, 2007.

Sec. 501.160. ALTERNATIVE DISPUTE RESOLUTION PROCEDURES. (a) The office shall develop and implement a policy to encourage the use of appropriate alternative dispute resolution procedures under Chapter 2009, Government Code, to assist in the resolution of internal and external disputes under the office's jurisdiction.

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

(c) The office shall:

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

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

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

Added by Acts 2011, 82nd Leg., R.S., Ch. 1231 (S.B. 647), Sec. 2, eff. September 1, 2011.

SUBCHAPTER E. ASSESSMENTS

Sec. 501.201. OFFICE EXPENSES. Expenses of the office shall be paid from the assessments collected under this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 501.202. ASSESSMENT. To defray the costs of operating the office, the comptroller shall collect assessments under this subchapter annually in connection with the collection of other taxes imposed on an insurer.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 501.203. ASSESSMENT ON PROPERTY AND CASUALTY INSURERS. Each property and casualty insurer authorized to engage in business in this state shall pay an annual assessment of 5.7 cents for each property and casualty insurance policy in force in this state at the end of the year.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 501.204. ASSESSMENT ON LIFE, HEALTH, AND ACCIDENT INSURERS AND RELATED ENTITIES. (a) This section applies to each insurer authorized to engage in business in this state under:

- (1) Chapter 841;
- (2) Chapter 842;
- (3) Section 1367.053, Subchapter A, Chapter 1452, Subchapter B, Chapter 1507, Chapter 222, 251, or 258, as applicable to a health maintenance organization, Chapter 843, Chapter 1271, or Chapter 1272;
- (4) Chapter 882;
- (5) Chapter 884;
- (6) Chapter 885;
- (7) Chapter 887;
- (8) Chapter 888;
- (9) Chapter 962;
- (10) Chapter 982;
- (11) Subchapter B, Chapter 1103;
- (12) Subchapter A, Chapter 1104;
- (13) Chapter 1201, or a provision listed in Section 1201.005;
- (14) Chapter 1551;
- (15) Chapter 1578; or

(16) Chapter 1601.

(b) Each insurer subject to this section shall pay an annual assessment of 5.7 cents for each individual policy, and for each certificate of insurance evidencing coverage under a group policy, of life, health, or accident insurance that is written for delivery and placed in force in this state during each calendar year and for which the initial premium is paid in full.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2D.002, eff. April 1, 2009.

Acts 2019, 86th Leg., R.S., Ch. 643 (S.B. 1623), Sec. 1, eff. September 1, 2019.

Sec. 501.205. ASSESSMENT ON TITLE INSURANCE COMPANIES. Each title insurance company authorized to engage in business in this state shall pay an annual assessment of 5.7 cents for each owner and mortgage policy that is written for delivery in this state during each calendar year and for which the full basic premium is charged.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

SUBCHAPTER F. DUTIES RELATING TO HEALTH MAINTENANCE ORGANIZATIONS

Sec. 501.251. COMPARISON OF HEALTH MAINTENANCE ORGANIZATIONS.

(a) The office shall develop and implement a system to compare and evaluate, on an objective basis, the quality of care provided by and the performance of health maintenance organizations established under Chapter 843.

(b) In developing the system, the office may use information or data from a person, agency, organization, or governmental unit that the office considers reliable.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 501.252. ANNUAL CONSUMER REPORT CARDS. (a) The office shall develop and issue annual consumer report cards that identify and compare, on an objective basis, health maintenance organizations

in this state. The consumer report cards may be based on information or data from any person, agency, organization, or governmental unit that the office considers reliable.

(b) The office may not endorse or recommend a specific health maintenance organization or plan, or subjectively rate or rank health maintenance organizations or plans, other than through comparison and evaluation of objective criteria.

(c) The office shall provide a copy of any consumer report card on request on payment of a reasonable fee.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 501.253. ACCESS TO INFORMATION. (a) The office is entitled to information that is confidential under a law of this state, including Section 843.006 of this code, Chapter 108, Health and Safety Code, and Chapter 552, Government Code.

(b) The department and the Texas Health Care Information Council shall provide any information or data as requested by the office in furtherance of the duties under this subchapter.

(c) The office shall use information collected or received under this subchapter for the benefit of the public.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 501.254. CONFIDENTIALITY AND USE OF INFORMATION. (a) Except as provided by this section, information collected under this subchapter is subject to Chapter 552, Government Code, and the office shall make determinations on requests for information in favor of access.

(b) The office may not make public any confidential information provided to the office under this subchapter but may disclose a summary of the information that does not directly or indirectly identify the health maintenance organization that is the subject of the information. The office may not release, and a person or entity may not gain access to, any information that:

- (1) could reasonably be expected to reveal the identity of a patient or physician;
- (2) reveals the zip code of a patient's primary residence;
- (3) discloses a provider discount or a differential between

a payment and a billed charge; or

(4) relates to an actual payment made by a payer to an identified provider.

(c) Information collected or used by the office under this subchapter is subject to the confidentiality provisions and criminal penalties of:

- (1) Section 81.103, Health and Safety Code;
- (2) Section 311.037, Health and Safety Code; and
- (3) Chapter 159, Occupations Code.

(d) Information on patients and physicians that is in the possession of the office and any compilation, report, or analysis produced from the information that identifies patients and physicians is not:

- (1) subject to discovery, subpoena, or other means of legal compulsion for release to any person or entity; or
- (2) admissible in any civil, administrative, or criminal proceeding.

(e) Notwithstanding Subsection (b)(2), the office may use zip code information to analyze information on a geographical basis.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

SUBTITLE B. CONSUMER SERVICE PROVISIONS

CHAPTER 521. CONSUMER INFORMATION AND COMPLAINTS

SUBCHAPTER A. PUBLIC INTEREST INFORMATION AND COMPLAINT PROCEDURES

Sec. 521.001. PUBLIC INTEREST INFORMATION. (a) The department shall prepare information of public interest describing the department's functions and the procedures by which complaints are filed with and resolved by the department.

(b) The department shall make the information available to the public and appropriate state agencies.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 521.002. COMPLAINT RESOLUTION PROGRAM. The department shall establish a program to facilitate resolution of policyholder complaints.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 521.003. NOTIFICATION OF COMPLAINT STATUS. If a written complaint is filed with the department, the department, at least quarterly and until final disposition of the complaint, shall notify each party to the complaint of the complaint's status unless the notice would jeopardize an undercover investigation.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 521.004. RECORDS OF COMPLAINTS. The department shall keep an information file about each complaint filed with the department that concerns an activity regulated by the department or the commissioner.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 521.005. NOTICE TO ACCOMPANY POLICY. (a) Each insurance policy delivered or issued for delivery in this state shall include with the policy a brief written notice that includes:

(1) a suggested procedure to be followed by a policyholder with a dispute concerning the policyholder's claim or premium;

(2) the department's name and address; and

(3) the department's toll-free telephone number maintained under Subchapter B.

(b) The commissioner shall adopt appropriate wording for the notice.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

SUBCHAPTER B. DEPARTMENT TOLL-FREE NUMBER FOR INFORMATION AND COMPLAINTS

Sec. 521.051. DEPARTMENT TOLL-FREE NUMBER FOR INFORMATION AND COMPLAINTS. The department shall maintain a toll-free telephone number to:

(1) provide the information described by Section 521.052;

and

(2) receive and aid in resolving complaints against

insurers.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 521.052. INFORMATION PROVIDED. The department shall provide to the public through the department's toll-free telephone number only the following information:

(1) information collected or maintained by the department relating to the number and disposition of complaints received against an insurer that are justified, verified as accurate, and documented as valid, expressed as a percentage of the total number of insurance policies written by the insurer and in force on December 31 of the preceding year;

(2) the rating of an insurer, if any, as published by a nationally recognized rating organization;

(3) the kinds of coverage available to a consumer through any insurer writing insurance in this state;

(4) an insurer's admitted assets-to-liabilities ratio; and

(5) other appropriate information collected and maintained by the department.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 521.053. PUBLICITY REQUIREMENTS. The department shall publicize the department's toll-free telephone number in public service announcements and publish that number in telephone books throughout the state, as the department finds appropriate.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 521.054. RECORD OF INQUIRY OR COMPLAINT REQUIRED. The department shall maintain a written record of each inquiry and complaint received through the department's toll-free telephone number.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 521.055. COMPLAINT NOTIFICATION SYSTEM. The department shall establish a system to notify insurers by electronic transmission to a facsimile machine or other appropriate system of complaints received by the department through the department's toll-free telephone number.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 521.056. INFORMATION BULLETIN TO ACCOMPANY POLICY. Each insurer that delivers, issues for delivery, or renews an insurance policy in this state shall include with the policy an information bulletin that includes:

- (1) the department's toll-free telephone number; and
- (2) a description of the services available through the department's toll-free telephone number.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

SUBCHAPTER C. HEALTH MAINTENANCE ORGANIZATION OR INSURER TOLL-FREE NUMBER FOR INFORMATION AND COMPLAINTS

Sec. 521.101. APPLICABILITY OF SUBCHAPTER. (a) Except as provided by Subsection (b), this subchapter applies to a health maintenance organization authorized to engage in the business of a health maintenance organization in this state or an insurer authorized to engage in the business of insurance in this state, including:

- (1) a capital stock insurance company;
- (2) a mutual insurance company;
- (3) a title insurance company;
- (4) a fraternal benefit society;
- (5) a local mutual aid association;
- (6) a statewide mutual assessment company;
- (7) a county mutual insurance company;
- (8) a Lloyd's plan;
- (9) a reciprocal or interinsurance exchange;
- (10) a stipulated premium company;
- (11) a group hospital service corporation; and
- (12) a risk retention group.

(b) This subchapter does not apply to a health maintenance

organization or insurer:

- (1) that has gross initial premium receipts collected in this state of less than \$2 million each year; or
- (2) with regard to fidelity, surety, or guaranty bonds.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 521.102. HEALTH MAINTENANCE ORGANIZATION OR INSURER TOLL-FREE NUMBER FOR INFORMATION AND COMPLAINTS. A health maintenance organization or insurer shall maintain a toll-free telephone number to:

- (1) provide information concerning evidences of coverage or policies issued by the health maintenance organization or insurer; and
- (2) receive complaints from enrollees or policyholders.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 521.103. INFORMATION INCLUDED IN EVIDENCE OF COVERAGE OR POLICY. (a) Each health maintenance organization or insurer that delivers, issues for delivery, or renews an evidence of coverage or insurance policy in this state shall print on the evidence of coverage or policy the health maintenance organization's or insurer's toll-free telephone number.

(b) The commissioner may adopt rules governing the manner in which the toll-free telephone number appears on the evidence of coverage or insurance policy.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

SUBCHAPTER D. RACE-BASED INSURANCE REGISTRY

Sec. 521.151. APPLICABILITY OF SUBCHAPTER. This subchapter applies to any legal entity engaged in the business of insurance in this state, including:

- (1) a capital stock insurance company;
- (2) a mutual insurance company;
- (3) a title insurance company;
- (4) a fraternal benefit society;

- (5) a local mutual aid association;
- (6) a statewide mutual assessment company;
- (7) a county mutual insurance company;
- (8) a Lloyd's plan;
- (9) a reciprocal or interinsurance exchange;
- (10) a stipulated premium company;
- (11) a group hospital service corporation;
- (12) a farm mutual insurance company;
- (13) a risk retention group;
- (14) an eligible surplus lines insurer; and
- (15) an agent, broker, or adjuster.

Added by Acts 2009, 81st Leg., R.S., Ch. 756 (S.B. 698), Sec. 1, eff. September 1, 2009.

Amended by:

Acts 2021, 87th Leg., R.S., Ch. 355 (H.B. 4030), Sec. 2, eff. September 1, 2021.

Sec. 521.152. REGISTRY; INTERNET POSTING. (a) The commissioner shall establish a registry of each legal entity engaged in the business of insurance in this state that, formally or informally, has entered into an agreement with the department:

- (1) that disposes of allegations of race-based pricing; and
- (2) under which all or part of the relief agreed on to make insureds whole includes a claims-made offer that remains in place and has not otherwise expired under the terms of the agreement.

(b) The registry must be prominently published on the department's Internet website, and must:

- (1) identify:
 - (A) each insurance company that has entered into an agreement described by Subsection (a); and
 - (B) the eligibility and terms of the insurance company's claims-made offer; and
- (2) include:
 - (A) a claim form; and
 - (B) links to the Internet website of the insurance company that is administrating the claims-made offer.

Added by Acts 2009, 81st Leg., R.S., Ch. 756 (S.B. 698), Sec. 1, eff. September 1, 2009.

Sec. 521.153. PRESERVATION OF CERTAIN RECORDS REGARDING RACE-BASED PRICING. (a) Notwithstanding Chapter 441, Government Code, the department shall preserve all examinations, exhibits to examinations, and other relevant documents regarding race-based pricing that the department has gathered or created with respect to a race-based pricing investigation that is completed or ongoing on September 1, 2009, other than those for which an attorney-client or attorney work product privilege can be claimed, until the time that those documents are eligible for delivery under Subsection (b).

(b) On the completion of the department's race-based pricing investigation, but not later than January 15, 2011, the department shall deliver the records identified under Subsection (a) or copies of those records to the state archivist.

(c) The state archives shall:

(1) using best efforts, preserve and catalogue the records identified under Subsection (a); and

(2) make the records available to the public as soon as appropriate, but not later than January 15, 2015.

Added by Acts 2009, 81st Leg., R.S., Ch. 756 (S.B. 698), Sec. 1, eff. September 1, 2009.

CHAPTER 522. CONSUMER INFORMATION IN SPANISH

Sec. 522.001. INFORMATIONAL SHEET FOR TEXAS PERSONAL AUTOMOBILE POLICIES. (a) The commissioner shall develop or adopt an informational sheet in the Spanish language to provide a general explanation of the terms most commonly used in the Texas personal automobile insurance policy. The department shall make the informational sheet available to the public.

(b) The informational sheet is intended to provide only a general explanation of insurance terms used in the Texas personal automobile insurance policy and is not intended to alter any rights, obligations, or responsibilities of the contracting parties. All other applicable laws, including provisions of this code, apply regardless of whether an informational sheet is used.

(c) The informational sheet must include a disclaimer in the Spanish language, prominently printed in 10-point boldfaced type at

the top of the informational sheet, that contains the following:

"This document is for informational purposes only and is not intended to alter or replace the insurance policy. Additionally, this informational sheet is not intended to fully set out your rights and obligations or the rights and obligations of the insurer. If you have questions about your insurance, you should consult your insurance agent, the insurer, or the language of the insurance policy."

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

This Chapter 524, HEALTH COVERAGE AWARENESS AND EDUCATION PROGRAM, was effective until September 1, 2009, if a specific appropriation was provided as described by Acts 2009, 81st Leg., R.S., Ch. 721, Sec. 2.04.

CHAPTER 524. HEALTH COVERAGE AWARENESS AND EDUCATION PROGRAM

Sec. 524.001. PROGRAM ESTABLISHED. (a) The department shall develop and implement a health coverage public awareness and education program that complies with this chapter. The program must:

- (1) increase public awareness of health coverage options available in this state;
- (2) educate the public on the value of health coverage; and
- (3) provide information on health coverage options, including health savings accounts and compatible high deductible health benefit plans.

(b) The department may include information about specific health coverage issuers but may not favor or endorse one particular issuer over another.

Added by Acts 2005, 79th Leg., Ch. 688 (S.B. 261), Sec. 1, eff. June 17, 2005.

Sec. 524.002. PUBLIC SERVICE ANNOUNCEMENTS. The department shall develop and make public service announcements to educate consumers and employers about the availability of health coverage in this state.

Added by Acts 2005, 79th Leg., Ch. 688 (S.B. 261), Sec. 1, eff. June 17, 2005.

Sec. 524.003. INTERNET WEBSITE; PUBLIC EDUCATION. (a) The department shall develop an Internet website designed to educate the public about the availability of health coverage in this state, including information about health savings accounts and compatible high deductible health benefit plans.

(b) The department shall provide other appropriate education to the public regarding the value of health coverage.

Added by Acts 2005, 79th Leg., Ch. 688 (S.B. 261), Sec. 1, eff. June 17, 2005.

Sec. 524.004. TASK FORCE. (a) The commissioner shall appoint a task force to make recommendations regarding the health coverage public awareness and education program. The task force is composed of:

(1) one representative from each of the following groups or entities:

- (A) health benefit coverage consumers;
- (B) small employers;
- (C) employers generally;
- (D) insurance agents;
- (E) the office of public insurance counsel;
- (F) the Texas Health Insurance Risk Pool;
- (G) physicians;
- (H) advanced practice nurses;
- (I) hospital trade associations; and
- (J) medical units of institutions of higher education;

(2) a representative of the Health and Human Services Commission responsible for programs under Medicaid and the children's health insurance program; and

(3) one or more representatives of health benefit plan issuers.

(b) The department shall consult the task force regarding the content for the public service announcements, Internet website, and educational materials required by this chapter. The commissioner has authority to make final decisions as to what the program's materials will contain.

Added by Acts 2005, 79th Leg., Ch. 688 (S.B. 261), Sec. 1, eff. June 17, 2005.

Sec. 524.005. FUNDING. The department may accept gifts and grants from any party, including a health benefit plan issuer or a foundation associated with a health benefit plan issuer, to assist with funding the program. The department shall adopt rules governing acceptance of donations that are consistent with Chapter 575, Government Code. Before adopting rules under this subsection, the department shall:

- (1) submit the proposed rules to the Texas Ethics Commission for review; and
- (2) consider the commission's recommendations regarding the regulations.

Added by Acts 2005, 79th Leg., Ch. 688 (S.B. 261), Sec. 1, eff. June 17, 2005.

This Chapter 524, TEXLINK TO HEALTH COVERAGE, was effective on September 1, 2009, if a specific appropriation was provided as described by Acts 2009, 81st Leg., R.S., Ch. 721, Sec. 2.04.

**CHAPTER 524. TEXLINK TO HEALTH COVERAGE
PROGRAM**

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 524.001. DEFINITIONS. In this chapter:

- (1) "Division" means the division of the department that administers the TexLink to Health Coverage Program.
- (2) "Program" means the TexLink to Health Coverage Program established in accordance with this chapter.

Added by Acts 2005, 79th Leg., Ch. 688 (S.B. 261), Sec. 1, eff. June 17, 2005.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 721 (S.B. 78), Sec. 1.01, eff. September 1, 2009.

Sec. 524.002. DIVISION RESPONSIBILITIES. Under the direction

of the commissioner, the division implements this chapter.

Added by Acts 2005, 79th Leg., Ch. 688 (S.B. 261), Sec. 1, eff. June 17, 2005.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 721 (S.B. 78), Sec. 1.01, eff. September 1, 2009.

Sec. 524.003. TEXLINK TO HEALTH COVERAGE PROGRAM ESTABLISHED.

(a) The department shall develop and implement a health coverage program that complies with this chapter. The program must:

(1) educate the public about the importance and value of health coverage;

(2) promote personal responsibility for health care through the purchase of health coverage;

(3) assist small employers, individuals, and others seeking to purchase health coverage with technical information necessary to understand available health insurance coverage;

(4) promote and facilitate the development and availability of new health coverage options;

(5) increase public awareness of health coverage options available in this state; and

(6) provide information on health coverage options, including health savings accounts and compatible high deductible health benefit plans.

(b) The program must include a public awareness and education component.

Added by Acts 2005, 79th Leg., Ch. 688 (S.B. 261), Sec. 1, eff. June 17, 2005.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 721 (S.B. 78), Sec. 1.01, eff. September 1, 2009.

SUBCHAPTER B. PUBLIC AWARENESS AND EDUCATION

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

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 721 (S.B. 78), Sec. 1.01, eff. September 1, 2009.

Sec. 524.052. PUBLIC SERVICE ANNOUNCEMENTS. The division shall develop and make public service announcements to educate consumers and employers about the availability of health coverage in this state.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 721 (S.B. 78), Sec. 1.01, eff. September 1, 2009.

Sec. 524.053. INTERNET WEBSITE; PRINTED MATERIALS; NEWSLETTER.

(a) The division shall develop an Internet website and printed materials designed to educate small employers, individuals, and others seeking to purchase health coverage about health coverage in accordance with Section 524.003(a), including information about health savings accounts and compatible high deductible health benefit plans.

(b) The division shall make the printed materials produced under the program available to small employers, individuals, and others seeking to purchase health coverage. The division may:

(1) distribute the printed materials through facilities such as libraries, health care facilities, and schools as well as other venues the division selects; and

(2) use other distribution methods the division selects.

(c) The division may produce a newsletter to provide updated information about health coverage to subscribers who elect to receive the newsletter. The division may:

(1) produce a newsletter under this subsection for small employers, for individuals, or for other purchasers of health coverage;

(2) distribute the newsletter on a monthly, quarterly, or other basis; and

(3) distribute the newsletter as a printed document or electronically.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 721 (S.B. 78), Sec. 1.01, eff. September 1, 2009.

Sec. 524.054. TOLL-FREE TELEPHONE HOTLINE; ACCESS TO INFORMATION. (a) The division may operate a toll-free telephone hotline to respond to inquiries and provide information and technical assistance concerning health insurance coverage.

(b) The Health and Human Services Commission, through its 2-1-1 telephone number for access to human services, may disseminate information regarding health insurance coverage provided to the commission by the department and may refer inquiries regarding health insurance coverage to the toll-free telephone hotline. The department may provide information to the Health and Human Services Commission as necessary to implement this subsection.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 721 (S.B. 78), Sec. 1.01, eff. September 1, 2009.

Sec. 524.055. EDUCATION FOR HIGH SCHOOL STUDENTS. (a) The division may develop educational materials and a curriculum to be used in high school classes that educate students about:

- (1) the importance and value of health coverage;
- (2) comparing health benefit plans; and
- (3) understanding basic provisions contained in health benefit plans.

(b) The division may consult with the Texas Education Agency in developing educational materials and a curriculum under this section.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 721 (S.B. 78), Sec. 1.01, eff. September 1, 2009.

Sec. 524.056. HEALTH COVERAGE FAIRS. (a) The division may conduct health coverage fairs to provide small employers, individuals, and others seeking to purchase health coverage the opportunity to obtain information about health coverage from division employees and from health benefit plan issuers and agents that elect

to participate.

(b) The division shall seek to obtain funding for health coverage fairs conducted under this section through gifts and grants obtained in accordance with Subchapter C.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 721 (S.B. 78), Sec. 1.01, eff. September 1, 2009.

Sec. 524.057. COMMUNITY EVENTS. The division may participate in events held in this state to promote awareness of the importance and value of health coverage and to educate small employers, individuals, and others seeking to purchase health coverage about health coverage in accordance with Section 524.003(a).

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 721 (S.B. 78), Sec. 1.01, eff. September 1, 2009.

Sec. 524.058. HEALTH COVERAGE PROVIDED THROUGH COLLEGES AND UNIVERSITIES. The division may cooperate with a public or private college or university to promote enrollment in health coverage programs sponsored by or through the college or university.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 721 (S.B. 78), Sec. 1.01, eff. September 1, 2009.

Sec. 524.059. SUPPORT FOR COMMUNITY-BASED PROJECTS. The division may provide support and assistance to individuals and organizations seeking to develop community-based health coverage plans for uninsured individuals.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 721 (S.B. 78), Sec. 1.01, eff. September 1, 2009.

Sec. 524.060. OTHER EDUCATION. The division may provide other appropriate education to the public regarding health coverage and the importance and value of health coverage in accordance with Section 524.003(a).

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 721 (S.B. 78), Sec. 1.01, eff. September 1, 2009.

Sec. 524.062. FEDERAL TAX "TOOL KIT" FOR CERTAIN BUSINESSES. The department may:

(1) produce materials that:

(A) provide step-by-step instructions for a small employer or single-employee business that is obtaining health coverage for the benefit of the employer or business and the employees of the business; and

(B) are designed to allow the employer or business to obtain the coverage in a manner that qualifies for favorable treatment under federal tax laws; and

(2) make department staff available to assist small employers and single-employee businesses that are obtaining health coverage as described by Subdivision (1).

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 721 (S.B. 78), Sec. 1.01, eff. September 1, 2009.

Sec. 524.063. ASSISTANCE FOR SMALL EMPLOYERS AND SINGLE-EMPLOYEE BUSINESSES. The department may train staff concerning available health coverage options for small employers and single-employee businesses to:

(1) respond to telephone inquiries from small employers and single-employee businesses; and

(2) speak at events to provide information about health coverage options for small employers and single-employee businesses and about the importance and value of health coverage.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 721 (S.B. 78), Sec. 1.01, eff.

September 1, 2009.

Sec. 524.064. ACCOUNTANT. The department may employ an accountant with experience in federal tax law and the purchase of group health coverage as necessary to implement this chapter.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 721 (S.B. 78), Sec. 1.01, eff. September 1, 2009.

SUBCHAPTER C. FUNDING

Sec. 524.101. FUNDING. The department may accept gifts and grants from any party, including a health benefit plan issuer or a foundation associated with a health benefit plan issuer, to assist with funding the program. The department shall adopt rules governing acceptance of donations that are consistent with Chapter 575, Government Code. Before adopting rules under this section, the department shall:

- (1) submit the proposed rules to the Texas Ethics Commission for review; and
- (2) consider the commission's recommendations regarding the regulations.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 721 (S.B. 78), Sec. 1.01, eff. September 1, 2009.

CHAPTER 525. DELIVERY OF INSURANCE POLICIES

Sec. 525.001. APPLICABILITY OF CHAPTER. This chapter applies to:

- (1) an insurer, as defined by Section 2301.051, writing personal automobile insurance or residential property insurance, as defined by Section 2301.051, in this state;
- (2) the Texas Windstorm Insurance Association;
- (3) the FAIR Plan Association; and
- (4) the Texas Automobile Insurance Plan Association.

Added by Acts 2015, 84th Leg., R.S., Ch. 254 (S.B. 956), Sec. 1, eff.

September 1, 2015.

Sec. 525.002. DELIVERY OF INSURANCE POLICIES. (a) Except as provided by Subsection (b), an insurer to whom this chapter applies shall deliver a policy issued by the insurer to the policyholder, or to the insurer's agent for delivery to the policyholder:

(1) not later than:

(A) the 30th day after the effective date of the policy if the policy term is more than 30 days; or

(B) the 10th day after the effective date of the policy if the policy term is more than 10 days and less than 31 days; or

(2) within the policy period for a policy with a term of 10 days or less.

(b) An insurer to whom this chapter applies shall deliver a policy renewed or amended by the insurer to the policyholder, or to the insurer's agent for delivery to the policyholder, not later than the 15th day after the date the insurer or insurer's agent receives a written request from the policyholder that the policy be delivered to the policyholder.

Added by Acts 2015, 84th Leg., R.S., Ch. 254 (S.B. 956), Sec. 1, eff. September 1, 2015.

Sec. 525.003. RULEMAKING AUTHORITY. The commissioner may adopt rules to implement this chapter.

Added by Acts 2015, 84th Leg., R.S., Ch. 254 (S.B. 956), Sec. 1, eff. September 1, 2015.

SUBTITLE C. DECEPTIVE, UNFAIR, AND PROHIBITED PRACTICES
CHAPTER 541. UNFAIR METHODS OF COMPETITION AND UNFAIR OR DECEPTIVE
ACTS OR PRACTICES

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 541.001. PURPOSE. The purpose of this chapter is to regulate trade practices in the business of insurance by:

(1) defining or providing for the determination of trade practices in this state that are unfair methods of competition or unfair or deceptive acts or practices; and

(2) prohibiting those trade practices.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 541.002. DEFINITIONS. In this chapter:

(1) "Knowingly" means actual awareness of the falsity, unfairness, or deceptiveness of the act or practice on which a claim for damages under Subchapter D is based. Actual awareness may be inferred if objective manifestations indicate that a person acted with actual awareness.

(2) "Person" means an individual, corporation, association, partnership, reciprocal or interinsurance exchange, Lloyd's plan, fraternal benefit society, or other legal entity engaged in the business of insurance, including an agent, broker, or adjuster.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Amended by:

Acts 2021, 87th Leg., R.S., Ch. 355 (H.B. 4030), Sec. 3, eff. September 1, 2021.

Sec. 541.003. UNFAIR METHODS OF COMPETITION AND UNFAIR OR DECEPTIVE ACTS OR PRACTICES PROHIBITED. A person may not engage in this state in a trade practice that is defined in this chapter as or determined under this chapter to be an unfair method of competition or an unfair or deceptive act or practice in the business of insurance.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 541.004. VENUE FOR ACTIONS INVOLVING DEPARTMENT OR COMMISSIONER. An action under this chapter in which the department or commissioner is a party must be brought in a district court in Travis County.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 541.005. APPLICABILITY TO RISK RETENTION OR PURCHASING

GROUP. (a) A risk retention group or purchasing group described by Subchapter B, Chapter 2201, or Section 2201.251 that is not chartered in this state may not engage in a trade practice in this state that is defined as unlawful under this chapter.

(b) A risk retention group or purchasing group is subject to this chapter and rules adopted under this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2D.005, eff. April 1, 2009.

Sec. 541.006. PROHIBITED CONTENT OF CERTAIN INSURANCE POLICIES. Notwithstanding any other provision of this code, it is unlawful for an insurer engaged in the business of life, accident, or health insurance to issue or deliver in this state a policy containing the words "Approved by the Texas Department of Insurance" or words of a similar meaning.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 541.007. IMMUNITY FROM PROSECUTION. (a) This section applies to a person who requests to be excused from attending and testifying at a hearing or from producing books, papers, records, correspondence, or other documents at the hearing on the ground that the testimony or evidence may:

- (1) tend to incriminate the person; or
- (2) subject the person to a penalty or forfeiture.

(b) A person who, notwithstanding a request described by Subsection (a), is directed to provide the testimony or produce the documents shall comply with that direction. Except as provided by Subsection (c), the person may not be prosecuted or subjected to a penalty or forfeiture for or on account of a transaction, matter, or thing about which the person testifies or produces documents, and the testimony or documents produced may not be received against the person in a criminal action, investigation, or proceeding.

(c) A person who complies with a direction to testify or produce documents is not exempt from prosecution or punishment for perjury committed while testifying and the testimony or evidence

given or produced is admissible against the person in a criminal action, investigation, or proceeding concerning the perjury, and the person is not exempt from the denial, revocation, or suspension of any license, permission, or authority conferred or to be conferred under this code.

(d) A person may waive the immunity or privilege granted by this section by executing, acknowledging, and filing with the department a statement expressly waiving the immunity or privilege for a specified transaction, matter, or thing. On filing the statement:

(1) the testimony or documents produced by the person in relation to the transaction, matter, or thing may be received by or produced before a judge or justice or a court, grand jury, or other tribunal; and

(2) the person is not entitled to immunity or privilege for the testimony or documents received or produced under Subdivision (1).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 541.008. LIBERAL CONSTRUCTION. This chapter shall be liberally construed and applied to promote the underlying purposes as provided by Section 541.001.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

SUBCHAPTER B. UNFAIR METHODS OF COMPETITION AND UNFAIR OR DECEPTIVE ACTS OR PRACTICES DEFINED

Sec. 541.051. MISREPRESENTATION REGARDING POLICY OR INSURER. It is an unfair method of competition or an unfair or deceptive act or practice in the business of insurance to:

(1) make, issue, or circulate or cause to be made, issued, or circulated an estimate, illustration, circular, or statement misrepresenting with respect to a policy issued or to be issued:

(A) the terms of the policy;

(B) the benefits or advantages promised by the policy;

or

(C) the dividends or share of surplus to be received on the policy;

- (2) make a false or misleading statement regarding the dividends or share of surplus previously paid on a similar policy;
- (3) make a misleading representation or misrepresentation regarding:
 - (A) the financial condition of an insurer; or
 - (B) the legal reserve system on which a life insurer operates;
- (4) use a name or title of a policy or class of policies that misrepresents the true nature of the policy or class of policies; or
- (5) make a misrepresentation to a policyholder insured by any insurer for the purpose of inducing or that tends to induce the policyholder to allow an existing policy to lapse or to forfeit or surrender the policy.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 541.052. FALSE INFORMATION AND ADVERTISING. (a) It is an unfair method of competition or an unfair or deceptive act or practice in the business of insurance to make, publish, disseminate, circulate, or place before the public or directly or indirectly cause to be made, published, disseminated, circulated, or placed before the public an advertisement, announcement, or statement containing an untrue, deceptive, or misleading assertion, representation, or statement regarding the business of insurance or a person in the conduct of the person's insurance business.

(b) This section applies to an advertisement, announcement, or statement made, published, disseminated, circulated, or placed before the public:

- (1) in a newspaper, magazine, or other publication;
- (2) in a notice, circular, pamphlet, letter, or poster;
- (3) over a radio or television station;
- (4) through the Internet; or
- (5) in any other manner.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 475 (H.B. [2251](#)), Sec. 2, eff. September 1, 2007.

Sec. 541.053. DEFAMATION OF INSURER. (a) It is an unfair method of competition or an unfair or deceptive act or practice in the business of insurance to directly or indirectly make, publish, disseminate, or circulate or to aid, abet, or encourage the making, publication, dissemination, or circulation of a statement that:

(1) is false, maliciously critical of, or derogatory to the financial condition of an insurer; and

(2) is calculated to injure a person engaged in the business of insurance.

(b) This section applies to any oral or written statement, including a statement in any pamphlet, circular, article, or literature.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 541.054. BOYCOTT, COERCION, OR INTIMIDATION. It is an unfair method of competition or an unfair or deceptive act or practice in the business of insurance to commit through concerted action or to enter into an agreement to commit an act of boycott, coercion, or intimidation that results in or tends to result in the unreasonable restraint of or a monopoly in the business of insurance.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 541.055. FALSE FINANCIAL STATEMENT. (a) It is an unfair method of competition or an unfair or deceptive act or practice in the business of insurance to, with intent to deceive:

(1) file with a supervisory or other public official a false statement of financial condition of an insurer; or

(2) make, publish, disseminate, circulate, deliver to any person, or place before the public or directly or indirectly cause to be made, published, disseminated, circulated, delivered to any person, or placed before the public a false statement of financial condition of an insurer.

(b) It is an unfair method of competition or an unfair or deceptive act or practice in the business of insurance to make a false entry in an insurer's book, report, or statement or wilfully omit to make a true entry of a material fact relating to the insurer's business in the insurer's book, report, or statement with

intent to deceive:

(1) an agent or examiner lawfully appointed to examine the insurer's condition or affairs; or

(2) a public official to whom the insurer is required by law to report or who has authority by law to examine the insurer's condition or affairs.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 541.056. PROHIBITED REBATES AND INDUCEMENTS. (a) Subject to Section 541.058 and except as otherwise expressly provided by law, it is an unfair method of competition or an unfair or deceptive act or practice in the business of insurance to knowingly permit the making of, offer to make, or make a life insurance contract, life annuity contract, or accident and health insurance contract or an agreement regarding the contract, other than as plainly expressed in the issued contract, or directly or indirectly pay, give, or allow or offer to pay, give, or allow as inducement to enter into a life insurance contract, life annuity contract, or accident and health insurance contract a rebate of premiums payable on the contract, a special favor or advantage in the dividends or other benefits of the contract, or a valuable consideration or inducement not specified in the contract, or give, sell, or purchase or offer to give, sell, or purchase in connection with a life insurance, life annuity, or accident and health insurance contract or as inducement to enter into the contract stocks, bonds, or other securities of an insurer or other corporation, association, or partnership, dividends or profits accrued from the stocks, bonds, or securities, or anything of value not specified in the contract.

(b) It is an unfair method of competition or an unfair or deceptive act or practice in the business of insurance to issue or deliver or to permit an agent, officer, or employee to issue or deliver as an inducement to insurance:

(1) company stock or other capital stock;

(2) a benefit certificate or share in a corporation;

(3) securities; or

(4) a special or advisory board contract or any other contract promising returns or profits.

(c) Subsection (b) does not prohibit issuing or delivering a

participating insurance policy otherwise authorized by law.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 541.057. UNFAIR DISCRIMINATION IN LIFE INSURANCE AND ANNUITY CONTRACTS. Subject to Section 541.058, it is an unfair method of competition or an unfair or deceptive act or practice in the business of insurance to make or permit with respect to a life insurance or life annuity contract an unfair discrimination between individuals of the same class and equal life expectancy regarding:

- (1) the rates charged;
- (2) the dividends or other benefits payable; or
- (3) any of the other terms and conditions of the contract.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 541.058. CERTAIN PRACTICES NOT CONSIDERED DISCRIMINATION OR INDUCEMENT. (a) In this section:

(1) "Health-related services" means services that are available in connection with an accident and health insurance policy or certificate or an evidence of coverage and that are directed to an individual's health improvement or maintenance.

(2) "Health-related information" means that information that is directed to an individual's health improvement or maintenance or to costs associated with particular options available in connection with an accident and health insurance policy or certificate or an evidence of coverage.

(b) It is not a rebate or discrimination prohibited by Section 541.056(a) or 541.057:

(1) for a life insurance or life annuity contract, to pay a bonus to a policyholder or otherwise abate the policyholder's premiums in whole or in part out of surplus accumulated from nonparticipating insurance policies if the bonus or abatement:

- (A) is fair and equitable to policyholders; and
- (B) is in the best interests of the insurer and its policyholders;

(2) for a life insurance policy issued on the industrial debit plan, to make to a policyholder who has continuously for a specified period made premium payments directly to the insurer's

office an allowance in an amount that fairly represents the saving in collection expenses;

(3) for a group insurance policy, to readjust the rate of premium based on the loss or expense experience under the policy at the end of a policy year if the adjustment is retroactive for only that policy year;

(4) for a life annuity contract, to waive surrender charges under the contract when the contract holder exchanges that contract for another annuity contract issued by the same insurer or an affiliate of the same insurer that is part of the same holding company group if:

(A) the waiver and the exchange are fully, fairly, and accurately explained to the contract holder in a manner that is not deceptive or misleading; and

(B) the contract holder is given credit for the time that the previous contract was held when determining any surrender charges under the new contract;

(5) in connection with an accident and health insurance policy, to provide to policy or certificate holders, in addition to benefits under the terms of the insurance contract, health-related services or health-related information, or to disclose the availability of those additional services and information to prospective policy or certificate holders;

(6) in connection with a health maintenance organization evidence of coverage, to provide to enrollees, in addition to benefits under the evidence of coverage, health-related services or health-related information, or to disclose the availability of those additional services and information to prospective enrollees or contract holders; or

(7) in connection with an offer or sale of a life insurance policy or contract, accident and health insurance policy or contract, or annuity contract, to give, provide, or allow or offer to give, provide, or allow an item that is a promotional advertising item, educational item, or traditional courtesy commonly extended to consumers and that is valued at \$25 or less.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 112 (H.B. [2252](#)), Sec. 1, eff. May 17, 2007.

Acts 2011, 82nd Leg., R.S., Ch. 1156 (H.B. 2277), Sec. 1, eff. September 1, 2011.

Acts 2013, 83rd Leg., R.S., Ch. 28 (S.B. 840), Sec. 1, eff. September 1, 2013.

Sec. 541.059. DECEPTIVE NAME, WORD, SYMBOL, DEVICE, OR SLOGAN.

(a) Except as provided by Subsection (b), it is an unfair method of competition or an unfair or deceptive act or practice in the business of insurance to use, display, publish, circulate, distribute, or cause to be used, displayed, published, circulated, or distributed in a letter, pamphlet, circular, contract, policy, evidence of coverage, article, poster, or other document, literature, or public media:

(1) a name as the corporate or business name of a person or entity engaged in the business of insurance or in an insurance-related business in this state that is the same as or deceptively similar to the name adopted and used by an insurance entity, health maintenance organization, third-party administrator, or group hospital service corporation authorized to engage in business under the laws of this state; or

(2) a word, symbol, device, or slogan, either alone or in combination and regardless of whether registered, and including the titles, designations, character names, and distinctive features of broadcast or other advertising, that is the same as or deceptively similar to a word, symbol, device, or slogan adopted and used by an insurance entity, health maintenance organization, third-party administrator, or group hospital service corporation to distinguish the entity or the entity's products or services from another entity.

(b) If more than one person or entity uses names, words, symbols, devices, or slogans, either alone or in combination, that are the same or deceptively similar and are likely to cause confusion or mistake, the person or entity that demonstrates the first continuous actual use of the name, word, symbol, device, slogan, or combination has not engaged in an unfair method of competition or deceptive act or practice under this section.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 541.060. UNFAIR SETTLEMENT PRACTICES. (a) It is an

unfair method of competition or an unfair or deceptive act or practice in the business of insurance to engage in the following unfair settlement practices with respect to a claim by an insured or beneficiary:

(1) misrepresenting to a claimant a material fact or policy provision relating to coverage at issue;

(2) failing to attempt in good faith to effectuate a prompt, fair, and equitable settlement of:

(A) a claim with respect to which the insurer's liability has become reasonably clear; or

(B) a claim under one portion of a policy with respect to which the insurer's liability has become reasonably clear to influence the claimant to settle another claim under another portion of the coverage unless payment under one portion of the coverage constitutes evidence of liability under another portion;

(3) failing to promptly provide to a policyholder a reasonable explanation of the basis in the policy, in relation to the facts or applicable law, for the insurer's denial of a claim or offer of a compromise settlement of a claim;

(4) failing within a reasonable time to:

(A) affirm or deny coverage of a claim to a policyholder; or

(B) submit a reservation of rights to a policyholder;

(5) refusing, failing, or unreasonably delaying a settlement offer under applicable first-party coverage on the basis that other coverage may be available or that third parties are responsible for the damages suffered, except as may be specifically provided in the policy;

(6) undertaking to enforce a full and final release of a claim from a policyholder when only a partial payment has been made, unless the payment is a compromise settlement of a doubtful or disputed claim;

(7) refusing to pay a claim without conducting a reasonable investigation with respect to the claim;

(8) with respect to a Texas personal automobile insurance policy, delaying or refusing settlement of a claim solely because there is other insurance of a different kind available to satisfy all or part of the loss forming the basis of that claim; or

(9) requiring a claimant as a condition of settling a claim to produce the claimant's federal income tax returns for examination

or investigation by the person unless:

(A) a court orders the claimant to produce those tax returns;

(B) the claim involves a fire loss; or

(C) the claim involves lost profits or income.

(b) Subsection (a) does not provide a cause of action to a third party asserting one or more claims against an insured covered under a liability insurance policy.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 541.061. MISREPRESENTATION OF INSURANCE POLICY. It is an unfair method of competition or an unfair or deceptive act or practice in the business of insurance to misrepresent an insurance policy by:

(1) making an untrue statement of material fact;

(2) failing to state a material fact necessary to make other statements made not misleading, considering the circumstances under which the statements were made;

(3) making a statement in a manner that would mislead a reasonably prudent person to a false conclusion of a material fact;

(4) making a material misstatement of law; or

(5) failing to disclose a matter required by law to be disclosed, including failing to make a disclosure in accordance with another provision of this code.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

SUBCHAPTER B-1. ADVERTISING REQUIREMENTS

Sec. 541.082. ADVERTISING AND INTERNET WEBSITES. (a) In this section, "insurer" includes:

(1) a life insurance company;

(2) a health insurance company;

(3) an accident insurance company;

(4) a general casualty company;

(5) a mutual life insurance company or other mutual insurance company;

(6) a mutual or natural premium life insurance company;

(7) a Lloyd's plan;

(8) a county mutual insurance company;
(9) a farm mutual insurance company;
(10) a reciprocal or interinsurance exchange;
(11) a fraternal benefit society;
(12) a local mutual aid association;
(13) a health maintenance organization;
(14) a group hospital service corporation; or
(15) a multiple employer welfare arrangement that holds a certificate of coverage under Chapter 846.

(b) A web page of an insurer's Internet website must include all appropriate disclosures and information required by applicable rules adopted by the commissioner relating to advertising only if the web page:

(1) describes specific policies or coverage available in this state; or

(2) includes an opportunity for an individual to apply for coverage or obtain a quote from an insurer for an insurance policy or certificate or an evidence of coverage.

(c) As may be permitted by commissioner rule, an insurer may comply with Subsection (b) by including a link to a web page that includes the information necessary to comply with the applicable rules relating to advertising. The link must be prominently placed on the insurer's web page.

(d) Web pages of an Internet website that do not refer to a specific insurance policy, certificate of coverage, or evidence of coverage or that do not provide an opportunity for an individual to apply for coverage or request a quote from an insurer are considered to be institutional advertisements subject to rules adopted by the commissioner relating to advertising.

(e) Web pages or navigation aids within an insurer's Internet website that provide a link to a web page described by Subsection (b) but that do not otherwise contain content described in Subsection (b) are considered to be institutional advertisements subject to rules adopted by the commissioner relating to advertising.

Added by Acts 2007, 80th Leg., R.S., Ch. 475 (H.B. [2251](#)), Sec. 1, eff. September 1, 2007.

Sec. 541.083. ADVERTISEMENTS TO CERTAIN ASSOCIATIONS. An

insurer may advertise to the general public policies or coverage available only to members of an association described by Section 1251.052.

Added by Acts 2007, 80th Leg., R.S., Ch. 475 (H.B. 2251), Sec. 1, eff. September 1, 2007.

Sec. 541.084. ADVERTISEMENTS RELATING TO MEDICARE PROGRAM. A person may not use an advertisement for an insurance product relating to Medicare coverage unless the advertisement includes in a prominent place the following language or similar language: "Not connected with or endorsed by the United States government or the federal Medicare program."

Added by Acts 2007, 80th Leg., R.S., Ch. 475 (H.B. 2251), Sec. 1, eff. September 1, 2007.

Sec. 541.085. ADVERTISEMENTS RELATING TO PREFERRED PROVIDER BENEFIT PLANS. It is sufficient for an insurer to use the term "PPO plan" in advertisements when referring to a preferred provider benefit plan offered under Chapter 1301.

Added by Acts 2007, 80th Leg., R.S., Ch. 475 (H.B. 2251), Sec. 1, eff. September 1, 2007.

Sec. 541.086. ADVERTISING REGARDING GUARANTEED RENEWABLE COVERAGE. (a) An advertisement for a guaranteed renewable accident and health insurance policy must include, in a prominent place, a statement indicating that rates for the policy may change if the advertisement suggests or implies that rates for the product will not change.

(b) If an advertisement is required to include the statement described by Subsection (a), the statement must generally identify the manner in which rates may change, such as by age, by health status, by class, or through application of other general criteria.

Added by Acts 2007, 80th Leg., R.S., Ch. 475 (H.B. 2251), Sec. 1, eff. September 1, 2007.

Sec. 541.087. ADVERTISEMENTS EXEMPT FROM FILING REQUIREMENTS. An advertisement subject to requirements regarding filing of the advertisement with the department for department review under this code or commissioner rule and that is the same as or substantially similar to an advertisement previously reviewed and accepted by the department is not required to be filed for department review.

Added by Acts 2007, 80th Leg., R.S., Ch. 475 (H.B. [2251](#)), Sec. 1, eff. September 1, 2007.

SUBCHAPTER C. DETERMINATION OF UNFAIR METHODS OF COMPETITION AND UNFAIR OR DECEPTIVE ACTS OR PRACTICES; SANCTIONS AND PENALTIES

Sec. 541.101. EXAMINATION AND INVESTIGATION. The department may examine and investigate the affairs of a person engaged in the business of insurance in this state to determine whether the person has or is engaged in an unfair method of competition or unfair or deceptive act or practice prohibited by Section 541.003.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 541.102. STATEMENT OF CHARGES; NOTICE OF HEARING. (a) When the department has reason to believe that a person engaged in the business of insurance in this state has engaged or is engaging in this state in an unfair method of competition or unfair or deceptive act or practice defined by Subchapter B and that a proceeding by the department regarding the charges is in the interest of the public, the department shall issue and serve on the person:

(1) a statement of the charges; and
(2) a notice of the hearing on the charges, including the time and place for the hearing.

(b) The department may not hold the hearing before the sixth day after the date the notice is served.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 541.103. HEARING. A person against whom charges are made

under Section 541.102 is entitled at the hearing on the charges to have an opportunity to be heard and show cause why the department should not issue an order requiring the person to cease and desist from the unfair method of competition or unfair or deceptive act or practice described in the charges.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 541.104. HEARING PROCEDURES. (a) Nothing in this chapter requires the observance of formal rules of pleading or evidence at a hearing under this subchapter.

(b) At a hearing under this subchapter, the department, on a showing of good cause, shall permit any person to intervene, appear, and be heard by counsel or in person.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 541.105. RECORD OF HEARING. (a) At a hearing under this subchapter, the department may, and at the request of a party to the hearing shall, make a stenographic record of the proceedings and the evidence presented at the hearing.

(b) If the department does not make a stenographic record and a person seeks judicial review of the decision made at the hearing, the department shall prepare a statement of the evidence and proceeding for use on review.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 541.106. COMPLIANCE WITH SUBPOENA. (a) If a person refuses to comply with a subpoena issued in connection with a hearing under this subchapter or refuses to testify with respect to a matter about which the person may be lawfully interrogated, on application of the department, a district court in Travis County or in the county in which the person resides may order the person to comply with the subpoena or testify.

(b) A court may punish as contempt a person's failure to obey an order under this section.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 541.107. DETERMINATION OF VIOLATION. After a hearing under this subchapter, the department shall determine whether:

(1) the method of competition or the act or practice considered in the hearing is defined as:

(A) an unfair method of competition or deceptive act or practice under Subchapter B or a rule adopted under this chapter; or

(B) a false, misleading, or deceptive act or practice under Section 17.46, Business & Commerce Code; and

(2) the person against whom the charges were made engaged in the method of competition or act or practice in violation of:

(A) this chapter or a rule adopted under this chapter;
or

(B) Subchapter E, Chapter 17, Business & Commerce Code, as specified in Section 17.46, Business & Commerce Code.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 541.108. CEASE AND DESIST ORDER. On determining that a person committed a violation described by Section 541.107, the department shall:

(1) make written findings; and

(2) issue and serve on the person an order requiring the person to cease and desist from engaging in the method of competition or act or practice determined to be a violation.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 541.109. MODIFICATION OR SETTING ASIDE OF ORDER. On the notice and in the manner the department determines proper, the department may modify or set aside in whole or in part a cease and desist order issued under Section 541.108 at any time before a petition appealing the order is filed in accordance with Subchapter D, Chapter 36.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 541.110. ADMINISTRATIVE PENALTY. (a) A person who violates a cease and desist order issued under Section 541.108 is subject to an administrative penalty under Chapter 84.

(b) In determining whether a person has violated a cease and desist order, the department shall consider the maintenance of procedures reasonably adapted to ensure compliance with the order.

(c) An administrative penalty imposed under this section may not exceed:

- (1) \$1,000 for each violation; or
- (2) \$5,000 for all violations.

(d) An order of the department imposing an administrative penalty under this section applies only to a violation of the cease and desist order committed before the date the order imposing the penalty is issued.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 541.111. CIVIL PENALTY FOR VIOLATION OF CEASE AND DESIST ORDER. (a) A person who is found by a court to have violated a cease and desist order issued under Section 541.108 is liable to the state for a penalty. The state may recover the penalty in a civil action.

(b) The penalty may not exceed \$50 unless the court finds the violation to be wilful, in which case the penalty may not exceed \$500.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

SUBCHAPTER D. PRIVATE ACTION FOR DAMAGES

Sec. 541.151. PRIVATE ACTION FOR DAMAGES AUTHORIZED. A person who sustains actual damages may bring an action against another person for those damages caused by the other person engaging in an act or practice:

(1) defined by Subchapter B to be an unfair method of competition or an unfair or deceptive act or practice in the business of insurance; or

(2) specifically enumerated in Section 17.46(b), Business & Commerce Code, as an unlawful deceptive trade practice if the person bringing the action shows that the person relied on the act or

practice to the person's detriment.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 541.152. DAMAGES, ATTORNEY'S FEES, AND OTHER RELIEF. (a) A plaintiff who prevails in an action under this subchapter may obtain:

- (1) the amount of actual damages, plus court costs and reasonable and necessary attorney's fees;
- (2) an order enjoining the act or failure to act complained of; or
- (3) any other relief the court determines is proper.

(b) Except as provided by Subsection (c), on a finding by the trier of fact that the defendant knowingly committed the act complained of, the trier of fact may award an amount not to exceed three times the amount of actual damages.

(c) Subsection (b) does not apply to an action under this subchapter brought against the Texas Windstorm Insurance Association.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.
Amended by:

Acts 2011, 82nd Leg., 1st C.S., Ch. 2 (H.B. 3), Sec. 2, eff. September 28, 2011.

Sec. 541.153. FRIVOLOUS ACTION. A court shall award to the defendant court costs and reasonable and necessary attorney's fees if the court finds that an action under this subchapter is groundless and brought in bad faith or brought for the purpose of harassment.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 541.154. PRIOR NOTICE OF ACTION. (a) A person seeking damages in an action against another person under this subchapter must provide written notice to the other person not later than the 61st day before the date the action is filed.

- (b) The notice must advise the other person of:
 - (1) the specific complaint; and
 - (2) the amount of actual damages and expenses, including

attorney's fees reasonably incurred in asserting the claim against the other person.

(c) The notice is not required if giving notice is impracticable because the action:

- (1) must be filed to prevent the statute of limitations from expiring; or
- (2) is asserted as a counterclaim.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 541.155. ABATEMENT. (a) A person against whom an action under this subchapter is pending who does not receive the notice as required by Section 541.154 may file a plea in abatement not later than the 30th day after the date the person files an original answer in the court in which the action is pending.

(b) The court shall abate the action if, after a hearing, the court finds that the person is entitled to an abatement because the claimant did not provide the notice as required by Section 541.154.

(c) An action is automatically abated without a court order beginning on the 11th day after the date a plea in abatement is filed if the plea:

(1) is verified and alleges that the person against whom the action is pending did not receive the notice as required by Section 541.154; and

(2) is not controverted by an affidavit filed by the claimant before the 11th day after the date the plea in abatement is filed.

(d) An abatement under this section continues until the 60th day after the date notice is provided in compliance with Section 541.154.

(e) This section does not apply if Section 541.154(c) applies.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 541.156. SETTLEMENT OFFER. (a) A person who receives notice provided under Section 541.154 or 542A.003 may make a settlement offer during a period beginning on the date notice under Section 541.154 or 542A.003 is received and ending on the 60th day after that date.

(b) In addition to the period described by Subsection (a), the person may make a settlement offer during a period:

(1) if mediation is not conducted under Section 541.161, beginning on the date an original answer is filed in the action and ending on the 90th day after that date; or

(2) if mediation is conducted under Section 541.161, beginning on the day after the date the mediation ends and ending on the 20th day after that date.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 151 (H.B. 1774), Sec. 1, eff. September 1, 2017.

Sec. 541.157. CONTENTS OF SETTLEMENT OFFER. A settlement offer made by a person against whom a claim under this subchapter is pending must include an offer to pay the following amounts, separately stated:

(1) an amount of money or other consideration, reduced to its cash value, as settlement of the claim for damages; and

(2) an amount of money to compensate the claimant for the claimant's reasonable and necessary attorney's fees incurred as of the date of the offer.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 541.158. REJECTION OF SETTLEMENT OFFER. (a) A settlement offer is rejected unless both parts of the offer required under Section 541.157 are accepted by the claimant not later than the 30th day after the date the offer is made.

(b) A settlement offer made by a person against whom a claim under this subchapter is pending that complies with this subchapter and is rejected by the claimant may be filed with the court accompanied by an affidavit certifying the offer's rejection.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 541.159. LIMIT ON RECOVERY AFTER SETTLEMENT OFFER. (a)

If the court finds that the amount stated in the settlement offer for damages under Section 541.157(1) is the same as, substantially the same as, or more than the amount of damages found by the trier of fact, the claimant may not recover as damages any amount in excess of the lesser of:

- (1) the amount of damages stated in the offer; or
- (2) the amount of damages found by the trier of fact.

(b) If the court makes the finding described by Subsection (a), the court shall determine reasonable and necessary attorney's fees to compensate the claimant for attorney's fees incurred before the date and time the rejected settlement offer was made. If the court finds that the amount stated in the offer for attorney's fees under Section 541.157(2) is the same as, substantially the same as, or more than the amount of reasonable and necessary attorney's fees incurred by the claimant as of the date of the offer, the claimant may not recover any amount of attorney's fees in excess of the amount of fees stated in the offer.

(c) This section does not apply if the court finds that the offering party:

- (1) could not perform the offer at the time the offer was made; or
- (2) substantially misrepresented the cash value of the offer.

(d) The court shall award:

- (1) damages as required by Section 541.152 if Subsection (a) does not apply; and
- (2) attorney's fees as required by Section 541.152 if Subsection (b) does not apply.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 541.160. EFFECT OF SETTLEMENT OFFER. A settlement offer is not an admission of engaging in an act or practice defined by Subchapter B to be an unfair method of competition or an unfair or deceptive act or practice in the business of insurance.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 541.161. MEDIATION. (a) A party may, not later than the

90th day after the date a pleading seeking relief under this subchapter is served, file a motion to compel mediation of the dispute in the manner provided by this section.

(b) The court shall, not later than the 30th day after the date a motion under this section is filed, sign an order setting the time and place of the mediation.

(c) The court shall appoint a mediator if the parties do not agree on a mediator.

(d) The mediation must be held not later than the 30th day after the date the order is signed, unless:

(1) the parties agree otherwise; or

(2) the court determines that additional time not to exceed 30 days is warranted.

(e) Each party who has appeared in the action, except as agreed to by all parties who have appeared, shall:

(1) participate in the mediation; and

(2) except as provided by Subsection (f), share the mediation fee.

(f) A party may not compel mediation under this section if the amount of actual damages claimed is less than \$15,000 unless the party seeking to compel mediation agrees to pay the costs of the mediation.

(g) Except as provided by this section, the following apply to the appointment of a mediator and the mediation process provided by this section:

(1) Section 154.023, Civil Practice and Remedies Code; and

(2) Subchapters C and D, Chapter 154, Civil Practice and Remedies Code.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 541.162. LIMITATIONS PERIOD. (a) A person must bring an action under this chapter before the second anniversary of the following:

(1) the date the unfair method of competition or unfair or deceptive act or practice occurred; or

(2) the date the person discovered or, by the exercise of reasonable diligence, should have discovered that the unfair method of competition or unfair or deceptive act or practice occurred.

(b) The limitations period provided by Subsection (a) may be extended for 180 days if the person bringing the action proves that the person's failure to bring the action within that period was caused by the defendant's engaging in conduct solely calculated to induce the person to refrain from or postpone bringing the action.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

SUBCHAPTER E. ENFORCEMENT BY ATTORNEY GENERAL

Sec. 541.201. INJUNCTIVE RELIEF. (a) The attorney general may bring an action under this section if the attorney general has reason to believe that:

(1) a person engaged in the business of insurance in this state is engaging in, has engaged in, or is about to engage in an act or practice defined as unlawful under:

(A) this chapter or a rule adopted under this chapter;

or

(B) Section 17.46, Business & Commerce Code; and

(2) the action is in the public interest.

(b) The attorney general may bring the action in the name of the state to restrain by temporary or permanent injunction the person's use of the method, act, or practice.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 541.202. VENUE FOR INJUNCTIVE ACTION. An action for an injunction under this subchapter may be commenced in a district court in:

(1) the county in which the person against whom the action is brought:

(A) resides;

(B) has the person's principal place of business; or

(C) is engaging in business;

(2) the county in which the transaction or a substantial portion of the transaction occurred; or

(3) Travis County.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 541.203. ISSUANCE OF INJUNCTION. (a) The court may issue an appropriate temporary or permanent injunction.

(b) The court shall issue the injunction without bond.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 541.204. CIVIL PENALTY. In addition to requesting a temporary or permanent injunction under Section 541.201, the attorney general may request a civil penalty of not more than \$10,000 for each violation on a finding by the court that the defendant has engaged in or is engaging in an act or practice defined as unlawful under:

- (1) this chapter or a rule adopted under this chapter; or
- (2) Section 17.46, Business & Commerce Code.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 541.205. COMPENSATION OR RESTORATION. The court may make an additional order or judgment as necessary to compensate an identifiable person for actual damages or for restoration of money or property that may have been acquired by means of an enjoined act or practice.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 541.206. CIVIL PENALTY FOR VIOLATION OF INJUNCTION. (a) A person who violates an injunction issued under this subchapter is liable for and shall pay to the state a civil penalty of not more than \$10,000 for each violation.

(b) The attorney general may, in the name of the state, petition the court for recovery of the civil penalty against the person who violates the injunction.

(c) The court shall consider the maintenance of procedures reasonably adapted to ensure compliance with the injunction in determining whether a person has violated an injunction.

(d) The court issuing the injunction retains jurisdiction and the cause is continued for the purpose of assessing a civil penalty under this section.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 541.207. REMEDIES NOT EXCLUSIVE. The remedies provided by this subchapter are:

- (1) not exclusive; and
- (2) in addition to any other remedy or procedure provided by another law or at common law.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

SUBCHAPTER F. CLASS ACTIONS BY ATTORNEY GENERAL OR PRIVATE INDIVIDUAL

Sec. 541.251. CLASS ACTION AUTHORIZED. (a) If a member of the insurance buying public has been damaged by an unlawful method, act, or practice defined in Subchapter B as an unlawful deceptive trade practice, the department may request the attorney general to bring a class action or the individual damaged may bring an action on the individual's own behalf and on behalf of others similarly situated to recover damages and obtain relief as provided by this subchapter.

(b) A class action may not be maintained under this subchapter if the department and attorney general have initiated an action under Subchapter G or an action under that subchapter has resulted in a final determination regarding the same act or practice and the same defendant in the action under this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 541.252. RECOVERY. A plaintiff who prevails in a class action under this subchapter may recover:

- (1) court costs and attorney's fees reasonable in relation to the amount of work expended in addition to actual damages;
- (2) an order enjoining the act or failure to act; and
- (3) any other relief the court determines is proper.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 541.253. FRIVOLOUS ACTION. The court may award to the defendant court costs and reasonable attorney's fees in relation to

the work expended on a finding by the court that a class action under this subchapter was brought by an individual plaintiff in bad faith or for the purpose of harassment.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 541.254. STATUTE OF LIMITATIONS TOLLED. The filing of a class action under this subchapter tolls the statute of limitations for bringing an action by an individual under Section 541.162.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 541.255. PRIOR NOTICE. (a) Not later than the 31st day before the date a class action for damages is commenced under this subchapter, the prospective plaintiff must:

(1) notify the intended defendant of the complaint; and
(2) demand that the defendant provide relief to the prospective plaintiff and others similarly situated.

(b) The notice must be in writing and be sent by certified or registered mail, return receipt requested, to:

(1) the place where the transaction occurred;
(2) the intended defendant's principal place of business in this state; or
(3) if notice to the place described by Subdivision (1) or (2) does not effect notice, the office of the secretary of state.

(c) A copy of the notice must also be sent to the commissioner.

(d) A class action for injunctive relief may be commenced under this subchapter without complying with Subsection (a).

(e) A plaintiff in a class action for injunctive relief under this subchapter may, on or after the 31st day after the date the action is commenced and after complying with Subsection (a), amend the complaint without leave of court to include a request for damages.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 541.256. PREREQUISITES TO CLASS ACTION. The court shall permit one or more members of a class to sue or be sued as

representative parties on behalf of the class only if:

- (1) the class is so numerous that joinder of all members is impracticable;
- (2) there are questions of law or fact common to the class;
- (3) the claims or defenses of the representative parties are typical of the claims or defenses of the class; and
- (4) the representative parties will fairly and adequately protect the interests of the class.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 541.257. CLASS ACTIONS MAINTAINABLE. (a) An action may be maintained as a class action under this subchapter if the prerequisites of Section 541.256 are satisfied and, in addition:

- (1) the prosecution of separate actions by or against individual members of the class would create a risk of:
 - (A) inconsistent or varying adjudications with respect to individual members of the class that would establish incompatible standards of conduct for the party opposing the class; or
 - (B) adjudication with respect to individual members of the class that would as a practical matter be dispositive of the interests of the other members not parties to the adjudications or substantially impair or impede their ability to protect their interests;
- (2) the party opposing the class has acted or refused to act on grounds generally applicable to the class, making appropriate final injunctive relief or corresponding declaratory relief with respect to the class as a whole; or
- (3) the court finds that the questions of law or fact common to the members of the class predominate over any questions affecting only individual members and that a class action is superior to other available methods for the fair and efficient adjudication of the controversy.

(b) Matters pertinent to a finding under Subsection (a)(3) include:

- (1) the interest of members of the class in individually controlling the prosecution or defense of separate actions;
- (2) the extent and nature of any litigation concerning the controversy already commenced by or against members of the class;

(3) the desirability or undesirability of concentrating the litigation of the claims in the particular forum; and

(4) the difficulties likely to be encountered in the management of a class action.

(c) In construing this section, the courts of this state shall be guided by the decisions of the federal courts interpreting Rule 23, Federal Rules of Civil Procedure, as amended.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 541.258. CLASS ACTIONS: ISSUES AND SUBCLASSES AUTHORIZED. When appropriate, an action may be brought or maintained as a class action under this subchapter with respect to particular issues or a class may be divided into subclasses and each subclass treated as a class, and the provisions of this subchapter shall be construed and applied accordingly.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 541.259. DETERMINATION REGARDING WHETHER CLASS ACTION MAY BE MAINTAINED. (a) As soon as practicable after the commencement of an action brought as a class action, the court shall determine by order whether it is to be maintained as a class action under this subchapter.

(b) An order under this section may be altered or amended before a decision on the merits.

(c) An order determining whether the action may be maintained as a class action under this subchapter is an interlocutory order that is appealable. The procedures applicable to accelerated appeals in the Texas Rules of Appellate Procedure apply to the appeal.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 541.260. EFFECT OF DENIAL OF CLASS ACTION. A court order denying that an action under this subchapter may be brought as a class action does not affect whether an individual may bring the same or a similar action under Subchapter D.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 541.261. NOTICE OF CLASS ACTION. (a) If an action is permitted as a class action under this subchapter, the court shall direct to the members of the class the best notice practicable under the circumstances, including individual notice to all members who can be identified through reasonable effort.

(b) The notice must contain a statement that:

(1) the court will exclude from the class a notified member if the member requests exclusion by a specified date;

(2) the judgment, whether favorable or not, includes all members who do not request exclusion; and

(3) a member who does not request exclusion may enter an appearance through counsel.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 541.262. PROCEDURES IN CLASS ACTION. In a class action under this subchapter, the court may make appropriate orders:

(1) determining the course of proceedings or prescribing measures to prevent undue repetition or complication in the presentation of evidence or argument;

(2) requiring, for the protection of the members of the class or otherwise for the fair conduct of the action, that notice be given in a manner the court directs to some or all of the members or the attorney general of:

(A) any step in the action;

(B) the proposed extent of the judgment; or

(C) the opportunity for members to:

(i) signify whether the members consider the representation to be fair and adequate;

(ii) intervene and present claims or defenses; or

(iii) otherwise come into the action;

(3) imposing conditions on the representative parties or intervenors;

(4) requiring that the pleadings be amended to eliminate allegations relating to representation of absent persons, and that the action proceed accordingly; or

(5) dealing with similar procedural matters.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 541.263. EFFECT OF SETTLEMENT OFFER. (a) Damages may not be awarded to a class under this subchapter if, not later than the 30th day after the date the intended defendant receives notice under Section 541.255, the intended defendant provides to the plaintiff by certified or registered mail, return receipt requested, a written settlement offer.

(b) The settlement offer must include:

(1) a statement that all persons similarly situated have been adequately identified or a reasonable effort to identify those persons has been made;

(2) a description of the class identified and the method used to identify that class;

(3) a statement that all persons identified have been notified that, on request, the intended defendant will provide relief to those persons and all others similarly situated;

(4) a complete explanation of the relief being afforded;

(5) a copy of the notice or communication the intended defendant is providing to the members of the class;

(6) a statement that the relief being afforded the consumer has been or, if the offer is accepted by the consumer, will be given within a stated reasonable time; and

(7) a statement that the practice complained of has ceased.

(c) Except as provided by Subsection (d), an attempt to comply with this section by a person receiving a demand is:

(1) an offer to compromise;

(2) not admissible as evidence; and

(3) not an admission of engaging in an unlawful act or practice.

(d) A defendant may introduce evidence of compliance or an attempt to comply with this section for the purpose of:

(1) establishing good faith; or

(2) showing compliance with this section.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 541.264. DEFENSES. Damages may not be awarded in a class action under this subchapter if the defendant:

(1) proves that the action complained of resulted from a bona fide error, notwithstanding the use of reasonable procedures adopted to avoid an error; and

(2) made restitution of any consideration received from any member of the class.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 541.265. LIMITATIONS PERIOD FOR DAMAGES. In a class action under this subchapter, damages may not include any damages incurred more than two years before the date the action is commenced.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 541.266. DISPOSITION. (a) A class action under this subchapter may not be dismissed, settled, or compromised without the approval of the court.

(b) Notice of the proposed dismissal, settlement, or compromise shall be given to all members of the class in the manner the court directs.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 541.267. CONTENTS OF JUDGMENT; NOTICE. (a) The judgment in a class action under this subchapter must describe those to whom the notice under Section 541.261 was directed and who have not requested exclusion and those the court finds to be members of the class.

(b) The court shall direct to the members of the class the best notice of the judgment practicable under the circumstances, including individual notice to each member who can be identified through reasonable effort.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

SUBCHAPTER G. DEPARTMENT ACTION FOR REFUND OF PREMIUMS

Sec. 541.301. REFUND OF PREMIUMS. (a) After notice and hearing as provided in Subchapter C, the department may require a person to make an accounting under Subsection (b):

(1) in connection with a method of competition or act or practice that is the basis of a cease and desist order issued under Section 541.108; or

(2) on application of an aggrieved person, in connection with a determination by the department that the aggrieved person and other persons similarly situated were induced to purchase an insurance policy as a result of the person engaging in a method of competition or act or practice in violation of:

(A) this chapter or a rule adopted under this chapter; or

(B) Section 17.46, Business & Commerce Code.

(b) A person required to make an accounting under this section must account for all premiums collected for policies issued by the person during the preceding two years in connection with the acts in violation of this chapter described by Subsection (a)(1) or (2).

(c) The department may require the person described by Subsection (a) to:

(1) give notice to all persons from whom the premiums were collected; and

(2) refund the total of all premiums collected from each person who elects to accept a premium refund in exchange for cancellation of the insurance policy issued.

(d) A person who refunds premiums under this section shall deduct from the amount of premiums refunded the amount of benefits actually paid by the person while the insurance policy was in force.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 541.302. TIME TO MAKE REFUNDS. The department shall specify a reasonable time within which a person required to make premium refunds under Section 541.301 must make the refunds.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 541.303. SANCTION. (a) The department may report to the

attorney general a person's failure to comply with the department's requirement to refund premiums within the time specified under Section 541.302. The department may request that the attorney general file an action to enforce the department's requirement to refund premiums.

(b) Venue for the action is in a district court in Travis County.

(c) The court shall enter an appropriate order to enforce the department's requirement to refund premiums if the court finds that:

- (1) the requirement was lawfully entered; and
- (2) the person failed to comply with the requirement.

(d) The court may enforce its order through contempt proceedings.

(e) The sanction provided by this section is in addition to any other sanctions provided in this code or other applicable laws.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 541.304. EVIDENTIARY USE OF COMPLIANCE OR ATTEMPT TO COMPLY. (a) Compliance or an attempt to comply with the department's requirement to refund premiums is:

- (1) an offer to compromise;
- (2) not admissible as evidence; and
- (3) not an admission of engaging in an unlawful act or practice.

(b) A defendant may introduce evidence of compliance or an attempt to comply with the department's requirement for the purpose of:

- (1) establishing good faith; or
- (2) showing compliance with the department's requirement.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

SUBCHAPTER H. ASSURANCE OF VOLUNTARY COMPLIANCE

Sec. 541.351. ACCEPTANCE OF ASSURANCE. (a) In administering this chapter, the department may accept assurance of voluntary compliance from a person who is engaging in, has engaged in, or is about to engage in an act or practice in violation of:

- (1) this chapter or a rule adopted under this chapter; or

(2) Section 17.46, Business & Commerce Code.

(b) The assurance must be in writing and be filed with the department.

(c) The department may condition acceptance of an assurance of voluntary compliance on the stipulation that the person offering the assurance restore to a person in interest money that may have been acquired by the act or practice described in Subsection (a).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 541.352. EFFECT OF ASSURANCE. (a) An assurance of voluntary compliance is not an admission of a prior violation of:

- (1) this chapter or a rule adopted under this chapter; or
- (2) Section 17.46, Business & Commerce Code.

(b) Unless an assurance of voluntary compliance is rescinded by agreement, a subsequent failure to comply with the assurance is prima facie evidence of a violation of:

- (1) this chapter or a rule adopted under this chapter; or
- (2) Section 17.46, Business & Commerce Code.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 541.353. REOPENING. A matter closed by the filing of an assurance of voluntary compliance may be reopened at any time.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 541.354. RIGHT TO BRING ACTION NOT AFFECTED. An assurance of voluntary compliance does not affect the right of an individual to bring an action under this chapter, except that the right of an individual in relation to money received according to a stipulation under Section 541.351(c) is governed by the terms of the assurance.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

SUBCHAPTER I. RULEMAKING

Sec. 541.401. RULEMAKING AUTHORITY. (a) The commissioner may

adopt and enforce reasonable rules the commissioner determines necessary to accomplish the purposes of this chapter.

(b) Notwithstanding a previous definition or interpretation of a term used in this chapter contained in or derived from the common law or other statutory law of this state, the commissioner may adopt an express provision necessary to accomplish the purposes of this chapter, including a provision the commissioner considers necessary to:

(1) achieve necessary uniformity with the laws of other states or the United States; or

(2) conform to the adopted procedures of the National Association of Insurance Commissioners.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 541.402. PETITION. (a) A petition may be submitted to the commissioner to adopt, amend, or repeal a rule. The petition must be:

(1) signed by 100 interested persons; and

(2) supported by evidence that:

(A) a particular act or practice has been or could be false, misleading, or deceptive to the insurance buying public; or

(B) an act or practice defined by department rule to be false, misleading, or deceptive is not false, misleading, or deceptive.

(b) Not later than the 30th day after the date the department receives the petition, the department shall:

(1) deny the petition as provided by Section 541.403; or

(2) initiate hearing proceedings under Section 541.404.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 541.403. DENIAL OF PETITION. (a) The department must state in writing the reason for denying a petition to adopt, amend, or repeal a rule.

(b) The department is expressly authorized to deny the petition if the action sought would:

(1) destroy uniformity with the laws of other states or the United States; or

(2) not conform to the adopted procedures of the National Association of Insurance Commissioners.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 541.404. HEARING ON PETITION. (a) A hearing held by the department in response to a petition to adopt, amend, or repeal a rule must be open to the public.

(b) At the hearing, any person may present to the department in writing or orally testimony, data, or other information regarding the act or practice under consideration.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 541.405. JUDICIAL REVIEW OF DEPARTMENT ACTION. (a) A person aggrieved by the denial of a petition under Section 541.402 or the adoption, amendment, or repeal of or failure to adopt a rule under this subchapter may file a petition in a district court in Travis County for:

(1) a declaratory judgment on the validity or applicability of an adopted, amended, or repealed rule; or

(2) review of the denial of a petition under Section 541.402.

(b) The commissioner must be made a party to the action.

(c) An action of the commissioner under this subchapter in adopting, amending, repealing, or failing to adopt a rule or denying a petition may be invalidated only if the court finds that the action:

(1) violates a constitutional or state statutory provision;

(2) exceeds the commissioner's statutory authority;

(3) is arbitrary or capricious or characterized by abuse of discretion or unwarranted exercise of discretion;

(4) is so vague that it does not establish sufficiently definite standards to which conduct can be conformed;

(5) is made following unlawful procedure; or

(6) is clearly erroneous in view of the reliable, probative, and substantial evidence in the whole record as submitted.

(d) The court may issue an injunction in an action under this section.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

SUBCHAPTER J. CONSTRUCTION OF CHAPTER WITH OTHER LAWS

Sec. 541.451. LIABILITY UNDER OTHER LAW. An order of the department under this chapter or an order by a court to enforce that order does not relieve or absolve a person affected by either order from liability under another law of this state.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 541.452. POWERS IN ADDITION TO OTHER POWERS AUTHORIZED BY LAW. The powers vested in the department and the commissioner by this chapter are in addition to any other powers to enforce a penalty, fine, or forfeiture authorized by law with respect to a method of competition or act or practice defined as unfair or deceptive.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 541.453. DOUBLE RECOVERY PROHIBITED. A person may not recover damages and penalties for the same act or practice under both this chapter and another law.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 541.454. PENALTIES AND RELATED PAYMENTS BY INSURER. (a) Civil penalties, premium refunds, judgments, compensatory judgments, individual recoveries, orders, class action awards, costs, damages, or attorney's fees assessed or awarded under this chapter:

(1) may be paid only from the capital or surplus funds of the offending insurer; and

(2) may not take precedence over, be in priority to, or in any other manner apply to:

(A) Chapter 462 or 463 or any other insurance guaranty act; or

(B) Chapter 422.

(b) The statutes described by Subsection (a)(2) and the

priorities of funds created by those statutes are exempt from the provisions of this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2D.006, eff. April 1, 2009.

CHAPTER 542. PROCESSING AND SETTLEMENT OF CLAIMS

SUBCHAPTER A. UNFAIR CLAIM SETTLEMENT PRACTICES

Sec. 542.001. SHORT TITLE. This subchapter may be cited as the Unfair Claim Settlement Practices Act.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 542.002. APPLICABILITY OF SUBCHAPTER. This subchapter applies to the following insurers whether organized as a proprietorship, partnership, stock or mutual corporation, or unincorporated association:

- (1) a life, health, or accident insurance company;
- (2) a fire or casualty insurance company;
- (3) a hail or storm insurance company;
- (4) a title insurance company;
- (5) a mortgage guarantee company;
- (6) a mutual assessment company;
- (7) a local mutual aid association;
- (8) a local mutual burial association;
- (9) a statewide mutual assessment company;
- (10) a stipulated premium company;
- (11) a fraternal benefit society;
- (12) a group hospital service corporation;
- (13) a county mutual insurance company;
- (14) a Lloyd's plan;
- (15) a reciprocal or interinsurance exchange; and
- (16) a farm mutual insurance company.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 542.003. UNFAIR CLAIM SETTLEMENT PRACTICES PROHIBITED.

(a) An insurer engaging in business in this state may not engage in an unfair claim settlement practice.

(b) Any of the following acts by an insurer constitutes unfair claim settlement practices:

(1) knowingly misrepresenting to a claimant pertinent facts or policy provisions relating to coverage at issue;

(2) failing to acknowledge with reasonable promptness pertinent communications relating to a claim arising under the insurer's policy;

(3) failing to adopt and implement reasonable standards for the prompt investigation of claims arising under the insurer's policies;

(4) not attempting in good faith to effect a prompt, fair, and equitable settlement of a claim submitted in which liability has become reasonably clear;

(5) compelling a policyholder to institute a suit to recover an amount due under a policy by offering substantially less than the amount ultimately recovered in a suit brought by the policyholder;

(6) failing to maintain the information required by Section 542.005; or

(7) committing another act the commissioner determines by rule constitutes an unfair claim settlement practice.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 542.004. EXAMINATION OF TAX RETURNS PROHIBITED. (a) An insurer regulated under this code may not require a claimant, as a condition of settling a claim, to produce the claimant's federal income tax returns for examination or investigation by the insurer unless:

(1) the claimant is ordered to produce the tax returns by a court; or

(2) the claim involves:

(A) a fire loss; or

(B) a loss of profits or income.

(b) An insurer that violates this section commits:

(1) a prohibited practice under this subchapter; and

(2) a deceptive trade practice under Subchapter E, Chapter 17, Business & Commerce Code.

(c) A claimant affected by a violation of this section is entitled to remedies under Subchapter E, Chapter 17, Business & Commerce Code.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 542.005. RECORD OF COMPLAINTS. (a) In this section, "complaint" means any written communication primarily expressing a grievance.

(b) An insurer shall maintain a complete record of all complaints received by the insurer during the preceding three years or since the date of the insurer's last examination by the department, whichever period is shorter. The record must indicate:

- (1) the total number of complaints;
- (2) the classification of complaints by line of insurance;
- (3) the nature of each complaint;
- (4) the disposition of the complaints; and
- (5) the time spent processing each complaint.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 542.006. PERIODIC REPORTING REQUIREMENT. (a) In this section, "claim" means a written claim filed by a resident of this state with an insurer engaging in business in this state.

(b) If, based on complaints of unfair claim settlement practices under this subchapter, the department finds that an insurer should be subjected to closer supervision with respect to the insurer's claim settlement practices, the department may require the insurer to file periodic reports at intervals the department determines necessary.

(c) Repealed by Acts 2015, 84th Leg., R.S., Ch. 42 , Sec. 3.01(4), eff. September 1, 2015.

(d) If at any time the department determines that the requirement to file a periodic report is no longer necessary to accomplish the objectives of this subchapter, the department may rescind the reporting requirement.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.
Amended by:

Acts 2015, 84th Leg., R.S., Ch. 42 (S.B. 784), Sec. 3.01(4), eff. September 1, 2015.

Sec. 542.007. COMPARISON OF CERTAIN INSURERS TO MINIMUM STANDARD OF PERFORMANCE; INVESTIGATION. (a) The department shall compile the information received from an insurer under Section 542.006 in a manner that enables the department to compare the insurer's performance to a minimum standard of performance adopted by the commissioner.

(b) If the department determines that the insurer does not meet the minimum standard of performance, the department shall investigate the insurer to determine the reason, if any, that the insurer does not meet the minimum standard.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 542.008. COMPLAINTS AGAINST INSURERS; INVESTIGATION. (a) The department shall establish a system for receiving and processing individual complaints alleging a violation of this subchapter by an insurer regardless of whether the insurer is required to file a periodic report under Section 542.006.

(b) The department shall investigate an insurer if the department determines that:

(1) based on the number and type of complaints against an insurer, the insurer does not meet the minimum standard of performance adopted under Section 542.007; or

(2) the number and type of complaints against the insurer are not proportionate to the number and type of complaints against other insurers writing similar lines of insurance.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 542.009. REVIEW OF INVESTIGATION RESULTS; HEARING. (a) On receiving the results of an investigation instituted under Section 542.007 or 542.008, the department shall review those results considering the standards of this subchapter to determine whether

further action is necessary.

(b) If the department determines that further action is necessary, the department shall:

(1) set a date for a hearing to review the alleged violations of this subchapter; and

(2) notify the insurer of:

(A) the date of the hearing; and

(B) the nature of the charges.

(c) The department shall provide the notice required by Subsection (b)(2) not later than the 30th day before the date of the hearing.

(d) At a hearing under this section, the insurer may present the insurer's case with the assistance of counsel.

(e) Evidence relating to the number and type of complaints or claims prepared by the department from information received or compiled under Section 542.006, 542.007, or 542.008 is admissible in evidence at:

(1) the hearing; and

(2) any related judicial proceeding.

(f) The hearing shall be conducted in accordance with this code and rules adopted by the commissioner.

(g) An insurer may not be found to be in violation of this subchapter solely because of the number and type of complaints or claims against the insurer.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 542.010. CEASE AND DESIST ORDER; ENFORCEMENT. (a) If the department determines that an insurer has violated this subchapter, the department shall issue a cease and desist order to the insurer directing the insurer to stop the unlawful practice.

(b) If the insurer fails to comply with the cease and desist order, the department may:

(1) revoke or suspend the insurer's certificate of authority; or

(2) limit, regulate, and control:

(A) the insurer's line of business;

(B) the insurer's writing of policy forms or other particular forms; and

(C) the volume of the insurer's:

(i) line of business; or

(ii) writing of policy forms or other particular forms.

(c) The department shall exercise authority under this section to the extent that the department determines is necessary to obtain the insurer's compliance with the cease and desist order.

(d) At the request of the department, the attorney general shall assist the department in enforcing the cease and desist order.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 542.011. TIME LIMIT TO APPEAL. An insurer affected by a ruling or order of the department under this subchapter may appeal the ruling or order, in accordance with Subchapter D, Chapter 36, by filing a petition for judicial review not later than the 20th day after the date of the ruling or order.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 542.012. ATTORNEY'S FEES. The department is entitled to reasonable attorney's fees if judicial action is necessary to enforce an order of the department under this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 542.013. PERSONNEL. The department may hire employees and examiners as needed to enforce this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 542.014. RULES. The commissioner shall adopt reasonable rules as necessary to implement and augment the purposes and provisions of this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

SUBCHAPTER B. PROMPT PAYMENT OF CLAIMS

Sec. 542.051. DEFINITIONS. In this subchapter:

- (1) "Business day" means a day other than a Saturday, Sunday, or holiday recognized by this state.
- (2) "Claim" means a first-party claim that:
 - (A) is made by an insured or policyholder under an insurance policy or contract or by a beneficiary named in the policy or contract; and
 - (B) must be paid by the insurer directly to the insured or beneficiary.
- (3) "Claimant" means a person making a claim.
- (4) "Notice of claim" means any written notification provided by a claimant to an insurer that reasonably apprises the insurer of the facts relating to the claim.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 542.052. APPLICABILITY OF SUBCHAPTER. This subchapter applies to any insurer authorized to engage in business as an insurance company or to provide insurance in this state, including:

- (1) a stock life, health, or accident insurance company;
- (2) a mutual life, health, or accident insurance company;
- (3) a stock fire or casualty insurance company;
- (4) a mutual fire or casualty insurance company;
- (5) a Mexican casualty insurance company;
- (6) a Lloyd's plan;
- (7) a reciprocal or interinsurance exchange;
- (8) a fraternal benefit society;
- (9) a stipulated premium company;
- (10) a nonprofit legal services corporation;
- (11) a statewide mutual assessment company;
- (12) a local mutual aid association;
- (13) a local mutual burial association;
- (14) an association exempt under Section 887.102;
- (15) a nonprofit hospital, medical, or dental service corporation, including a corporation subject to Chapter 842;
- (16) a county mutual insurance company;
- (17) a farm mutual insurance company;
- (18) a risk retention group;

- (19) a purchasing group;
- (20) an eligible surplus lines insurer; and
- (21) except as provided by Section 542.053(b), a guaranty association operating under Chapter 462 or 463.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2D.007, eff. April 1, 2009.

Sec. 542.053. EXCEPTION. (a) This subchapter does not apply to:

- (1) workers' compensation insurance;
- (2) mortgage guaranty insurance;
- (3) title insurance;
- (4) fidelity, surety, or guaranty bonds;
- (5) marine insurance as defined by Section 1807.001; or
- (6) a guaranty association created and operating under Chapter 2602.

(b) A guaranty association operating under Chapter 462 or 463 is not subject to the damage provisions of Section 542.060.

(c) This subchapter does not apply to a health maintenance organization except as provided by Section 1271.005(c).

(d) This subchapter does not apply to a claim governed by Subchapter C, Chapter 1301.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.
Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.009(a), eff. September 1, 2005.

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2D.008, eff. April 1, 2009.

Sec. 542.054. LIBERAL CONSTRUCTION. This subchapter shall be liberally construed to promote the prompt payment of insurance claims.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 542.055. RECEIPT OF NOTICE OF CLAIM. (a) Not later than the 15th day or, if the insurer is an eligible surplus lines insurer, the 30th business day after the date an insurer receives notice of a claim, the insurer shall:

- (1) acknowledge receipt of the claim;
- (2) commence any investigation of the claim; and
- (3) request from the claimant all items, statements, and forms that the insurer reasonably believes, at that time, will be required from the claimant.

(b) An insurer may make additional requests for information if during the investigation of the claim the additional requests are necessary.

(c) If the acknowledgment of receipt of a claim is not made in writing, the insurer shall make a record of the date, manner, and content of the acknowledgment.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 542.056. NOTICE OF ACCEPTANCE OR REJECTION OF CLAIM. (a) Except as provided by Subsection (b) or (d), an insurer shall notify a claimant in writing of the acceptance or rejection of a claim not later than the 15th business day after the date the insurer receives all items, statements, and forms required by the insurer to secure final proof of loss.

(b) If an insurer has a reasonable basis to believe that a loss resulted from arson, the insurer shall notify the claimant in writing of the acceptance or rejection of the claim not later than the 30th day after the date the insurer receives all items, statements, and forms required by the insurer.

(c) If the insurer rejects the claim, the notice required by Subsection (a) or (b) must state the reasons for the rejection.

(d) If the insurer is unable to accept or reject the claim within the period specified by Subsection (a) or (b), the insurer, within that same period, shall notify the claimant of the reasons that the insurer needs additional time. The insurer shall accept or reject the claim not later than the 45th day after the date the insurer notifies a claimant under this subsection.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 542.057. PAYMENT OF CLAIM. (a) Except as otherwise provided by this section, if an insurer notifies a claimant under Section 542.056 that the insurer will pay a claim or part of a claim, the insurer shall pay the claim not later than the fifth business day after the date notice is made.

(b) If payment of the claim or part of the claim is conditioned on the performance of an act by the claimant, the insurer shall pay the claim not later than the fifth business day after the date the act is performed.

(c) If the insurer is an eligible surplus lines insurer, the insurer shall pay the claim not later than the 20th business day after the notice or the date the act is performed, as applicable.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 542.058. DELAY IN PAYMENT OF CLAIM. (a) Except as otherwise provided, if an insurer, after receiving all items, statements, and forms reasonably requested and required under Section 542.055, delays payment of the claim for a period exceeding the period specified by other applicable statutes or, if other statutes do not specify a period, for more than 60 days, the insurer shall pay damages and other items as provided by Section 542.060.

(b) Subsection (a) does not apply in a case in which it is found as a result of arbitration or litigation that a claim received by an insurer is invalid and should not be paid by the insurer.

(c) A life insurer that receives notice of an adverse, bona fide claim to all or part of the proceeds of the policy before the applicable payment deadline under Subsection (a) shall pay the claim or properly file an interpleader action and tender the benefits into the registry of the court not later than the 90th day after the date the insurer receives all items, statements, and forms reasonably requested and required under Section 542.055. A life insurer that delays payment of the claim or the filing of an interpleader and tender of policy proceeds for more than 90 days shall pay damages and other items as provided by Section 542.060 until the claim is paid or an interpleader is properly filed.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 833 (S.B. [1812](#)), Sec. 1, eff.

June 19, 2009.

Sec. 542.059. EXTENSION OF DEADLINES. (a) A court may grant a request by a guaranty association for an extension of the periods under this subchapter on a showing of good cause and after reasonable notice to policyholders.

(b) In the event of a weather-related catastrophe or major natural disaster, as defined by the commissioner, the claim-handling deadlines imposed under this subchapter are extended for an additional 15 days.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 542.060. LIABILITY FOR VIOLATION OF SUBCHAPTER. (a) Except as provided by Subsection (c), if an insurer that is liable for a claim under an insurance policy is not in compliance with this subchapter, the insurer is liable to pay the holder of the policy or the beneficiary making the claim under the policy, in addition to the amount of the claim, interest on the amount of the claim at the rate of 18 percent a year as damages, together with reasonable and necessary attorney's fees. Nothing in this subsection prevents the award of prejudgment interest on the amount of the claim, as provided by law.

(b) If a suit is filed, the attorney's fees shall be taxed as part of the costs in the case.

(c) In an action to which Chapter 542A applies, if an insurer that is liable for a claim under an insurance policy is not in compliance with this subchapter, the insurer is liable to pay the holder of the policy, in addition to the amount of the claim, simple interest on the amount of the claim as damages each year at the rate determined on the date of judgment by adding five percent to the interest rate determined under Section 304.003, Finance Code, together with reasonable and necessary attorney's fees. Nothing in this subsection prevents the award of prejudgment interest on the amount of the claim, as provided by law. Interest awarded under this subsection as damages accrues beginning on the date the claim was required to be paid.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 151 (H.B. 1774), Sec. 2, eff. September 1, 2017.

Sec. 542.061. REMEDIES NOT EXCLUSIVE. The remedies provided by this subchapter are in addition to any other remedy or procedure provided by law or at common law.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

SUBCHAPTER C. PROVIDING CERTAIN CLAIMS INFORMATION ON REQUEST

Sec. 542.101. REQUEST BY NAMED INSURED UNDER LIABILITY

INSURANCE POLICY. (a) In this section, "liability insurance" means:

- (1) general liability insurance;
- (2) professional liability insurance, including medical professional liability insurance;
- (3) commercial automobile liability insurance; and
- (4) the liability portion of commercial multiperil insurance.

(b) On written request of a named insured under a liability insurance policy, the insurer that wrote the policy shall provide to the insured information relating to the disposition of a claim filed under the policy. The information must include:

- (1) the name of each claimant;
- (2) details relating to:
 - (A) the amount paid on the claim;
 - (B) settlement of the claim; or
 - (C) judgment on the claim;
- (3) details as to how the claim, settlement, or judgment is to be paid; and
- (4) any other information required by rule of the commissioner that the commissioner considers necessary to adequately inform an insured with regard to any claim under a liability insurance policy.

(c) A request for information under this section must be transmitted to the insurer not later than six months after the date of disposition of the claim.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 542.102. REQUEST BY POLICYHOLDER UNDER PROPERTY AND CASUALTY INSURANCE POLICY. (a) On written request of a policyholder, an insurer that writes property and casualty insurance in this state shall provide the policyholder with a list of claims charged against the policy and payments made on each claim.

(b) This section does not apply to a workers' compensation insurance policy subject to Section 2051.151.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2D.009, eff. April 1, 2009.

Sec. 542.103. DEADLINE FOR PROVIDING REQUESTED INFORMATION.

(a) An insurer shall provide the information requested under this subchapter in writing not later than the 30th day after the date the insurer receives the request for the information.

(b) For purposes of this section, information is considered to be provided on the date the information is deposited with the United States Postal Service or is personally delivered.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 542.104. RULES. The commissioner may by rule prescribe forms for requesting information and for providing requested information under this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

SUBCHAPTER C-1. REQUEST FOR CLAIMS INFORMATION BY CERTAIN OFFICIALS

Sec. 542.131. REQUEST BY CERTAIN OFFICIALS ENGAGED IN CRIMINAL INVESTIGATION. (a) This section applies only to a claim for a burglary or robbery loss or a death claim seeking life insurance proceeds that is filed with an insurance company on or after September 1, 2001.

(b) In the course of a criminal investigation and subject to

Subsection (c), the state fire marshal, the fire marshal of a political subdivision of this state, the chief of a fire department in this state, a chief of police of a municipality in this state, or a sheriff in this state may request in writing that an insurance company investigating a claimed burglary or robbery loss or a death claim seeking life insurance proceeds release information in the company's possession that relates to that claimed loss. The company shall release the information to any official authorized to request the information under this subsection if the company has reason to believe that the insurance claim is false or fraudulent.

(c) An official who requests information under this section may not request anything other than:

- (1) an insurance policy relevant to an insurance claim under investigation and the application for that policy;
- (2) policy premium payment records;
- (3) the history of the insured's previous claims; and
- (4) material relating to the investigation of the insurance claim, including:
 - (A) statements of any person;
 - (B) proof of loss; or
 - (C) other relevant evidence.

(d) This section does not authorize a public official or agency to adopt or require any form of periodic report by an insurance company.

(e) In the absence of fraud or malice, an insurance company or a person who releases information on behalf of an insurance company is not liable for damages in a civil action or subject to criminal prosecution for an oral or written statement made, or any other action taken, that relates to the information required to be released under this section.

(f) An official or department employee receiving information under this section shall maintain the confidentiality of the information until the information is required to be released during a criminal or civil proceeding.

(g) An insurance company or the company's representative may not intentionally refuse to release to an official described by Subsection (b) the information required to be released to that official under this section.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 1D.001,

eff. April 1, 2009.

**SUBCHAPTER D. NOTICE OF SETTLEMENT OF CLAIM UNDER CASUALTY INSURANCE
POLICY**

Sec. 542.151. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to the settlement of a claim under a casualty insurance policy that is delivered, issued for delivery, or renewed in this state, including a policy written by:

- (1) a county mutual insurance company;
- (2) a Lloyd's plan;
- (3) an eligible surplus lines insurer; or
- (4) a reciprocal or interinsurance exchange.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 542.152. EXCEPTION. This subchapter does not apply to:

- (1) a casualty insurance policy that requires the insured's consent to settle a claim against the insured;
- (2) fidelity, surety, or guaranty bonds; or
- (3) marine insurance as defined by Section 1807.001.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.010(a), eff. September 1, 2005.

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2D.010, eff. April 1, 2009.

Sec. 542.153. NOTICE REQUIRED. (a) Not later than the 10th day after the date an initial offer to settle a claim against a named insured under a casualty insurance policy issued to the insured is made, the insurer shall notify the insured in writing of the offer.

(b) Not later than the 30th day after the date a claim against a named insured under a casualty insurance policy issued to the insured is settled, the insurer shall notify the insured in writing of the settlement.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 542.154. RULES. The commissioner may adopt rules to implement this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

**SUBCHAPTER E. RECOVERY OF DEDUCTIBLE FROM THIRD PARTIES UNDER CERTAIN
AUTOMOBILE INSURANCE POLICIES**

Sec. 542.201. PURPOSE. This subchapter is intended to encourage insurers to take appropriate and necessary steps to collect from third parties or the insurers of the third parties.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 542.202. DEFINITION. In this subchapter, "action" includes taking various actions such as reasonable and diligent collection efforts, mediation, arbitration, and litigation against a responsible third party or the third party's insurer.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 542.203. APPLICABILITY OF SUBCHAPTER. This subchapter applies to any insurer that delivers, issues for delivery, or renews in this state a private passenger automobile insurance policy, including a reciprocal or interinsurance exchange, mutual insurance company, association, Lloyd's plan, or other insurer.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 542.204. ACTION TO RECOVER DEDUCTIBLE. (a)
Notwithstanding any other provision of this code and except as provided by Subsection (b), if an insurer is liable to an insured for a claim that is subject to a deductible payable by the insured and a third party may be liable to the insurer or the insured for the amount of the deductible, the insurer shall:

- (1) take action to recover the deductible against the third

party not later than the first anniversary of the date the insured's claim is paid; or

(2) pay the amount of the deductible to the insured.

(b) An insurer is not required to take action or pay the amount of the deductible as required by Subsection (a) if, not later than the earlier of the first anniversary of the date the insured's claim is paid or the 90th day before the date the statute of limitations for a negligence action expires, the insurer:

(1) notifies the insured in writing that the insurer does not intend to take further collection actions against the third party; and

(2) authorizes the insured to take further collection actions.

(c) This section applies regardless of whether the third party who may be liable for the amount of the deductible is insured or uninsured.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 542.205. ENFORCEMENT; RULES. The commissioner may enforce this subchapter and adopt and enforce reasonable rules necessary to accomplish the purposes of this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

SUBCHAPTER F. WATER DAMAGE CLAIMS

Sec. 542.251. PURPOSES. The purposes of this subchapter are to:

(1) provide for the prompt, efficient, and effective handling and processing of water damage claims filed under residential property insurance policies, including claims involving losses due to mold;

(2) reduce the confusion and inconvenience policyholders experience in filing and resolving water damage claims filed under residential property insurance policies, including claims involving losses due to mold; and

(3) reduce claim costs and premiums for residential property insurance issued in this state.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.011(a), eff. September 1, 2005.

Sec. 542.252. APPLICABILITY OF SUBCHAPTER. This subchapter applies to any insurer that handles or processes water damage claims filed under residential property insurance policies.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.011(a), eff. September 1, 2005.

Sec. 542.253. RULES. (a) The commissioner may adopt rules that identify the types of water damage claims that require more prompt, efficient, and effective processing and handling than the processing and handling required under Subchapter B.

(b) The commissioner by rule may regulate the following aspects of water damage claims:

- (1) required notice;
- (2) acceptance and rejection of a claim;
- (3) claim handling and processing procedures and time frames;
- (4) claim investigation requirements, procedures, and time frames;
- (5) settlement of claims; and
- (6) any other area of claim processing, handling, and response determined to be relevant and necessary by the commissioner.

(c) A rule adopted under this section supersedes the minimum standards described by Subchapter B.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.011(a), eff. September 1, 2005.

SUBCHAPTER G. INSURER'S RECOVERY FROM UNINSURED THIRD PARTY

Sec. 542.301. APPLICABILITY OF SUBCHAPTER. This subchapter applies to any insurer that delivers, issues for delivery, or renews a private passenger automobile insurance policy in this state, including a county mutual, a reciprocal or interinsurance exchange, or a Lloyd's plan.

Added by Acts 2005, 79th Leg., Ch. 1074 (H.B. 1572), Sec. 1, eff. September 1, 2005.

Redesignated from Insurance Code - Not Codified, Art/Sec 21.79H and amended by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.020(a), eff. September 1, 2007.

Redesignated from Insurance Code - Not Codified, Art/Sec 21.79H and amended by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.020(a), eff. September 1, 2007.

Sec. 542.302. RECOVERY IN SUIT OR OTHER ACTION. An insurer that brings suit or takes other action described by Section 542.202 against a responsible third party relating to a loss that is covered under a private passenger automobile insurance policy issued by the insurer and for which the responsible third party is uninsured is entitled to recover, in addition to payments made by the insurer or insured, the costs of bringing the suit or taking the action, including reasonable attorney's fees and court costs.

Added by Acts 2005, 79th Leg., Ch. 1074 (H.B. 1572), Sec. 1, eff. September 1, 2005.

Redesignated from Insurance Code - Not Codified, Art/Sec 21.79H and amended by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.020(a), eff. September 1, 2007.

Redesignated from Insurance Code - Not Codified, Art/Sec 21.79H and amended by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.020(a), eff. September 1, 2007.

CHAPTER 542A. CERTAIN CONSUMER ACTIONS RELATED TO CLAIMS FOR PROPERTY DAMAGE

Sec. 542A.001. DEFINITIONS. In this chapter:

(1) "Agent" means an employee, agent, representative, or adjuster who performs any act on behalf of an insurer.

(2) "Claim" means a first-party claim that:

(A) is made by an insured under an insurance policy providing coverage for real property or improvements to real property;

(B) must be paid by the insurer directly to the insured; and

(C) arises from damage to or loss of covered property caused, wholly or partly, by forces of nature, including an earthquake or earth tremor, a wildfire, a flood, a tornado, lightning, a hurricane, hail, wind, a snowstorm, or a rainstorm.

(3) "Claimant" means a person making a claim.

(4) "Insurer" means a corporation, association, partnership, or individual, other than the Texas Windstorm Insurance Association, engaged as a principal in the business of insurance and authorized or eligible to write property insurance in this state, including:

(A) an insurance company;

(B) a reciprocal or interinsurance exchange;

(C) a mutual insurance company;

(D) a capital stock insurance company;

(E) a county mutual insurance company;

(F) a farm mutual insurance company;

(G) a Lloyd's plan;

(H) an eligible surplus lines insurer; or

(I) the FAIR Plan Association, unless a claim-related dispute resolution procedure is available to policyholders under Chapter 2211.

(5) "Person" means a corporation, association, partnership, or other legal entity or individual.

Added by Acts 2017, 85th Leg., R.S., Ch. 151 (H.B. [1774](#)), Sec. 3, eff. September 1, 2017.

Sec. 542A.002. APPLICABILITY OF CHAPTER. (a) Except as provided by Subsection (b), this chapter applies to an action on a claim against an insurer or agent, including:

(1) an action alleging a breach of contract;

(2) an action alleging negligence, misrepresentation, fraud, or breach of a common law duty; or

(3) an action brought under:

(A) Subchapter D, Chapter 541;

(B) Subchapter B, Chapter 542; or

(C) Subchapter E, Chapter 17, Business & Commerce Code.

(b) This chapter does not apply to an action against the Texas Windstorm Insurance Association or to an action relating to or

arising from a policy ceded to an insurer by the Texas Windstorm Insurance Association under Subchapter O, Chapter 2210. This chapter applies to an action that relates to or arises from a policy renewed under Section 2210.703.

Added by Acts 2017, 85th Leg., R.S., Ch. 151 (H.B. 1774), Sec. 3, eff. September 1, 2017.

Sec. 542A.003. NOTICE REQUIRED. (a) In addition to any other notice required by law or the applicable insurance policy, not later than the 61st day before the date a claimant files an action to which this chapter applies in which the claimant seeks damages from any person, the claimant must give written notice to the person in accordance with this section as a prerequisite to filing the action.

(b) The notice required under this section must provide:

(1) a statement of the acts or omissions giving rise to the claim;

(2) the specific amount alleged to be owed by the insurer on the claim for damage to or loss of covered property; and

(3) the amount of reasonable and necessary attorney's fees incurred by the claimant, calculated by multiplying the number of hours actually worked by the claimant's attorney, as of the date the notice is given and as reflected in contemporaneously kept time records, by an hourly rate that is customary for similar legal services.

(c) If an attorney or other representative gives the notice required under this section on behalf of a claimant, the attorney or representative shall:

(1) provide a copy of the notice to the claimant; and

(2) include in the notice a statement that a copy of the notice was provided to the claimant.

(d) A presuit notice under Subsection (a) is not required if giving notice is impracticable because:

(1) the claimant has a reasonable basis for believing there is insufficient time to give the presuit notice before the limitations period will expire; or

(2) the action is asserted as a counterclaim.

(e) To ensure that a claimant is not prejudiced by having given the presuit notice required by this chapter, a court shall dismiss

without prejudice an action relating to the claim for which notice is given by the claimant and commenced:

- (1) before the 61st day after the date the claimant provides presuit notice under Subsection (a);
- (2) by a person to whom presuit notice is given under Subsection (a); and
- (3) against the claimant giving the notice.

(f) A claimant who gives notice in accordance with this chapter is not relieved of the obligation to give notice under any other applicable law. Notice given under this chapter may be combined with notice given under any other law.

(g) Notice given under this chapter is admissible in evidence in a civil action or alternative dispute resolution proceeding relating to the claim for which the notice is given.

(h) The giving of a notice under this chapter does not provide a basis for limiting the evidence of attorney's fees, damage, or loss a claimant may offer at trial.

Added by Acts 2017, 85th Leg., R.S., Ch. 151 (H.B. 1774), Sec. 3, eff. September 1, 2017.

Sec. 542A.004. INSPECTION. Not later than the 30th day after receiving a presuit notice given under Section 542A.003(a), a person to whom notice is given may send a written request to the claimant to inspect, photograph, or evaluate, in a reasonable manner and at a reasonable time, the property that is the subject of the claim. If reasonably possible, the inspection, photography, and evaluation must be completed not later than the 60th day after the date the person receives the presuit notice.

Added by Acts 2017, 85th Leg., R.S., Ch. 151 (H.B. 1774), Sec. 3, eff. September 1, 2017.

Sec. 542A.005. ABATEMENT. (a) In addition to taking any other act allowed by contract or by any other law, a person against whom an action to which this chapter applies is pending may file a plea in abatement not later than the 30th day after the date the person files an original answer in the court in which the action is pending if the person:

(1) did not receive a presuit notice complying with Section 542A.003; or

(2) requested under Section 542A.004 but was not provided a reasonable opportunity to inspect, photograph, or evaluate the property that is the subject of the claim.

(b) The court shall abate the action if the court finds that the person filing the plea in abatement:

(1) did not, for any reason, receive a presuit notice complying with Section 542A.003; or

(2) requested under Section 542A.004 but was not provided a reasonable opportunity to inspect, photograph, or evaluate the property that is the subject of the claim.

(c) An action is automatically abated without a court order beginning on the 11th day after the date a plea in abatement is filed if the plea:

(1) is verified and alleges that the person against whom the action is pending:

(A) did not receive a presuit notice complying with Section 542A.003; or

(B) requested under Section 542A.004 but was not provided a reasonable opportunity to inspect, photograph, or evaluate the property that is the subject of the claim; and

(2) is not controverted by an affidavit filed by the claimant before the 11th day after the date the plea in abatement is filed.

(d) An affidavit described by Subsection (c)(2) controverting whether the person against whom the action is pending received a presuit notice complying with Section 542A.003 must:

(1) include as an attachment a copy of the document the claimant sent to give notice of the claimant's action; and

(2) state the date on which the notice was given.

(e) An abatement under this section continues until the later of:

(1) the 60th day after the date a notice complying with Section 542A.003 is given; or

(2) the 15th day after the date of the requested inspection, photographing, or evaluating of the property is completed.

(f) If an action is abated under this section, a court may not compel participation in an alternative dispute resolution proceeding

until after the abatement period provided by Subsection (e) has expired.

Added by Acts 2017, 85th Leg., R.S., Ch. 151 (H.B. 1774), Sec. 3, eff. September 1, 2017.

Sec. 542A.006. ACTION AGAINST AGENT; INSURER ELECTION OF LEGAL RESPONSIBILITY. (a) Except as provided by Subsection (h), in an action to which this chapter applies, an insurer that is a party to the action may elect to accept whatever liability an agent might have to the claimant for the agent's acts or omissions related to the claim by providing written notice to the claimant.

(b) If an insurer makes an election under Subsection (a) before a claimant files an action to which this chapter applies, no cause of action exists against the agent related to the claimant's claim, and, if the claimant files an action against the agent, the court shall dismiss that action with prejudice.

(c) If a claimant files an action to which this chapter applies against an agent and the insurer thereafter makes an election under Subsection (a) with respect to the agent, the court shall dismiss the action against the agent with prejudice.

(d) If an insurer makes an election under Subsection (a) but, after having been served with a notice of intent to take a deposition of the agent who is the subject of the election, fails to make that agent available at a reasonable time and place to give deposition testimony, Sections 542A.007(a), (b), and (c) do not apply to the action with respect to which the insurer made the election unless the court finds that:

(1) it is impracticable for the insurer to make the agent available due to a change in circumstances arising after the insurer made the election under Subsection (a);

(2) the agent whose liability was assumed would not have been a proper party to the action; or

(3) obtaining the agent's deposition testimony is not warranted under the law.

(e) An insurer's election under Subsection (a) is ineffective to obtain the dismissal of an action against an agent if the insurer's election is conditioned in a way that will result in the insurer avoiding liability for any claim-related damage caused to the

claimant by the agent's acts or omissions.

(f) An insurer may not revoke, and a court may not nullify, an insurer's election under Subsection (a).

(g) If an insurer makes an election under Subsection (a) and the agent is not a party to the action, evidence of the agent's acts or omissions may be offered at trial and, if supported by sufficient evidence, the trier of fact may be asked to resolve fact issues as if the agent were a defendant, and a judgment against the insurer must include any liability that would have been assessed against the agent. To the extent there is a conflict between this subsection and Chapter 33, Civil Practice and Remedies Code, this subsection prevails.

(h) If an insurer is in receivership at the time the claimant commences an action against the insurer, the insurer may not make an election under Subsection (a), and the court shall disregard any prior election made by the insurer relating to the claimant's claim.

(i) In an action tried by a jury, an insurer's election under Subsection (a) may not be made known to the jury.

Added by Acts 2017, 85th Leg., R.S., Ch. 151 (H.B. [1774](#)), Sec. 3, eff. September 1, 2017.

Sec. 542A.007. AWARD OF ATTORNEY'S FEES. (a) Except as otherwise provided by this section, the amount of attorney's fees that may be awarded to a claimant in an action to which this chapter applies is the lesser of:

(1) the amount of reasonable and necessary attorney's fees supported at trial by sufficient evidence and determined by the trier of fact to have been incurred by the claimant in bringing the action;

(2) the amount of attorney's fees that may be awarded to the claimant under other applicable law; or

(3) the amount calculated by:

(A) dividing the amount to be awarded in the judgment to the claimant for the claimant's claim under the insurance policy for damage to or loss of covered property by the amount alleged to be owed on the claim for that damage or loss in a notice given under this chapter; and

(B) multiplying the amount calculated under Paragraph (A) by the total amount of reasonable and necessary attorney's fees

supported at trial by sufficient evidence and determined by the trier of fact to have been incurred by the claimant in bringing the action.

(b) Except as provided by Subsection (d), the court shall award to the claimant the full amount of reasonable and necessary attorney's fees supported at trial by sufficient evidence and determined by the trier of fact to have been incurred by the claimant in bringing the action if the amount calculated under Subsection (a)(3)(A) is:

- (1) greater than or equal to 0.8;
- (2) not limited by this section or another law; and
- (3) otherwise recoverable under law.

(c) The court may not award attorney's fees to the claimant if the amount calculated under Subsection (a)(3)(A) is less than 0.2.

(d) If a defendant in an action to which this chapter applies pleads and proves that the defendant was entitled to but was not given a presuit notice stating the specific amount alleged to be owed by the insurer under Section 542A.003(b)(2) at least 61 days before the date the action was filed by the claimant, the court may not award to the claimant any attorney's fees incurred after the date the defendant files the pleading with the court. A pleading under this subsection must be filed not later than the 30th day after the date the defendant files an original answer in the court in which the action is pending.

Added by Acts 2017, 85th Leg., R.S., Ch. 151 (H.B. 1774), Sec. 3, eff. September 1, 2017.

CHAPTER 543. PROHIBITED PRACTICES RELATED TO POLICY OR CERTIFICATE OF MEMBERSHIP

SUBCHAPTER A. PROHIBITIONS

Sec. 543.001. MISREPRESENTATION PROHIBITED. (a) In this section, "life, health, or casualty insurer" includes a corporation operating on a cooperative or assessment plan, a mutual insurance company, a fraternal benefit society, and any other society or association authorized to issue an insurance policy in this state.

(b) A life, health, or casualty insurer, an officer, director, agent, or representative of that insurer, or any other person, corporation, or copartnership may not:

- (1) issue, circulate, or cause or permit to be issued or

circulated any statement, including an illustration or estimate, that misrepresents:

- (A) the terms of a policy or certificate of membership issued by a life, health, or casualty insurer;
 - (B) other benefits or advantages provided by the policy or certificate; or
 - (C) the dividends or share of surplus to be received on the policy or certificate;
- (2) use a name or title of a policy, policy class, certificate of membership, or certificate class that misrepresents the policy, certificate, or class; or
- (3) make a misleading representation or incomplete comparison of a policy or certificate of membership to an insured or member for the purpose of inducing or tending to induce the insured or member to forfeit, surrender, or allow the lapse of the insurance or membership.

(c) The commissioner may adopt and enforce reasonable rules as provided by Subchapter I, Chapter 541, to accomplish the purposes of Subsection (b)(1) as those purposes relate to life insurance companies.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 543.002. CONTRACT EXPRESSED IN POLICY ONLY. An insurer or an agent of an insurer may not make an insurance contract or an agreement relating to an insurance contract other than as expressed in the policy issued in connection with the contract.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 543.003. THING OF VALUE NOT SPECIFIED IN POLICY. An insurer or an officer, agent, or representative of an insurer may not:

- (1) directly or indirectly pay, allow, or give or offer to pay, allow, or give as an inducement to insurance a thing of value or other inducement that is not specified in the policy, including:
 - (A) a rebate of premium payable on the policy;
 - (B) a special favor or advantage in the dividends or other benefits to accrue on the policy; or

(C) paid employment or a contract for service; or
 (2) give, sell, or purchase or offer to give, sell, or purchase as an inducement to insurance or in connection with insurance a thing of value that is not specified in the policy, including:

(A) stocks, bonds, or other securities of an insurer or other corporation, association, or partnership; or

(B) dividends or profits to accrue on the stocks, bonds, or other securities of an insurer or other corporation, association, or partnership.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 543.004. SHARING OF OR PARTICIPATION IN SPECIAL FUND PROHIBITED. An insurer or an officer, agent, or representative of an insurer may not issue a policy that contains a special or board contract or similar provision by the terms of which the policy will share or participate in a special fund derived from a tax or a charge against any portion of the premium on another policy.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

SUBCHAPTER B. ENFORCEMENT; PENALTY

Sec. 543.051. SUSPENSION OR REVOCATION OF CERTIFICATE, CHARTER, PERMIT, OR LICENSE. (a) On a hearing, the commissioner may suspend or revoke the certificate, charter, permit, or license to engage in the business of insurance of A society, association, corporation, or person that violates Subchapter A.

(b) The commissioner must give 10 days' notice of the hearing by certified mail to the society, association, corporation, or person.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 543.052. CRIMINAL PENALTY. (a) A person commits an offense if the person violates Subchapter A.

(b) An offense under this section is a Class A misdemeanor.

(c) The penalty provided by this section is in addition to any

other penalty specifically provided by law.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

CHAPTER 544. PROHIBITED DISCRIMINATION

SUBCHAPTER A. GENERAL PROHIBITIONS AGAINST DISCRIMINATION BY AN INSURER OR HEALTH MAINTENANCE ORGANIZATION

Sec. 544.001. APPLICABILITY OF SUBCHAPTER. This subchapter applies to:

(1) any legal entity engaged in the business of insurance in this state, including:

- (A) a capital stock insurance company;
- (B) a mutual insurance company;
- (C) a title insurance company;
- (D) a fraternal benefit society;
- (E) a local mutual aid association;
- (F) a statewide mutual assessment company;
- (G) a county mutual insurance company;
- (H) a Lloyd's plan;
- (I) a reciprocal or interinsurance exchange;
- (J) a stipulated premium company;
- (K) a group hospital service corporation;
- (L) a farm mutual insurance company;
- (M) a risk retention group;
- (N) an eligible surplus lines insurer; and
- (O) an agent, broker, or adjuster; and

(2) a health maintenance organization.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Amended by:

Acts 2021, 87th Leg., R.S., Ch. 355 (H.B. 4030), Sec. 4, eff. September 1, 2021.

Sec. 544.002. UNFAIR DISCRIMINATION. (a) A person may not refuse to insure or provide coverage to an individual, refuse to continue to insure or provide coverage to an individual, limit the amount, extent, or kind of coverage available for an individual, or charge an individual a rate that is different from the rate charged to other individuals for the same coverage because of the

individual's:

- (1) race, color, religion, or national origin;
- (2) age, gender, marital status, or geographic location;

or

- (3) disability or partial disability.

(b) Subsection (a)(2) does not prohibit an insurer or health maintenance organization from considering marital status in defining persons eligible for dependent benefits.

(c) Subsection (a) does not prevent requirements to provide title insurance coverage relating to possible community, homestead, or other marital rights in land.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 544.003. EXCEPTIONS. (a) A person does not violate Section 544.002 by providing coverage only to persons who are required to obtain or maintain membership or qualification for membership in a club, group, or organization to be eligible for coverage if:

(1) the requirements are uniform requirements of the insurer or health maintenance organization as a condition of providing coverage and are applied uniformly throughout this state; and

(2) the person does not engage in an act prohibited under Section 544.002 against a qualified member, except as provided by this section.

(b) A person does not violate Section 544.002(a)(2) or (3) if the refusal, limitation, or charge is based on sound underwriting or actuarial principles reasonably related to actual or anticipated loss experience. For the purposes of this subsection, a refusal, limitation, or charge relating to title insurance is based on sound actuarial principles if the action is based on an examination of title or on closing the transaction.

(c) A person does not violate Section 544.002 if the refusal, limitation, or charge is required or authorized by law or a regulatory mandate.

(d) A person does not violate Section 544.002 if policyholders or enrollees with similar expense factors but different loss exposures are charged different premiums or rates under a mass

marketing plan. The commissioner by rule shall define selected groups eligible for issuance of policies or evidences of coverage under a mass marketing plan.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 544.004. ENFORCEMENT ACTIONS. (a) A health maintenance organization or legal entity engaged in the business of insurance that is found to be in violation of or to have failed to comply with this subchapter is subject to the sanctions provided by Chapter 82 or administrative penalties authorized under Chapter 84.

(b) In addition to the procedures provided by Subsection (a), the commissioner may use the cease and desist procedures authorized by Chapter 83.

(c) It is not a defense to an action of the commissioner under this section that the contract giving rise to the alleged violation was entered into before August 28, 1995.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.012(a), eff. September 1, 2005.

SUBCHAPTER B. OTHER GENERAL PROHIBITIONS AGAINST DISCRIMINATION BY INSURERS

Sec. 544.051. APPLICABILITY OF SUBCHAPTER. This subchapter applies to any individual, corporation, association, partnership, or other legal entity engaged in the business of insurance, including:

- (1) a fraternal benefit society;
- (2) a county mutual insurance company;
- (3) a Lloyd's plan;
- (4) a reciprocal or interinsurance exchange;
- (5) a farm mutual insurance company; and
- (6) an agent, broker, or adjuster.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Amended by:

Acts 2021, 87th Leg., R.S., Ch. 355 (H.B. 4030), Sec. 5, eff. September 1, 2021.

Sec. 544.052. UNFAIR DISCRIMINATION. A person may not in any manner engage in unfair discrimination or permit unfair discrimination between individuals of the same class and of essentially the same hazard, including unfair discrimination in:

(1) the amount of premium, policy fees, or rates charged for a policy or contract of insurance;

(2) the benefits payable under a policy or contract of insurance; or

(3) any of the terms or conditions of a policy or contract of insurance.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 544.053. EXCEPTIONS. (a) A person does not violate Section 544.052 if the refusal to insure or to continue to insure, the limiting of the amount, extent, or kind of coverage, or the charging of an individual a rate that is different from the rate charged another individual for the same coverage is based on sound actuarial principles.

(b) A person does not violate Section 544.052 by providing insurance coverage only to persons who are required to obtain or maintain membership or qualification for membership in a club, group, or organization to be eligible for coverage if:

(1) the requirements are uniform requirements of the insurer as a condition of providing insurance and are applied uniformly throughout this state; and

(2) the person does not engage in an act prohibited under Section 544.052 against a qualified member, except as provided by this section.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 544.054. JUDICIAL ACTION; AWARD BY COURT. (a) A person who has sustained economic damages as the result of a violation of Section 544.052 may maintain only in a Travis County district court an action against the person who violated that section.

(b) An action under this section must be commenced on or before

the second anniversary of:

(1) the date on which the plaintiff was denied insurance or the unfair act occurred; or

(2) the date the plaintiff, in the exercise of reasonable diligence, should have discovered the occurrence of the unfair act.

(c) A plaintiff who prevails in an action under this section may obtain:

(1) the amount of economic damages, court costs, and attorney's fees; and

(2) an order enjoining the violation.

(d) Court costs under Subsection (c) may include any reasonable and necessary expert witness fees.

(e) If the trier of fact finds that the defendant knowingly committed an act prohibited by Section 544.052, the court may award a civil penalty in an amount of not more than \$25,000 for each claimant.

(f) The court shall award the defendant reasonable and necessary attorney's fees if the court finds that an action under this section was:

(1) groundless; and

(2) brought in bad faith or for the purpose of harassment.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.
Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.013(a), eff. September 1, 2005.

SUBCHAPTER C. ENGLISH FLUENCY

Sec. 544.101. DEFINITIONS. In this subchapter:

(1) "Health benefit plan issuer" means an insurance company, association, organization, group hospital service corporation, or health maintenance organization that delivers or issues for delivery an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an evidence of coverage that provides health insurance or health care benefits. The term includes:

(A) a life, health, and accident insurance company operating under Chapter 841 or 982;

(B) a general casualty insurance company operating

under Chapter 861;

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

(D) a mutual life insurance company operating under Chapter 882;

(E) a local mutual aid association operating under Chapter 886;

(F) a statewide mutual assessment company operating under Chapter 881;

(G) a mutual assessment company or mutual assessment life, health, and accident association operating under Chapter 887;

(H) a mutual insurance company operating under Chapter 883 that writes coverage other than life insurance;

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

(J) a reciprocal exchange operating under Chapter 942;
and

(K) a stipulated premium company operating under Chapter 884.

(2) "Underwriting guideline" means a written, electronic, or oral rule, standard, marketing decision, or practice that is used by a health benefit plan issuer or an agent of a health benefit plan issuer to examine, bind, accept, reject, renew or refuse to renew, cancel, or limit coverages available to classes of consumers or charge a different rate for the same coverage.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 544.102. APPLICABILITY OF SUBCHAPTER. This subchapter applies to any health insurance policy, agreement, contract, or evidence of coverage delivered or issued for delivery by a health benefit plan issuer.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 544.103. PROHIBITION ON USE OF CERTAIN GUIDELINES. (a) A health benefit plan issuer may not use an underwriting guideline that is based on:

(1) the ability of an insured or enrollee or an applicant for insurance coverage or health care benefits to speak English

fluently; or

(2) the literacy in English of the insured, enrollee, or applicant.

(b) An applicant has the burden of proof to establish a violation of this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

SUBCHAPTER D. FAMILY VIOLENCE

Sec. 544.151. DEFINITION. In this subchapter, "family violence" means an act between individuals who reside together or resided together in which one individual:

(1) wilfully attempts to cause bodily injury, or wilfully or wantonly causes bodily injury, to another;

(2) wilfully by physical threat places another in fear of imminent bodily injury;

(3) engages in the act of sexual intercourse with a minor under 16 years of age who is not the spouse of the individual; or

(4) engages, with the intent to arouse or to satisfy the sexual desires of the individual, a minor under 16 years of age who is not the spouse of the individual, or both the individual and the minor, in any lewd fondling or touching of the individual or the minor.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 544.152. APPLICABILITY OF SUBCHAPTER. (a) This subchapter applies only to:

(1) a life insurer that delivers, issues for delivery, or renews a life insurance contract or policy in this state, including a group contract, policy, or certificate of life insurance; and

(2) a health benefit plan issuer that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) an insurance company;

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

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

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

(E) a health benefit plan issuer under Chapter 1501;

(F) a health maintenance organization operating under Chapter 843;

(G) an employer under a multiple employer welfare arrangement as defined by Section 3, Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1002), or an analogous benefit arrangement, to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.);

(H) an issuer of a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss); and

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

(b) This subchapter does not apply to the issuer of:

(1) a health benefit plan that provides coverage:

(A) only for a specified disease;

(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 liability insurance;

(E) only for limited benefits; or

(F) only for dental or vision care;

(2) hospital confinement indemnity coverage;

(3) a credit insurance policy;

(4) workers' compensation insurance coverage;

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

(6) a long-term care 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 as described by Subsection (a)(2).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 544.153. PROHIBITIONS. (a) A health benefit plan issuer

or life insurer may not, because of an individual's status as a victim of family violence:

- (1) deny coverage to the individual;
- (2) refuse to renew the individual's coverage;
- (3) cancel the individual's coverage;
- (4) limit the amount, extent, or kind of coverage available to the individual; or
- (5) charge the individual or a group to which the individual belongs a rate that is different from the rate charged to other individuals or groups, respectively, for the same coverage.

(b) A health benefit plan issuer or life insurer may not, as a part of an application for coverage, require an applicant to reveal whether the applicant has been or may become a victim of family violence.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 544.154. CONFIDENTIALITY OF CERTAIN INFORMATION. (a) Except as provided by Subsection (b), a health benefit plan issuer, life insurer, or person employed by or under contract with a health benefit plan issuer or life insurer may not release information relating to the status as a victim of family violence of an individual who is clearly a victim of family violence, including:

- (1) information about specific acts of family violence directed at the individual;
- (2) the individual's address or telephone number at home or at work; and
- (3) information about the individual's employment, associations, family membership, or relationships.

(b) A health benefit plan issuer or life insurer may release information to which Subsection (a) applies only:

- (1) to the individual;
- (2) to another individual designated in writing by the individual;
- (3) to a licensed physician designated by the individual;
- (4) to a physician or other health care provider for the provision of health care services;
- (5) to an attorney who needs the information to effectively represent the issuer or insurer, if the issuer or insurer notifies

the attorney of the requirements of this subchapter and requests that the attorney exercise due diligence to protect the information consistent with the attorney's obligation to represent the issuer or insurer;

(6) to an individual covered under, or the owner of, the health benefit plan or life insurance contract or policy that contains information about status as a victim of family violence;

(7) to an individual or entity to whom the commissioner considers the release appropriate;

(8) as required by other law or an order of the commissioner or a court; or

(9) as necessary for a valid business purpose if:

(A) the information cannot be segregated from other information about the individual without undue hardship to the issuer or insurer;

(B) the recipient of the information is:

(i) a reinsurer that seeks to indemnify or indemnifies all or part of a health benefit plan or life insurance contract or policy covering the individual if the reinsurer cannot underwrite or satisfy obligations under the reinsurance agreement without the release of the information;

(ii) a party to a proposed or consummated sale, transfer, merger, or consolidation of all or part of the business of the issuer or insurer;

(iii) medical or claims personnel under contract with the issuer or insurer, including a parent or affiliate company under a service agreement with the issuer or insurer, if the release of the information is necessary to process an application, to perform duties under the health benefit plan or life insurance contract or policy, or to protect the safety or privacy of a victim of family violence; or

(iv) an entity with which the issuer transacts business if the information is only the address or telephone number of the individual and the entity cannot transact the business without the address or telephone number; and

(C) the recipient of the information agrees in writing to be subject to the requirements of this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 544.155. UNDERWRITING CRITERIA. Notwithstanding any other provision of this subchapter, a health benefit plan issuer or life insurer may underwrite a risk on the basis of an individual's physical or mental condition regardless of the underlying cause of the condition or on the basis of any underwriting criteria not prohibited by this code or another insurance law of this state or a rule adopted under this code or another insurance law of this state if the issuer or insurer consistently applies the criteria and does not merely use the criteria as a pretext to evade the application of Section 544.153.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 544.156. HEALTH BENEFIT PLAN ISSUER OR LIFE INSURER NOT LIABLE FOR DEATH OR BODILY INJURY. A health benefit plan issuer or life insurer that delivers, issues for delivery, or renews a health benefit plan or a life insurance policy or contract for an individual who has been or may become a victim of family violence may not be held civilly or criminally liable for the death of or bodily injuries incurred by that individual as a result of family violence.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 544.157. RIGHT TO CONTINUED COVERAGE UNAFFECTED. This subchapter does not affect the right of an individual to continued coverage under Subchapter G, Chapter 1251.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 544.158. UNFAIR OR DECEPTIVE ACT OR PRACTICE. A violation of this subchapter is an unfair or deceptive act or practice under Chapter 541.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

SUBCHAPTER E. FIBROCYSTIC BREAST CONDITION

Sec. 544.201. DEFINITION. In this subchapter, "health benefit

plan issuer" means an insurer, a group hospital service corporation operating under Chapter 842, or a health maintenance organization operating under Chapter 843 that delivers or issues for delivery or renews any health insurance policy or contract in this state, including a group policy, contract, or certificate of health insurance or evidence of coverage.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 544.202. PROHIBITION. A health benefit plan issuer may not, solely or in part because an individual has been diagnosed with or has a history of a fibrocystic breast condition:

- (1) deny coverage to the individual;
- (2) refuse to renew the individual's coverage;
- (3) cancel the individual's coverage;
- (4) limit the amount, extent, or kind of coverage available to the individual for any other breast condition; or
- (5) charge the individual or a group to which the individual belongs a rate that is different from the rate charged to other individuals or groups, respectively, for the same coverage.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 544.203. UNFAIR OR DECEPTIVE ACT OR PRACTICE. A violation of this subchapter is an unfair or deceptive act or practice under Chapter 541.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 544.204. PAYMENT FOR DISEASE NOT REQUIRED. This subchapter does not require a health benefit plan issuer to pay benefits for fibrocystic breast disease.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

SUBCHAPTER F. CHURCH PROPERTY

Sec. 544.251. DEFINITIONS. In this subchapter:

(1) "Church" means a facility that is owned by a religious organization and is used primarily for religious services.

(2) "Religious organization" means a church, synagogue, or other organization or association organized primarily for religious purposes.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 544.252. APPLICABILITY OF SUBCHAPTER. This subchapter applies to an insurer that is admitted to engage in the business of insurance and authorized to write an insurance policy providing coverage for losses resulting from fire in this state, including a county mutual insurance company, a Lloyd's plan, a reciprocal or interinsurance exchange, or a farm mutual insurance company.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 544.253. PROHIBITION. An insurer writing insurance for a church may not cancel or decline to renew an insurance policy solely because of:

(1) an occurrence of arson against the church, if the religious organization that owns the church cooperated with police, fire, and other authorities in the investigation of the arson and in the prosecution of those responsible for the arson; or

(2) a verbal or written threat of arson against the church that was directed to the religious organization or an official of the religious organization and that the organization or official reported to the appropriate law enforcement agency within a reasonable amount of time.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 544.254. UNFAIR OR DECEPTIVE ACT OR PRACTICE. A violation of this subchapter is an unfair or deceptive act or practice in the business of insurance under Chapter 541.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

SUBCHAPTER G. MOLD CLAIM OR DAMAGE

Sec. 544.301. DEFINITIONS. In this subchapter:

(1) "Insurer" means an insurance company, reciprocal or interinsurance exchange, mutual insurance company, capital stock company, county mutual insurance company, farm mutual insurance company, Lloyd's plan, or other legal entity authorized to write residential property insurance in this state. The term includes an affiliate, as described by Section 823.003(a), if that affiliate is authorized to write and is writing residential property insurance in this state. The term does not include:

(A) an eligible surplus lines insurer regulated under Chapter 981;

(B) the Texas Windstorm Insurance Association under Chapter 2210; or

(C) the FAIR Plan Association under Chapter 2211.

(2) "Mold" means any living or dead fungi or related products or parts, including spores, hyphae, and mycotoxins.

(3) "Mold remediation" means the removal, cleaning, sanitizing, demolition, or other treatment, including preventive activities, of mold or mold-contaminated matter that was not purposely grown at that location.

(4) "Residential property insurance" means insurance against damage to or loss of real or tangible personal property at a fixed location provided in a homeowners insurance policy or residential fire and allied lines insurance policy.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.014(a), eff. September 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2D.011, eff. April 1, 2009.

Sec. 544.302. APPLICABILITY OF SUBCHAPTER. This subchapter applies to each insurer that writes residential property insurance in this state.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.014(a), eff. September 1, 2005.

Sec. 544.303. PROHIBITION OF CERTAIN UNDERWRITING DECISIONS BASED ON PREVIOUS MOLD CLAIM OR DAMAGE. An insurer may not make an underwriting decision regarding a residential property insurance policy based on previous mold damage or a claim for mold damage if:

- (1) the applicant for insurance coverage has property eligible for coverage under a residential property policy;
- (2) the property has had mold damage;
- (3) mold remediation has been performed on the property;

and

- (4) the property was:

- (A) remediated, as evidenced by a certificate of mold remediation issued to the property owner under Section 1958.154, Occupations Code, that establishes with reasonable certainty that the underlying cause of the mold at the property has been remediated; or

- (B) inspected by an independent assessor or adjustor who determined, based on the inspection, that the property does not contain evidence of mold damage.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.014(a), eff. September 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.021(a), eff. September 1, 2007.

Sec. 544.304. RULES. The commissioner shall adopt rules as necessary to implement this subchapter.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.014(a), eff. September 1, 2005.

Sec. 544.305. PENALTY. An insurer that violates this subchapter is subject, after notice and opportunity for hearing, to sanctions as provided by Chapters 82, 83, and 84.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.014(a), eff. September 1, 2005.

SUBCHAPTER H. WATER DAMAGE CLAIMS

Sec. 544.351. PURPOSE. The purpose of this subchapter is to protect persons and property from being unfairly stigmatized in obtaining residential property insurance by the filing of a water damage claim or claims under a residential property insurance policy.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.015(a), eff. September 1, 2005.

Sec. 544.352. DEFINITIONS. In this subchapter:

(1) "Appliance" means a household device operated by gas or electric current, including hoses directly attached to the device. The term includes air conditioning units, heating units, refrigerators, dishwashers, icemakers, clothes washers, water heaters, and disposals.

(2) "Insurer" means an insurance company, reciprocal or interinsurance exchange, mutual insurance company, capital stock company, county mutual insurance company, farm mutual insurance company, association, Lloyd's plan, or other entity writing residential property insurance in this state. The term includes an affiliate, as described by Section 823.003(a), if that affiliate is authorized to write and is writing residential property insurance in this state. The term does not include:

(A) the Texas Windstorm Insurance Association created and operated under Chapter 2210; or

(B) the FAIR Plan created and operated under Chapter 2211.

(3) "Residential property insurance" means insurance against loss to residential real property at a fixed location or tangible personal property provided in a homeowners policy, which includes a tenant policy, a condominium owners policy, or a residential fire and allied lines policy.

(4) "Underwriting guideline" means a rule, standard, guideline, or practice, whether written, oral, or electronic, that is used by an insurer or an agent of an insurer to:

(A) decide whether to accept or reject an application for a residential property insurance policy; or

(B) determine how to classify the risks that are accepted for the purpose of determining a rate.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.015(a),

eff. September 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.022(a),
eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.022(a),
eff. September 1, 2007.

Sec. 544.353. RESTRICTIONS ON USE OF CLAIMS HISTORY FOR WATER DAMAGE. (a) Underwriting guidelines relating to a water damage claim or claims used by an insurer shall be governed by rules adopted by the commissioner in accordance with the purpose of this subchapter. An insurer may not use an underwriting guideline relating to a water damage claim or claims that is not in accordance with the rules adopted by the commissioner under this subchapter.

(b) An insurer shall file with the department its underwriting guidelines relating to a water damage claim or claims in accordance with the rules adopted by the commissioner.

(c) Except as provided by Subsection (e), an insurer may not use a prior appliance-related claim filed by a person as a basis for determining the rate to be paid by the person for insurance coverage or for determining whether to issue, renew, or cancel an insurance policy to or for the person if the person:

(1) properly remediated the prior appliance-related claim;
and

(2) had the remediation inspected and certified by a person or entity knowledgeable and experienced in the remediation of water damage.

(d) Except as provided by Subsection (e), an insurer may not use a prior appliance-related claim filed regarding specific property as a basis for determining the rate to be paid by a person for insurance coverage for that property or for determining whether to issue, renew, or cancel an insurance policy to or for a person seeking insurance coverage for that property if the prior appliance-related claim was properly remediated and was inspected and certified by a person knowledgeable and experienced in remediation of water damage.

(e) Subsections (c) and (d) do not apply to:

(1) a person who has made and has received payment for three or more appliance-related claims within a three-year period; or

(2) specific property that has been the subject of three or more appliance-related claims within a three-year period.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.015(a), eff. September 1, 2005.

Sec. 544.354. RULES. The commissioner shall adopt rules to accomplish the purposes of this subchapter, including rules with regard to the definition of a water damage claim.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.015(a), eff. September 1, 2005.

SUBCHAPTER I. CRIMINAL OFFENSES

Sec. 544.401. OFFENSE: CERTAIN DISCRIMINATION. (a) In this section, "person" means a legal entity listed below and engaged in the business of life insurance or an officer or director of one of those entities:

- (1) a capital stock insurance company;
- (2) a mutual insurance company;
- (3) a local mutual aid association;
- (4) a statewide mutual assessment company; or
- (5) a stipulated premium company.

(b) A person commits an offense if the person recklessly:

(1) offers insurance coverage at a premium based on a rate that is, because of race, color, religion, ethnicity, or national origin, different from another premium rate offered or used by the person for the same coverage, other than for classifications applicable alike to persons of every race, color, religion, ethnicity, or national origin; or

(2) collects an insurance premium based on a rate that is, because of race, color, religion, ethnicity, or national origin, different from another premium rate offered or used by the person for the same coverage, other than for classifications applicable alike to persons of every race, color, religion, ethnicity, or national origin.

(c) An offense under this section is a state jail felony.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.016(a),

eff. September 1, 2005.

**SUBCHAPTER J. PROHIBITED PRACTICES RELATING TO EXPOSURE TO ASBESTOS
OR SILICA**

Sec. 544.451. DEFINITION. In this subchapter, "health benefit plan" means a plan that provides benefits for medical, surgical, or other treatment expenses incurred as a result of a health condition, a mental health condition, an accident, sickness, or substance abuse, 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. The term includes:

- (1) a small employer health benefit plan or a health benefit plan written to provide coverage with a cooperative under Chapter 1501;
- (2) a standard health benefit plan offered under Subchapter A or Subchapter B, Chapter 1507; and
- (3) a health benefit plan offered under Chapter 1551, 1575, 1579, or 1601.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 3B.023(a), eff. September 1, 2007.

Added by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. [3167](#)), Sec. 9.023(a), eff. September 1, 2007.

Sec. 544.452. APPLICABILITY OF SUBCHAPTER. This subchapter applies to any entity that offers a health benefit plan or an annuity or life insurance policy or contract in this state, including:

- (1) a stock or mutual life, health, or accident insurance company;
- (2) a group hospital service corporation operating under Chapter 842;
- (3) a fraternal benefit society operating under Chapter 885;
- (4) a stipulated premium insurance company operating under Chapter 884;
- (5) a Lloyd's plan operating under Chapter 941;
- (6) an exchange operating under Chapter 942;

- (7) a health maintenance organization operating under Chapter 843;
- (8) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846;
- (9) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844;
- (10) a statewide mutual assessment company operating under Chapter 881;
- (11) a local mutual aid association operating under Chapter 886; and
- (12) a local mutual burial association operating under Chapter 888.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.023(a), eff. September 1, 2007.

Added by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.023(a), eff. September 1, 2007.

Sec. 544.453. PROHIBITION. An entity that offers a health benefit plan or an annuity or life insurance policy or contract may not use the fact that a person has been exposed to asbestos fibers or silica or has filed a claim governed by Chapter 90, Civil Practice and Remedies Code, to reject, deny, limit, cancel, refuse to renew, increase the premiums for, or otherwise adversely affect the person's eligibility for or coverage under the policy or contract.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.023(a), eff. September 1, 2007.

Added by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.023(a), eff. September 1, 2007.

SUBCHAPTER K. PREVIOUS DENIAL OF HEALTH BENEFIT PLAN COVERAGE

Sec. 544.501. DEFINITION. In this subchapter, "individual health benefit plan" means:

- (1) an individual accident and health insurance policy to which Chapter 1201 applies; or
- (2) individual health maintenance organization coverage.

Added by Acts 2005, 79th Leg., Ch. 748 (H.B. 2810), Sec. 1, eff.

September 1, 2005.

Renumbered from Insurance Code, Section 544.301 by Acts 2009, 81st Leg., R.S., Ch. 87 (S.B. 1969), Sec. 27.001(61), eff. September 1, 2009.

Sec. 544.502. LIMITATION ON CERTAIN INQUIRIES. A health benefit plan issuer may ask an individual who is an applicant for an individual health benefit plan or any other person or entity whether the applicant has previously been denied health benefit plan coverage only for the purpose of determining whether to ask for other information relating to a factor used by the insurer in underwriting the coverage. The insurer may not consider a determination that the applicant has or has not previously been denied health benefit plan coverage in underwriting the coverage for which the applicant has applied.

Added by Acts 2005, 79th Leg., Ch. 748 (H.B. 2810), Sec. 1, eff. September 1, 2005.

Renumbered from Insurance Code, Section 544.302 by Acts 2009, 81st Leg., R.S., Ch. 87 (S.B. 1969), Sec. 27.001(61), eff. September 1, 2009.

Sec. 544.503. VIOLATION OF SUBCHAPTER; UNFAIR DISCRIMINATION. A health benefit plan issuer who violates this subchapter engages in unfair discrimination under Subchapter B.

Added by Acts 2005, 79th Leg., Ch. 748 (H.B. 2810), Sec. 1, eff. September 1, 2005.

Renumbered from Insurance Code, Section 544.303 by Acts 2009, 81st Leg., R.S., Ch. 87 (S.B. 1969), Sec. 27.001(61), eff. September 1, 2009.

SUBCHAPTER L. CONSUMER INQUIRY

Sec. 544.551. DEFINITION. In this subchapter, "consumer inquiry" has the meaning assigned by Section 551.113 for "customer inquiry."

Added by Acts 2013, 83rd Leg., R.S., Ch. 570 (S.B. 736), Sec. 1, eff.

September 1, 2013.

Sec. 544.552. APPLICABILITY. This subchapter applies only to:

(1) a standard fire, homeowners, or farm and ranch owners insurance policy, including such policies written by:

(A) a farm mutual insurance company;

(B) a county mutual insurance company;

(C) a Lloyd's plan; and

(D) a reciprocal or interinsurance exchange; or

(2) a personal automobile insurance policy, including a policy written by a county mutual insurance company.

Added by Acts 2013, 83rd Leg., R.S., Ch. 570 (S.B. 736), Sec. 1, eff. September 1, 2013.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 592 (S.B. 188), Sec. 1, eff. September 1, 2015.

Acts 2015, 84th Leg., R.S., Ch. 1137 (S.B. 189), Sec. 1, eff. September 1, 2015.

Reenacted and amended by Acts 2017, 85th Leg., R.S., Ch. 324 (S.B. 1488), Sec. 10.001, eff. September 1, 2017.

Sec. 544.553. PROHIBITION OF UNDERWRITING AND RATING DECISIONS BASED ON CONSUMER INQUIRY. An insurer may not:

(1) use an underwriting guideline based solely on whether a consumer inquiry has been made by or on behalf of the applicant or insured; or

(2) charge a rate that is different from the rate charged to other individuals for the same coverage or increase a rate charged to an insured based solely on whether a consumer inquiry has been made by or on behalf of the applicant or insured.

Added by Acts 2013, 83rd Leg., R.S., Ch. 570 (S.B. 736), Sec. 1, eff. September 1, 2013.

SUBCHAPTER M. POLITICAL AFFILIATION AND EXPRESSION

Sec. 544.601. APPLICABILITY OF SUBCHAPTER. This subchapter applies to:

(1) any legal entity engaged in the business of insurance in this state, including:

- (A) a capital stock insurance company;
- (B) a mutual insurance company;
- (C) a title insurance company;
- (D) a fraternal benefit society;
- (E) a local mutual aid association;
- (F) a statewide mutual assessment company;
- (G) a county mutual insurance company;
- (H) a Lloyd's plan;
- (I) a reciprocal or interinsurance exchange;
- (J) a stipulated premium company;
- (K) a group hospital service corporation;
- (L) a farm mutual insurance company;
- (M) a risk retention group;
- (N) an eligible surplus lines insurer; and
- (O) an agent, broker, adjuster, or life and health

insurance counselor; and

(2) a health maintenance organization.

Added by Acts 2021, 87th Leg., R.S., Ch. 926 (H.B. 3433), Sec. 1, eff. September 1, 2021.

Sec. 544.602. PROHIBITION. Except as provided by Section 544.603, a person may not refuse to insure or provide coverage to an individual, refuse to continue to insure or provide coverage to an individual, limit the amount, extent, or kind of coverage available for an individual, or charge an individual a rate that is different from the rate charged to other individuals for the same coverage because of the individual's political affiliation or expression.

Added by Acts 2021, 87th Leg., R.S., Ch. 926 (H.B. 3433), Sec. 1, eff. September 1, 2021.

Sec. 544.603. EXCEPTIONS. A person does not violate Section 544.602 if the refusal, limitation, or charge is:

- (1) based on sound underwriting or actuarial principles reasonably related to actual or anticipated loss experience; or
- (2) required or authorized by law or a regulatory mandate.

Added by Acts 2021, 87th Leg., R.S., Ch. 926 (H.B. 3433), Sec. 1, eff. September 1, 2021.

Sec. 544.604. ENFORCEMENT ACTIONS. (a) A health maintenance organization or legal entity engaged in the business of insurance that is found to be in violation of or to have failed to comply with this subchapter is subject to the sanctions provided by Chapter 82 or administrative penalties authorized under Chapter 84.

(b) In addition to the procedures provided by Subsection (a), the commissioner may use the cease and desist procedures authorized by Chapter 83.

Added by Acts 2021, 87th Leg., R.S., Ch. 926 (H.B. 3433), Sec. 1, eff. September 1, 2021.

SUBCHAPTER N. LIVING ORGAN DONORS

Sec. 544.651. DEFINITION. In this subchapter, "living organ donor" means a living individual who donates an organ to another individual.

Added by Acts 2021, 87th Leg., R.S., Ch. 71 (H.B. 317), Sec. 2, eff. September 1, 2021.

Redesignated by Acts 2023, 88th Leg., R.S., Ch. 768 (H.B. 4595), Sec. 24.001(26), eff. September 1, 2023.

Sec. 544.652. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a life insurance policy or contract, disability insurance policy, or long-term care insurance policy.

Added by Acts 2021, 87th Leg., R.S., Ch. 71 (H.B. 317), Sec. 2, eff. September 1, 2021.

Redesignated by Acts 2023, 88th Leg., R.S., Ch. 768 (H.B. 4595), Sec. 24.001(26), eff. September 1, 2023.

Sec. 544.653. PROHIBITIONS. (a) An insurer may not, based solely on the status of an individual as a living organ donor:

- (1) deny coverage to the individual;

- (2) refuse to renew the individual's coverage;
- (3) cancel the individual's coverage;
- (4) limit the amount, extent, or kind of coverage available to the individual; or
- (5) charge the individual or a group to which the individual belongs a rate that is different than the rate charged to other individuals or groups, as applicable, for the same coverage unless the rate differential is based on sound actuarial principles or sound underwriting related to actual or anticipated loss experience for a particular risk.

(b) An insurer may not prevent an insured from donating all or part of an organ as a condition of continuing coverage.

Added by Acts 2021, 87th Leg., R.S., Ch. 71 (H.B. 317), Sec. 2, eff. September 1, 2021.

Redesignated by Acts 2023, 88th Leg., R.S., Ch. 768 (H.B. 4595), Sec. 24.001(26), eff. September 1, 2023.

CHAPTER 545. HIV TESTING

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 545.001. DEFINITIONS. In this chapter:

- (1) "AIDS" has the meaning assigned by Section 81.101, Health and Safety Code.
- (2) "Applicant" means an individual who applies to an issuer for coverage.
- (3) "HIV" has the meaning assigned by Section 81.101, Health and Safety Code.
- (4) "Issuer" means a person who delivers, issues for delivery, or renews coverage in this state, including a group policy, contract, or certificate of health insurance or evidence of coverage delivered, issued for delivery, or renewed in this state by an insurer, including a group hospital service corporation operating under Chapter 842, or by a health maintenance organization operating under Chapter 843.
- (5) "Test result" means a statement:
 - (A) that an identifiable individual is positive, negative, at risk, or has or does not have a certain level of antigen or antibody; or
 - (B) that indicates that an identifiable individual has

or has not been tested for AIDS or HIV infection, antibodies to HIV, or infection with any other probable causative agent of AIDS.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 545.002. EXCLUSIVE APPLICABILITY. This chapter and rules adopted under this chapter exclusively govern the practices of an issuer in testing applicants to determine or help determine if an applicant has:

- (1) AIDS or HIV infection;
- (2) antibodies to HIV; or
- (3) an infection with any other probable causative agent of

AIDS.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 545.003. RULES. The commissioner may adopt:

- (1) reasonable rules and forms necessary to implement this chapter; and
- (2) rules to be followed for an HIV-related test requested or required by an issuer.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

SUBCHAPTER B. ISSUER POWERS AND DUTIES

Sec. 545.051. HIV-RELATED TESTING AUTHORIZED. An issuer may request or require an applicant to take an HIV-related test in connection with the application.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 545.052. NONDISCRIMINATORY BASIS REQUIRED. (a) An issuer that requests or requires applicants to take an HIV-related test must request or require the test on a nondiscriminatory basis.

(b) An issuer may require an applicant to take an HIV-related test only if:

- (1) the test is based on the applicant's current medical

condition or medical history; or

(2) underwriting guidelines for the coverage amounts require all applicants in the risk class to be tested.

(c) In determining who will be requested or required to take an HIV-related test, an issuer may not use the marital status, occupation, sex, beneficiary designation, or territorial classification, including zip code, of an applicant.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 545.053. EXPLANATION AND AUTHORIZATION REQUIRED. (a) An issuer that requests or requires an applicant to take an HIV-related test in connection with an application must:

(1) provide an explanation to the applicant, or another person legally authorized to consent to the test, of how the test will be used; and

(2) obtain a written authorization from the person to whom the explanation is provided.

(b) The authorization must:

(1) be on a form adopted by the commissioner; and

(2) be separate from any other document presented to the applicant or other person legally authorized to consent to the test.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 545.054. INQUIRIES REGARDING PREVIOUS TESTS. (a) An issuer may inquire whether an applicant has:

(1) tested positive on an HIV-related test; or

(2) been diagnosed with HIV or AIDS.

(b) An issuer may not inquire whether an applicant has been tested for or has received a negative result from a specific test for:

(1) exposure to HIV; or

(2) a sickness or a medical condition derived from infection with HIV.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 545.055. NOTICE OF POSITIVE TEST RESULT; FEE. (a) An applicant must be given written notice of a positive HIV-related test result by:

- (1) a physician designated by the applicant; or
- (2) the Texas Department of Health, if the applicant has not designated a physician.

(b) The Texas Department of Health by rule may set a fee, not to exceed \$25, to cover the cost of giving written notice under this section.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 545.056. ADVERSE UNDERWRITING DECISION; TEST PROTOCOL RULES. An issuer may not make an adverse underwriting decision based on a positive HIV-related test unless a test protocol established by commissioner rule is followed.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 545.057. CONFIDENTIALITY OF TEST RESULT REQUIRED. (a) An HIV-related test result is confidential.

(b) An issuer may not release or disclose the test result or otherwise allow the test result to become known except as:

- (1) required by law; or
- (2) requested or authorized in writing by the applicant or a person legally authorized to consent to the test on the applicant's behalf.

(c) A test result released under Subsection (b)(2) may be released only to:

- (1) the applicant;
- (2) a person legally authorized to consent to the test;
- (3) a licensed physician, medical practitioner, or other person designated by the applicant;
- (4) an insurance medical information exchange under procedures designed to ensure confidentiality, including the use of general codes that cover results of tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular applicant;

(5) a reinsurer, if the reinsurer is involved in the underwriting process, under procedures designed to ensure confidentiality;

(6) persons within the issuer's organization who have the responsibility to make underwriting decisions for the issuer; or

(7) outside legal counsel that needs the information to effectively represent the issuer regarding the applicant.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

SUBCHAPTER O. SANCTIONS; PENALTIES; INJUNCTIONS

Sec. 545.701. SANCTIONS. The commissioner may impose sanctions under Chapter 82 on an issuer that violates this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 545.702. CIVIL ACTION; PENALTY. (a) A person who is injured by a violation of Section 545.057 may bring a civil action for damages.

(b) A person may bring an action to restrain a violation or threatened violation of Section 545.057.

(c) If it is found in a civil action that a person or entity has released or disclosed a test result or allowed a test result to become known in violation of Section 545.057, the person or entity is liable for:

(1) actual damages;

(2) a civil penalty of:

(A) not more than \$1,000 if the release or disclosure was negligent; or

(B) not less than \$1,000 or more than \$5,000 if the release or disclosure was wilful; and

(3) court costs and reasonable attorney's fees incurred by the person bringing the action.

(d) A defendant in a civil action brought under this section is not entitled to claim a privilege as a defense to the action.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 545.703. CRIMINAL PENALTY. (a) A person or entity commits an offense if the person or entity, with criminal negligence, violates Section 545.057 by:

- (1) releasing or disclosing a test result or other information; or
- (2) allowing a test result or other information to become known.

(b) An offense under this section is a Class A misdemeanor.

(c) Each release or disclosure made or allowance of a test result to become known in violation of this chapter constitutes a separate offense.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

CHAPTER 546. USE OF GENETIC TESTING INFORMATION

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 546.001. DEFINITIONS. In this chapter:

- (1) "DNA" means deoxyribonucleic acid.
- (2) "Genetic characteristic" means a scientifically or medically identifiable genetic or chromosomal variation, composition, or alteration that predisposes an individual to a disease, disorder, or syndrome.
- (3) "Genetic information" means information that is:
 - (A) obtained from or based on a scientific or medical determination of the presence or absence in an individual of a genetic characteristic; or
 - (B) derived from the results of a genetic test performed on an individual.
- (4) "Genetic test" means a presymptomatic laboratory test of an individual's genes, gene products, or chromosomes that:
 - (A) analyzes the individual's DNA, RNA, proteins, or chromosomes; and
 - (B) is performed to identify any genetic variation, composition, or alteration that is associated with the individual's having a predisposition for:
 - (i) developing a clinically recognized disease, disorder, or syndrome; or
 - (ii) being a carrier of a clinically recognized disease, disorder, or syndrome.

The term does not include a blood test, cholesterol test, urine test, or other physical test used for a purpose other than determining a genetic or chromosomal variation, composition, or alteration in a specific individual; a routine physical examination or a routine test performed as part of a physical examination; a test to determine drug use; or a test to determine the presence of the human immunodeficiency virus.

(5) "RNA" means ribonucleic acid.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 546.002. APPLICABILITY OF CHAPTER. This chapter applies only to a health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(i) an insurance company;

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

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

(iv) a stipulated premium company operating under Chapter 884; or

(v) a health maintenance organization operating under Chapter 843; and

(B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:

(i) a multiple employer welfare arrangement as defined by Section 3 of that Act;

(ii) another entity not authorized under this code or another insurance law of this state that directly contracts for health care services on a risk-sharing basis, including a capitation basis; or

(iii) another analogous benefit arrangement; or

(2) is offered by an approved nonprofit health corporation that holds a certificate of authority under Chapter 844.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.
Amended by:

Acts 2005, 79th Leg., Ch. 670 (S.B. 53), Sec. 1, eff. September 1, 2005.

Sec. 546.003. EXCEPTIONS. This chapter does not apply to:

- (1) a plan that provides coverage:
 - (A) only for a specified disease;
 - (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; or
 - (D) as a supplement to liability insurance;
- (2) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);
- (3) workers' compensation insurance coverage;
- (4) medical payment insurance coverage provided under a motor vehicle insurance policy; or
- (5) a long-term care 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 as described by Section 546.002.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.
Amended by:

Acts 2005, 79th Leg., Ch. 670 (S.B. 53), Sec. 2, eff. September 1, 2005.

SUBCHAPTER B. GENETIC TESTING AND USE OF TEST RESULTS

Sec. 546.051. CERTAIN TESTING PERMITTED; INDUCEMENT PROHIBITED.

(a) A health benefit plan issuer that requests an applicant for coverage under the plan to submit to a genetic test in connection with the application for coverage for a purpose not prohibited under Section 546.052 must:

- (1) notify the applicant that the test is required;
- (2) disclose to the applicant the proposed use of the test

results; and

(3) obtain the applicant's written informed consent before the test is administered.

(b) The applicant shall state in the consent form whether the applicant elects to be informed of the test results. If the applicant elects to be informed, the person or entity that performs the test shall disclose the test results to the applicant and the health benefit plan issuer. The issuer shall ensure that:

(1) the applicant receives an interpretation of the test results made by a qualified health care practitioner; and

(2) a physician or other health care practitioner designated by the applicant receives a copy of the test results.

(c) A health benefit plan issuer may not use the results of a genetic test conducted in accordance with Subsection (a) to induce the purchase of coverage under the plan.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.
Amended by:

Acts 2005, 79th Leg., Ch. 670 (S.B. 53), Sec. 3, eff. September 1, 2005.

Sec. 546.052. IMPROPER USE OF TEST RESULTS; REFUSAL TO SUBMIT TO TESTING. A health benefit plan issuer may not use genetic information or the refusal of an applicant to submit to a genetic test to reject, deny, limit, cancel, refuse to renew, increase the premiums for, or otherwise adversely affect eligibility for or coverage under the plan.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.
Amended by:

Acts 2005, 79th Leg., Ch. 670 (S.B. 53), Sec. 4, eff. September 1, 2005.

Sec. 546.053. TESTING RELATED TO PREGNANCY. (a) In this section, "coerce" means to restrain or dominate a woman's free will by actual or implied:

(1) force; or

(2) threat of rejecting, denying, limiting, canceling, refusing to renew, or otherwise adversely affecting eligibility for

coverage under a health benefit plan.

(b) A health benefit plan issuer may not:

- (1) require as a condition of coverage genetic testing of a child in utero without the pregnant woman's consent; or
- (2) use genetic information to coerce or compel a pregnant woman to have an induced abortion.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 670 (S.B. 53), Sec. 5, eff. September 1, 2005.

Sec. 546.054. DESTRUCTION OF SAMPLE MATERIAL; EXCEPTIONS. A sample of genetic material obtained from an individual for a genetic test shall be destroyed promptly after the purpose for which the sample was obtained is accomplished unless:

- (1) the sample is retained under a court order;
- (2) the individual authorizes retention of the sample for medical treatment or scientific research;
- (3) the sample was obtained for research that is cleared by an institutional review board and retention of the sample is:
 - (A) under a requirement the institutional review board imposes on a specific research project; or
 - (B) authorized by the research participant with institutional review board approval under federal law; or
- (4) the sample was obtained for a screening test established by the Texas Department of Health under Section 33.011, Health and Safety Code, and performed by that department or a laboratory approved by that department.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

SUBCHAPTER C. DISCLOSURE OF GENETIC INFORMATION; CONFIDENTIALITY; EXCEPTIONS

Sec. 546.101. DISCLOSURE OF TEST RESULTS TO INDIVIDUAL TESTED.

- (a) An individual who submits to a genetic test has the right to know the results of the test. On the written request by the individual, the health benefit plan issuer or other entity that performed the test shall disclose the test results to:

- (1) the individual; or
- (2) a physician designated by the individual.

(b) The right to receive information under this section is in addition to any right or requirement established under Sections 546.051 and 546.052.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.
Amended by:

Acts 2005, 79th Leg., Ch. 670 (S.B. 53), Sec. 6, eff. September 1, 2005.

Sec. 546.102. CONFIDENTIALITY OF GENETIC INFORMATION. (a) Except as provided by Sections 546.103(a) and (b), genetic information is confidential and privileged regardless of the source of the information.

(b) A person or entity that holds genetic information about an individual may not disclose or be compelled to disclose, by subpoena or otherwise, that information unless the disclosure is specifically authorized by the individual as provided by Section 546.104.

(c) This section applies to a redisclosure of genetic information by a secondary recipient of the information after disclosure of the information by an initial recipient. Except as provided by Section 546.103(b), a health benefit plan issuer may not redisclose genetic information unless the redisclosure is consistent with the disclosures authorized by the tested individual under an authorization executed under Section 546.104.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.
Amended by:

Acts 2005, 79th Leg., Ch. 670 (S.B. 53), Sec. 7, eff. September 1, 2005.

Sec. 546.103. EXCEPTIONS TO CONFIDENTIALITY. (a) Subject to Subchapter G, Chapter 411, Government Code, genetic information may be disclosed without an authorization under Section 546.104 if the disclosure is:

(1) authorized under a state or federal criminal law relating to:

- (A) the identification of individuals; or

(B) a criminal or juvenile proceeding, an inquest, or a child fatality review by a multidisciplinary child-abuse team;

(2) required under a specific order of a state or federal court;

(3) for the purpose of establishing paternity as authorized under a state or federal law;

(4) made to provide genetic information relating to a decedent and the disclosure is made to the blood relatives of the decedent for medical diagnosis; or

(5) made to identify a decedent.

(b) A health benefit plan issuer may redisclose genetic information without an authorization under Section 546.104:

(1) for actuarial or research studies if:

(A) a tested individual could not be identified in any actuarial or research report; and

(B) any materials that identify a tested individual are returned or destroyed as soon as reasonably practicable;

(2) to the department for the purpose of enforcing this chapter; or

(3) for a purpose directly related to enabling a business decision to be made about:

(A) purchasing, transferring, merging, or selling all or part of an insurance business; or

(B) obtaining reinsurance affecting that insurance business.

(c) A redisclosure authorized under Subsection (b) may contain only information reasonably necessary to accomplish the purpose for which the information is disclosed.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 670 (S.B. 53), Sec. 8, eff. September 1, 2005.

Sec. 546.104. AUTHORIZED DISCLOSURE. An individual or an individual's legal representative may authorize disclosure of genetic information relating to the individual by an authorization that:

(1) is written in plain language;

(2) is dated;

(3) contains a specific description of the information to be disclosed;

(4) identifies or describes each person authorized to disclose the genetic information to a health benefit plan issuer;

(5) identifies or describes the individuals or entities to whom the disclosure or subsequent redisclosure of the genetic information may be made;

(6) describes the specific purpose of the disclosure;

(7) is signed by the individual or legal representative and, if the disclosure is made to claim proceeds of an affected life insurance policy, the claimant; and

(8) advises the individual or legal representative that the individual's authorized representative is entitled to receive a copy of the authorization.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 670 (S.B. 53), Sec. 9, eff. September 1, 2005.

SUBCHAPTER D. ENFORCEMENT

Sec. 546.151. CEASE AND DESIST ORDER. (a) On a finding by the commissioner that a health benefit plan issuer is in violation of this chapter, the commissioner may issue a cease and desist order in the manner provided by Chapter 83.

(b) If a health benefit plan issuer refuses or fails to comply with a cease and desist order issued under this section, the commissioner may, in the manner provided by this code and other insurance laws of this state, revoke or suspend the issuer's certificate of authority or other authorization to operate a health benefit plan in this state.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 670 (S.B. 53), Sec. 10, eff. September 1, 2005.

Sec. 546.152. ADMINISTRATIVE PENALTY. A health benefit plan issuer that operates a plan in violation of this chapter is subject

to an administrative penalty as provided by Chapter 84.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 670 (S.B. 53), Sec. 11, eff. September 1, 2005.

CHAPTER 547. FALSE ADVERTISING BY UNAUTHORIZED INSURERS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 547.001. DEFINITIONS. In this chapter:

- (1) "Alien or foreign insurer" means an insurance company organized under the laws of:
- (A) a country other than the United States; or
 - (B) a state of the United States other than this state.
- (2) "Resident" includes a domestic, alien, or foreign:
- (A) corporation;
 - (B) partnership; or
 - (C) person.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 547.002. CONSTRUCTION OF CHAPTER. This chapter shall be construed liberally.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

SUBCHAPTER B. PROHIBITION; ENFORCEMENT

Sec. 547.051. ACTS PROHIBITED. (a) This section applies only to an insurer's misrepresentation of:

- (1) the insurer's financial condition;
- (2) the terms of an existing or future contract;
- (3) the benefits or advantages promised by an existing or future contract; or
- (4) the dividends or share of surplus to be received on an existing or future contract.

(b) An unauthorized alien or foreign insurer may not:

- (1) make, issue, circulate, or cause to be made, issued, or circulated to a resident of this state a misrepresentation in an

advertisement, estimate, illustration, circular, pamphlet, or letter that violates Chapter 541; or

(2) cause to be made to a resident of this state in a newspaper, magazine, or other publication, or over a radio or television station, a misrepresentation in an announcement or statement that violates Chapter 541.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 547.052. NOTICE OF VIOLATION TO INSURER'S DOMICILIARY STATE. (a) In this section, the domiciliary state of an alien insurer is the state of entry or the state of the insurer's principal office in the United States.

(b) If the department has reason to believe that an insurer has engaged in an act prohibited by Section 547.051, the department shall notify, by registered mail, the insurer and the insurance supervisory official of the insurer's domiciliary state.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 547.053. ENFORCEMENT ACTION. The department shall take action under Chapter 541 against an insurer notified under Section 547.052 if:

(1) after the 30th day following the date of notice, the insurer has not stopped making, issuing, or circulating or causing to be made, issued, or circulated in this state the false misrepresentations; and

(2) the department has reason to believe that:

(A) the insurer is issuing or delivering insurance contracts to residents of this state or is collecting premiums on those contracts; and

(B) a department proceeding regarding the misrepresentations is in the public interest.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

CHAPTER 548. INSURER INSIDER TRADING AND PROXY REGULATION
SUBCHAPTER A. GENERAL PROVISIONS

Sec. 548.001. PURPOSE. (a) The purpose of this chapter is to provide for protection of the public interest, investors, and shareholders of domestic stock insurers by:

- (1) regulating proxy solicitation by domestic stock insurers;
- (2) regulating transactions by officers, directors, and principal equity security holders of domestic stock insurers; and
- (3) requiring appropriate reporting of those solicitations and transactions.

(b) To that end the misuse of information by certain insiders of domestic stock insurers shall be prevented and a full and fair disclosure of all material matters relevant to the exercise of the corporate franchise of a shareholder of such an insurer will be promoted and the free exercise of that franchise will be assured.

(c) In exercising the authority granted by this chapter to adopt rules, the commissioner shall promote the purposes of this chapter to prevent misuse of information and to encourage good faith dealing and full and fair disclosure.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 548.002. DEFINITIONS. In this chapter:

(1) "Domestic stock insurer" includes a domestic title insurance company regulated by Title 11 and a stipulated premium company regulated by Chapter 884.

(2) "Equity security" means:

- (A) a stock or similar security;
- (B) a security that:
 - (i) is convertible, with or without consideration, into an equity security; or
 - (ii) carries a warrant or right to subscribe to or purchase an equity security;
- (C) a warrant or right to subscribe to or purchase an equity security; or
- (D) any other security defined as an equity security in accordance with Section 548.004(a)(1).

(3) "Federal Securities Exchange Act" means the Securities Exchange Act of 1934 (15 U.S.C. Section 77b et seq.), as amended.

(4) "Officer" means:

(A) a president, vice president, treasurer, actuary, secretary, or controller of a domestic stock insurer; or

(B) any other person who performs for a domestic stock insurer the functions of an officer described by Paragraph (A).

(5) "Person" means an individual, corporation, partnership, association, joint-stock company, business trust, or unincorporated organization.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 548.003. RULEMAKING AUTHORITY. The commissioner may:

(1) adopt rules necessary for the execution of the powers and duties of the department or commissioner under this subchapter and Subchapter B; and

(2) for that purpose classify domestic stock insurers, securities, and other persons or matters under the jurisdiction of the department or commissioner.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 548.004. RULES RELATING TO EQUITY SECURITIES AND EXEMPT SECURITIES. (a) If the commissioner considers it necessary or appropriate in the public interest or for the protection of investors, the commissioner by rule may define:

(1) "equity security" to include a security that is similar in nature to an equity security; and

(2) "exempt security" for purposes of this chapter.

(b) In adopting a rule under Subsection (a)(2), the commissioner may define the term conditionally, on specified terms, or for a stated period.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

SUBCHAPTER B. REQUIRED ACTS; PROHIBITIONS

Sec. 548.101. DEFINITION. In this subchapter, "insider" means a person who:

(1) is directly or indirectly the beneficial owner of more than 10 percent of any class of an equity security of a domestic

stock insurer, other than an exempt security; or

(2) is a director or officer of a domestic stock insurer.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 548.102. STATEMENT OF BENEFICIAL OWNERSHIP OF EQUITY SECURITIES. (a) Not later than the 10th day after the date a person becomes an insider, the insider shall file with the department a statement of the amount of all equity securities of the insurer of which the insider is a beneficial owner.

(b) If in any month a change occurs in the amount of the equity securities of which the insider is a beneficial owner, the insider shall file with the department not later than the 10th day of the following month a statement that indicates:

(1) the amount of all equity securities of which the insider is a beneficial owner as of the end of that month; and

(2) the changes in the insider's ownership that occurred in that month.

(c) A statement under this section must be in the form prescribed by the department.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 548.103. RECOVERY OF CERTAIN PROFITS. (a) The purpose of this section is to prevent the unfair use of information that may be obtained by an insider because of the insider's relationship with the domestic stock insurer.

(b) Any profit realized by the insider from the purchase and sale or from the sale and purchase of an equity security of the domestic stock insurer within a period of less than six months inures to and is recoverable by the insurer.

(c) A suit to recover the profit must be brought not later than the second anniversary of the date the profit is realized. The suit may be instituted at law or in equity by:

(1) the domestic stock insurer; or

(2) the owner of any security of the domestic stock insurer, in the name of and in behalf of the insurer, if the insurer does not:

(A) bring suit not later than the 60th day after the

date a request is made; or

(B) diligently prosecute a suit that is timely brought by the insurer.

(d) Subsection (b) applies regardless of whether:

(1) the insider intended to hold the equity security purchased for longer than six months; or

(2) the insider did not intend to repurchase the sold equity security during the six-month period following the date the insider sold the equity security.

(e) Subsection (b) does not apply to:

(1) a transaction in which an equity security was acquired in good faith in connection with a previously contracted debt;

(2) a transaction in which the beneficial owner of an equity security was not the beneficial owner at both the time of the purchase and the time of the sale, or the sale and purchase, of the security involved;

(3) a transaction involving an exempt security;

(4) a transaction that the commissioner by rule exempts from this section because it is beyond the scope of the purpose of this section; or

(5) a transaction involving an equity security of a domestic stock insurer that is not held by a dealer in an investment account if the transaction:

(A) is in the ordinary course of the dealer's business; and

(B) is incident to the establishment or maintenance by the dealer of a primary or secondary market, other than on an exchange, as defined by the federal Securities Exchange Act, for the security.

(f) The commissioner may adopt rules the commissioner considers necessary or appropriate in the public interest to define and prescribe terms and conditions with respect to a security held in an investment account and a transaction made in the ordinary course of business and incident to the establishment or maintenance of a primary or secondary market.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 548.104. SALE OR NONDELIVERY OF CERTAIN EQUITY SECURITIES

PROHIBITED. (a) An insider may not directly or indirectly sell an equity security of the domestic stock insurer if the insider selling the security or the insider's principal:

- (1) does not own the security; or
- (2) owns the security, but does not:

(A) deliver the security before the 21st day after the date of the sale; or

(B) deposit the security in the mail or another usual channel of transportation before the sixth day after the date of the sale.

(b) An insider is not considered to have violated Subsection (a)(2) if the insider proves that:

- (1) notwithstanding the exercise of good faith, the insider was unable to make a timely delivery or deposit; or
- (2) to make a timely delivery or deposit would cause undue inconvenience or expense.

(c) Subsection (a) does not apply to the sale of:

- (1) an exempt security; or
 - (2) an equity security of a domestic stock insurer that is not held by a dealer in an investment account if the sale:
 - (A) is in the ordinary course of the dealer's business;
- and

(B) is incident to the establishment or maintenance by the dealer of a primary or secondary market, other than on an exchange, as defined by the federal Securities Exchange Act, for the security.

(d) The commissioner may adopt rules implementing Subsection (c) in the manner prescribed by Section 548.103(f).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 548.105. CERTAIN SOLICITATIONS PROHIBITED; DISCLOSURE BY INSURER. (a) A person, in violation of any rule adopted by the commissioner under this section, may not solicit or permit the use of the person's name to solicit a proxy, consent, or authorization with respect to an equity security, other than an exempt security, of a domestic stock insurer that is not listed on a national securities exchange registered as such under the federal Securities Exchange Act.

(b) Unless before an annual or other meeting a proxy, consent, or authorization with respect to a security of a domestic stock insurer covered by Subsection (a) is solicited by or on behalf of the management of the insurer from a holder of record of the security in compliance with rules adopted by the commissioner under this section, the insurer shall, in accordance with rules adopted by the commissioner, file with the department information substantially equivalent to the information that would be required to be sent if a solicitation were made. The insurer shall send the information to each holder of record of the security.

(c) The commissioner may adopt rules to implement this section that the commissioner considers necessary or appropriate in the public interest or for the protection of investors.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 548.106. NONAPPLICABILITY OF SUBCHAPTER. (a) This subchapter does not apply to an equity security of a domestic stock insurer if:

(1) the security is or is required to be registered under Section 12 of the federal Securities Exchange Act; or

(2) the insurer does not have any class of its equity securities held of record by 100 or more persons on the last business day of the year preceding the year in which the equity security would otherwise be subject to this subchapter.

(b) Sections 548.101-548.104 do not apply to a foreign or domestic arbitrage transaction unless the transaction is made in violation of a rule adopted by the commissioner to accomplish the purposes of this chapter.

(c) A provision of this subchapter that imposes liability does not apply to an act or omission made in good faith in conformity with a rule adopted by the commissioner. This subsection applies regardless of whether the rule is subsequently amended, rescinded, or determined by judicial or other authority to be invalid for any reason.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

SUBCHAPTER C. ENFORCEMENT

Sec. 548.201. OFFENSES; CRIMINAL PENALTY. (a) A person commits an offense if the person intentionally:

(1) violates this chapter or a rule adopted under this chapter; or

(2) makes or causes to be made a statement that is false or misleading with respect to a material fact in a document required to be filed by this chapter or a rule adopted under this chapter.

(b) Except as provided by Subsection (c), an offense under this section is punishable by:

(1) a fine not to exceed \$10,000;

(2) imprisonment for not more than two years; or

(3) both the fine and imprisonment.

(c) A person may not be punished by imprisonment for violating a rule as prescribed by this section if the person proves that the person had no knowledge of the rule.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 548.202. CIVIL PENALTY. (a) A person who wilfully violates this chapter or a rule adopted under this chapter is liable for a civil penalty of not less than \$100 or more than \$1,000 for:

(1) each act of violation; and

(2) each day of violation.

(b) The attorney general, at the request of the commissioner, shall bring a suit in the name of the state to recover the civil penalty. The suit must be brought:

(1) in Travis County or the county in which the person resides;

(2) if more than one person commits the violation, in the county in which any of the persons resides; or

(3) in the county in which the violation allegedly occurred.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 548.203. INJUNCTIVE ACTION. A suit to enjoin a violation or a threatened violation of this chapter may be brought in any district court in which an action for a civil penalty under Section 548.202 may be brought.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

CHAPTER 549. PROHIBITED PRACTICES RELATING TO PROPERTY INSURANCE
SUBCHAPTER A. GENERAL PROVISIONS

Sec. 549.001. DEFINITIONS. In this chapter:

(1) "Borrower" means an individual, partnership, corporation, association, or other entity who has or acquires a legal or equitable interest in real or personal property that is or becomes subject to a mortgage, lien, security agreement, deed of trust, or other security instrument.

(2) "Insurance binder" means a contract that provides insurance coverage pending the issuance of an original insurance policy that will be issued on or before the 30th day after the date the insurance binder is issued.

(3) "Lender" means an individual, partnership, corporation, association, or other entity, agent, loan agent, servicing agent, or loan or mortgage broker who lends money and receives or otherwise acquires a mortgage, a lien, a deed of trust, or any other security interest in or on any real or personal property as security for the loan.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 549.002. INAPPLICABILITY OF CHAPTER TO TITLE INSURANCE. This chapter does not apply to title insurance.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 549.003. CANCELLATION OF POLICY AFTER FORECLOSURE AUTHORIZED. In the event of a foreclosure under a deed of trust, the lender may cancel an insurance policy covering the foreclosed property and is entitled to any unearned premiums from the policy if the lender:

(1) credits the amount of the unearned premiums against any deficiency owed by the borrower; and

(2) delivers to the borrower any excess unearned premiums not credited against a deficiency under Subdivision (1).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

SUBCHAPTER B. PROHIBITED PRACTICES

Sec. 549.051. FEES FOR SUBSTITUTION OR REPLACEMENT OF POLICY.

(a) A lender may not require a fee in an amount greater than \$10 for the substitution by the borrower of a new insurance policy for another insurance policy in effect, or require a fee for the furnishing by the borrower of a new insurance policy to replace an existing insurance policy on termination of the existing policy, if the new insurance policy is provided through an insurer authorized to engage in business in this state.

(b) On the sale or transfer of the lender's ownership interest in real or personal property, the lender is subject to the payment of a substitution fee as described by Subsection (a) and may not, directly or indirectly, charge the borrower for the substitution fee.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 549.052. REQUIRING POLICY FROM PARTICULAR SOURCE. A lender may not directly or indirectly require as a condition of the financing or lending of money or the renewal or extension of financing or lending of money that the purchaser or borrower or the successors of the purchaser or borrower obtain an insurance policy or the renewal or extension of an insurance policy covering the property involved in the transaction from or through:

- (1) a particular agent, insurer, or other person; or
- (2) a particular type or class of agent, insurer, or other person.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 549.053. USE OF POLICY INFORMATION. (a) Except as otherwise provided by this section, a lender may not:

- (1) use or permit the use of any information taken from an insurance policy insuring the borrower's property for the purpose of soliciting insurance business from the borrower; or
- (2) make information taken from an insurance policy insuring the borrower's property available to any other person for

any purpose.

(b) Subsection (a) does not:

(1) apply if the borrower provides the lender with specific written authority permitting or directing the particular use or disclosure of information before the use or disclosure occurs; or

(2) prevent a lender who is a licensed general property and casualty agent or a personal lines property and casualty agent from selling insurance to a borrower.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 548 (S.B. 1263), Sec. 2.02, eff. September 1, 2007.

Sec. 549.054. REQUIRING EVIDENCE OF INSURANCE BEFORE TERMINATION OF POLICY. A lender may not require a borrower to provide evidence of insurance earlier than the 15th day before the termination date of an existing insurance policy.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 549.055. INSURANCE BINDER AS EVIDENCE OF INSURANCE. (a) A lender that requires a borrower to secure insurance coverage before the lender will provide a residential mortgage or commercial real estate loan must accept an insurance binder as evidence of the required insurance and may not require the borrower to provide an original insurance policy instead of a binder if:

(1) the binder is issued by a licensed general property and casualty agent or a personal lines property and casualty agent who is appointed to represent the insurer whose name appears on the binder and who is authorized to issue binders;

(2) the binder is accompanied by evidence of payment of the required premium; and

(3) the binder will be replaced by an original insurance policy for the required coverage on or before the 30th day after the date the binder is issued.

(b) A property and casualty agent who issues an insurance binder under Subsection (a) must, on request, provide the lender with appropriate evidence for purposes of Subsection (a)(1).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 548 (S.B. 1263), Sec. 2.03, eff. September 1, 2007.

Sec. 549.0551. REQUIRING CERTAIN AMOUNTS OF COVERAGE. (a) A lender may not require as a condition of financing a residential mortgage or providing other financing arrangements for residential property, including a mobile or manufactured home, that a borrower purchase homeowners insurance coverage, mobile or manufactured home insurance coverage, or other residential property insurance coverage in an amount that exceeds the replacement value of the dwelling and its contents, regardless of the amount of the mortgage or other financing arrangement entered into by the borrower.

(b) For purposes of this section, a lender may not include the fair market value of the land on which a dwelling is located in the replacement value of the dwelling and its contents.

Added by Acts 2005, 79th Leg., Ch. 69 (H.B. 2761), Sec. 1(a), eff. May 17, 2005; Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.017(a), eff. September 1, 2005.

Sec. 549.056. CERTAIN ACTIONS BY LENDER NOT PROHIBITED. (a) This subchapter does not prevent a lender from requiring evidence to be produced before the commencement or renewal of a risk that insurance has been obtained that:

(1) has a fixed termination date;

(2) except as provided by Section 549.0551, provides adequate coverage in an amount sufficient to cover the debt or loan; and

(3) will not be canceled without reasonable notice to the lender.

(b) This subchapter does not prevent a lender from requiring insurance from an insurer that is authorized to engage in business in this state and that has a licensed resident agent in this state.

(c) This subchapter does not prevent a lender from refusing to accept or approve insurance from a particular insurer on reasonable and nondiscriminatory grounds relating to the financial soundness of

the insurer or the insurer's ability to service the policy.

(d) Except as provided by Section 549.0551, this subchapter does not prevent a lender from providing, in accordance with the terms of the mortgage, security agreement, deed of trust, or other security instrument, insurance coverage adequate to protect the lender's security interest in property in the event the borrower fails to provide on or before the 15th day before the termination date of an existing insurance policy an insurance policy meeting the requirements established by the lender as authorized by this chapter. A lender that provides insurance coverage under this subsection may use information contained in the existing policy for the purpose of determining that the insurance coverage provided is adequate.

(e) Except as provided by this subsection, this subchapter does not prevent a lender from requiring, at or before the time of delivery to the lender of an insurance policy by a general property and casualty agent or a personal lines property and casualty agent or by the insurer, a written statement from the borrower designating the agent or insurer as the borrower's agent for the delivery of the policy. A lender may not require a statement described by this subsection when an agent or insurer is providing a renewal of an existing expiring insurance policy provided by the agent or insurer.

(f) This subchapter does not prevent a lender from providing to a person, firm, or corporation that is or becomes the owner or holder of a note or obligation secured by a mortgage, security agreement, deed of trust, or other security instrument an insurance policy or any information contained in an insurance policy that covers property that is security for the loan.

(g) This subchapter does not prevent a lender from processing a claim under the terms of an insurance policy that covers property that is security for a loan.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 69 (H.B. [2761](#)), Sec. 2, eff. May 17, 2005.

Acts 2007, 80th Leg., R.S., Ch. 548 (S.B. [1263](#)), Sec. 2.04, eff. September 1, 2007.

SUBCHAPTER C. ENFORCEMENT AND CIVIL REMEDIES

Sec. 549.101. ENFORCEMENT ACTION. The attorney general, commissioner, or department may institute a proceeding to enforce this chapter and to enjoin any individual, partnership, corporation, association, or other entity from engaging or attempting to engage in any activity in violation of this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 549.102. CIVIL DAMAGES. (a) A borrower may recover from a lender who violates this chapter civil damages in an amount equal to three times the annual premium for the insurance policy in force on the property that is security for the loan.

(b) If the insurance policy is for a period of more than one year, the annual premium is computed by dividing the total premium specified in the policy for the entire period of the policy by the number of years of the duration of the policy.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

CHAPTER 550. PROHIBITED PRACTICES RELATING TO PAYMENTS

Sec. 550.001. SOLICITATION OR COLLECTION OF CERTAIN PAYMENTS.

(a) An insurer or an insurer's agent or sponsoring organization may not solicit or collect, in connection with an application for insurance or the issuance of a policy, a payment other than:

- (1) a premium;
- (2) a tax;
- (3) a finance charge;
- (4) a policy fee;
- (5) an agent fee;
- (6) a service fee, including a charge for costs described by Section 4005.003;
- (7) an inspection fee; or
- (8) membership dues in a sponsoring organization.

(b) The commissioner by rule shall permit a sponsoring organization to solicit a voluntary contribution with a membership renewal solicitation if the membership renewal solicitation is separate from an insurance billing.

(c) Except as otherwise provided by statute, an insurer may require that membership dues in its sponsoring organization be paid

as a condition for issuance or renewal of an insurance policy.

(d) Criminal penalties for a violation of this section are the same as criminal penalties provided for a violation under Subchapter K, Chapter 823.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 550.002. INCREASE IN CERTAIN PREMIUM PAYMENTS. (a) In this section:

(1) "Account" means a person's account in a financial institution.

(2) "Financial institution" means a state or national bank, a state or federal savings and loan association or corporation, or a state or federal credit union.

(3) "Insurer" means a person or entity engaged in the business of insurance in this state as described by Chapter 101. The term includes a person or entity engaged in the business of surplus lines insurance in this state.

(4) "Person" means an insured, a policy or certificate holder, or an owner of an insurance policy or certificate.

(b) An insurer receiving automatic premium payments through withdrawal of funds from a person's account, including an escrow account, as authorized by that person to pay premiums on insurance coverage provided through that insurer, may not increase the amount of funds to be withdrawn from the account to pay premiums on that coverage unless the insurer, not later than the 30th day before the effective date of the increase in the premium payment amount, notifies the person of the increase by mailing a notice through the United States Postal Service.

(b-1) The notice must include the insurer's toll-free telephone number, mailing address, and electronic mail address, if applicable, through which the person may object to the increase described by Subsection (b). An objection made by the policyholder through a telephone call, mail, or electronic mail constitutes a valid objection for purposes of this section.

(b-2) The insurer may increase the amount of funds to be withdrawn from the account only if the insurer does not receive a valid objection to the increase on or before the fifth day before the date on which the increase is scheduled to take effect.

(c) This section does not require an insurer to notify a person of an increase in a premium payment amount if:

- (1) the insurance contract or certificate:
 - (A) when issued contains a schedule of increasing premiums;
 - (B) expressly specifies the exact amount of each premium; and
 - (C) specifies the period for which each premium is payable; or
- (2) the increase is the result of a change ordered by the insured.

(d) This section does not apply to an increase in a premium payment that is less than \$10 or 10 percent of the previous amount per month.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.
Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1167 (H.B. [3221](#)), Sec. 1, eff. June 19, 2009.

**CHAPTER 551. PRACTICES RELATING TO DECLINATION, CANCELLATION, AND
NONRENEWAL OF INSURANCE POLICIES
SUBCHAPTER A. GENERAL PROVISIONS**

Sec. 551.001. RULES. (a) The commissioner may, as necessary, adopt and enforce reasonable rules, including notice requirements, relating to the cancellation and nonrenewal of any insurance policy regulated by the department under:

- (1) Chapter 5;
- (2) Chapter 1804, 1805, 2171, or 2301; or
- (3) Subtitle C, D, E, or F, Title 10.

(a-1) Notwithstanding Subsection (a), Subsection (a) does not apply to:

- (1) an insurance policy subject to Subchapter B or C of this chapter; or
- (2) a marine insurance policy other than inland marine.

(b) In adopting rules under this section, the commissioner shall consider the reasonable needs of the public and the operations of the insurers.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2D.012, eff. April 1, 2009.

Sec. 551.002. WRITTEN STATEMENT OF REASONS FOR DECLINATION, CANCELLATION, OR NONRENEWAL. (a) The commissioner shall require an insurer, on request by an applicant for insurance or a policyholder, to provide to the applicant or policyholder a written statement of the reasons for the declination, cancellation, or nonrenewal of an insurance policy to which Section 551.001 applies.

(b) An insurer's written statement giving the reasons for the declination, cancellation, or nonrenewal of an insurance policy must fully explain a decision that adversely affects an applicant for insurance or a policyholder by denying the applicant or policyholder insurance coverage or continued coverage.

(c) The statement must:

(1) state the precise incident, circumstance, or risk factors applicable to the applicant for insurance or the policyholder that violates any applicable guidelines;

(2) state the source of information on which the insurer relied regarding the incident, circumstance, or risk factors; and

(3) specify any other information considered relevant by the commissioner.

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

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 551.003. IMMUNITY FROM LIABILITY. An insurer or agent or an employee of an insurer or agent is not liable, and a cause of action does not arise against that individual or entity, for a statement, disclosure, or communication made in good faith under this subchapter. Immunity under this section does not apply to:

(1) disclosure of information known to be false; or

(2) a disclosure made with malice or the wilful intent to injure any person.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 551.004. TRANSFER NOT CONSIDERED A REFUSAL TO RENEW. For purposes of this chapter and Subchapters C and D, Chapter 1952, the transfer of a policyholder between admitted companies within the same insurance group is not considered a refusal to renew.

Added by Acts 2005, 79th Leg., Ch. 1295 (H.B. 2614), Sec. 4, eff. September 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.024, eff. September 1, 2007.

Sec. 551.005. MEMBERSHIP DUES. (a) In this section, "insurer" includes a county mutual insurance company, a Lloyd's plan, and a reciprocal or interinsurance exchange.

(b) Except as otherwise provided by law, an insurer may require that membership dues in its sponsoring organization be paid as a condition for issuance or renewal of a policy.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.0245, eff. September 1, 2007.

Added by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.0245(a), eff. September 1, 2007.

SUBCHAPTER B. CANCELLATION AND NONRENEWAL OF CERTAIN LIABILITY AND COMMERCIAL PROPERTY INSURANCE POLICIES

Sec. 551.051. DEFINITIONS. In this subchapter:

(1) "Commercial property insurance" has the meaning assigned by Section 2251.002.

(1-a) "Insurer" means an insurance company or other entity admitted to engage in business and authorized to write liability insurance or commercial property insurance in this state, including a county mutual insurance company, a Lloyd's plan, and a reciprocal or interinsurance exchange. The term does not include a county mutual fire insurance company that writes exclusively industrial fire insurance as described by Section 912.310 or a farm mutual insurance company.

(2) "Liability insurance" means:

(A) general liability insurance;

(B) professional liability insurance other than medical

professional liability insurance;

(C) commercial automobile liability insurance;

(D) commercial multiperil insurance; and

(E) any other type or line of liability insurance

designated by the department.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 72 (S.B. 590), Sec. 2, eff. September 1, 2019.

Sec. 551.052. CANCELLATION PROHIBITED; EXCEPTIONS. (a) An insurer may not cancel a liability insurance or commercial property insurance policy that is a renewal or continuation policy.

(b) An insurer may not cancel a liability insurance or commercial property insurance policy during the initial policy term after the 60th day following the date on which the policy was issued.

(c) Notwithstanding Subsections (a) and (b), an insurer may cancel a liability insurance or commercial property insurance policy at any time during the term of the policy for:

(1) fraud in obtaining coverage;

(2) failure to pay premiums when due;

(3) an increase in hazard within the control of the insured that would produce a rate increase; or

(4) loss of the insurer's reinsurance covering all or part of the risk covered by the policy.

(d) Notwithstanding Subsections (a) and (b), an insurer may cancel a liability insurance or commercial property insurance policy at any time during the term of the policy if the insurer is placed in supervision, conservatorship, or receivership and the cancellation or nonrenewal is approved or directed by the supervisor, conservator, or receiver.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 72 (S.B. 590), Sec. 3, eff. September 1, 2019.

Sec. 551.053. WRITTEN NOTICE OF CANCELLATION REQUIRED. Not

later than the 10th day before the date on which the cancellation of a liability insurance or commercial property insurance policy takes effect, an insurer must deliver or mail written notice of the cancellation to the first-named insured under the policy at the address shown on the policy.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.
Amended by:

Acts 2019, 86th Leg., R.S., Ch. 72 (S.B. 590), Sec. 3, eff. September 1, 2019.

Sec. 551.054. WRITTEN NOTICE OF NONRENEWAL REQUIRED. (a) An insurer may refuse to renew a liability insurance or commercial property insurance policy if the insurer delivers or mails written notice of the nonrenewal to the first-named insured under the policy at the address shown on the policy.

(b) The notice must be delivered or mailed not later than the 60th day before the date on which the policy expires. If the notice is delivered or mailed later than the 60th day before the date on which the policy expires, the coverage remains in effect until the 61st day after the date on which the notice is delivered or mailed.

(c) Earned premium for any period of coverage that extends beyond the expiration date of the policy shall be computed pro rata based on the previous year's rate.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.
Amended by:

Acts 2019, 86th Leg., R.S., Ch. 72 (S.B. 590), Sec. 4, eff. September 1, 2019.

Sec. 551.055. REASON FOR CANCELLATION OR NONRENEWAL REQUIRED. In a notice to an insured relating to cancellation or refusal to renew, an insurer must state the reason for the cancellation or nonrenewal. The statement must comply with:

- (1) Sections 551.002(b) and (c); and
- (2) rules adopted under Section 551.002(d).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 551.056. CHANGES TO POLICY ON RENEWAL. (a) In this section, "material change" means a change to a policy that, with respect to a previous or existing policy:

- (1) reduces coverage;
- (2) changes conditions of coverage; or
- (3) changes the duties of the insured.

(b) A change to a liability insurance or commercial property insurance policy provision on renewal is not a nonrenewal or cancellation under this subchapter if the insurer provides the insured with written notice in accordance with this section of any material change in each form of the policy offered to the insured on renewal from the form of the policy held immediately before renewal.

(c) Notice provided under Subsection (b) must:

- (1) appear in a conspicuous place in the notice of renewal;
- (2) clearly indicate each material change to the policy being made on renewal;
- (3) be written in plain language; and
- (4) be provided to the insured not later than the 30th day before the renewal date.

(d) In addition to the notice to the insured provided under Subsection (b), if an insurer elects to make a material change to a policy form on renewal, not later than the 30th day before the earliest renewal date on which the new policy form is used, the insurer shall provide written notice to each agent of the insurer that clearly indicates each material change being made to the policy form. An insurer may provide the notice to the agents in a single notice given to each agent of the insurer that summarizes substantially similar material changes to more than one policy form.

(e) This section does not apply if:

- (1) the policy form meets at least one of the conditions in Section 2301.004 both before and after renewal of the policy; or
- (2) before the renewal date:
 - (A) the insured requests the change; or
 - (B) the insured and the insurer agree to the change.

Added by Acts 2019, 86th Leg., R.S., Ch. 72 (S.B. 590), Sec. 5, eff. September 1, 2019.

**SUBCHAPTER C. DECLINATION, CANCELLATION, AND NONRENEWAL OF
CERTAIN PROPERTY AND CASUALTY POLICIES**

Sec. 551.101. DEFINITION. In this subchapter, "insurer" means any authorized insurer writing property and casualty insurance in this state, including:

- (1) a county mutual insurance company;
- (2) a Lloyd's plan;
- (3) a reciprocal or interinsurance exchange; and
- (4) a farm mutual insurance company.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 551.102. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to:

- (1) a personal automobile insurance policy, other than a policy written through the Texas Automobile Insurance Plan Association;
- (2) a homeowners or farm or ranch owners insurance policy;
- (3) a standard fire insurance policy insuring:
 - (A) a one-family dwelling or a duplex; or
 - (B) the contents of a one-family dwelling, a duplex, or an apartment; or
- (4) an insurance policy providing property and casualty coverage, other than a fidelity, surety, or guaranty bond, to:
 - (A) this state;
 - (B) an agency of this state;
 - (C) a political subdivision of this state, including:
 - (i) a municipality or county;
 - (ii) a school district or junior college district;
 - (iii) a levee improvement district, drainage district, or irrigation district;
 - (iv) a water improvement district, water control and improvement district, or water control and preservation district;
 - (v) a freshwater supply district;
 - (vi) a navigation district;
 - (vii) a conservation and reclamation district;
 - (viii) a soil conservation district;
 - (ix) a communication district; and
 - (x) a river authority; or
 - (D) any other governmental agency whose authority is derived from the laws or constitution of this state.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 551.103. CANCELLATION. For the purposes of this subchapter, an insurer has canceled an insurance policy if the insurer, without the consent of the insured:

- (1) terminates coverage provided under the policy;
- (2) refuses to provide additional coverage to which the insured is entitled under the policy; or
- (3) except as provided by Section 551.1055, reduces or restricts coverage under the policy by endorsement or other means.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 60 (S.B. 417), Sec. 1, eff. September 1, 2017.

Sec. 551.104. AUTHORIZED CANCELLATION OF POLICIES. (a) An insurer may cancel an insurance policy only as provided by this section.

(b) An insurer may cancel any policy if:

- (1) the named insured does not pay any portion of the premium when due;
- (2) the insured submits a fraudulent claim; or
- (3) the department determines that continuation of the policy would result in a violation of this code or any other law governing the business of insurance in this state.

(c) An insurer may cancel a policy, other than a personal automobile insurance policy, if there is an increase in the hazard covered by the policy that is within the control of the insured and that would produce an increase in the premium rate of the policy.

(d) An insurer may cancel a personal automobile insurance policy if the driver's license or motor vehicle registration of the named insured or any other motor vehicle operator who resides in the same household as the named insured or who customarily operates an automobile covered by the policy is suspended or revoked. An insurer may not cancel a policy under this subsection if the named insured consents to an endorsement terminating coverage under the policy for the person whose license is suspended or revoked.

(e) Cancellation of a policy under Subsection (b), (c), or (d) does not take effect until the 10th day after the date the insurer mails notice of the cancellation to the insured.

(f) An insurer may cancel a personal automobile insurance policy effective on any 12-month anniversary of the original effective date of the policy if the insurer mails to the named insured written notice of the cancellation not later than the 60th day before the effective date of the cancellation.

(g) An insurer may cancel any insurance policy other than a personal automobile or homeowners insurance policy if the policy has been in effect less than 90 days. An insurer may cancel a personal automobile insurance policy if the policy has been in effect less than 60 days. An insurer may cancel a homeowners insurance policy if the policy has been in effect less than 60 days and:

(1) the insurer identifies a condition that:

(A) creates an increased risk of hazard;

(B) was not disclosed in the application for insurance coverage; and

(C) 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 that:

(A) was completed by an inspector who is licensed by the Texas Real Estate Commission or who is otherwise authorized to perform inspections; and

(B) is dated not earlier than the 90th day before the effective date of the policy.

(h) For purposes of Subsection (g), an inspection report is considered accepted if an insurer does not reject the inspection report given to the insurer under Subsection (g)(2) before the 11th day after the date the inspection report is received by the insurer.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.
Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.019(a), eff. September 1, 2005.

Acts 2023, 88th Leg., R.S., Ch. 428 (H.B. 1900), Sec. 1, eff. September 1, 2023.

Sec. 551.1041. RULEMAKING AUTHORITY RELATING TO NOTICE OF

CANCELLATION OF CERTAIN PERSONAL AUTOMOBILE INSURANCE COVERAGES. The commissioner shall exercise the commissioner's rulemaking authority to adopt rules under which an insurer that cancels a personal automobile insurance policy that provides comprehensive or collision physical damage coverage for an automobile that is subject to a purchase money lien is required to notify the lienholder, if known, that the coverage will be canceled.

Added by Acts 2017, 85th Leg., R.S., Ch. 752 (S.B. 1450), Sec. 3, eff. September 1, 2017.

Sec. 551.105. NONRENEWAL OF POLICIES; NOTICE REQUIRED. Unless the insurer has mailed written notice of nonrenewal or renewal with written notice of change in coverage as provided by Section 2002.001 to the insured not later than the 60th day before the date on which the insurance policy expires, an insurer must renew an insurance policy, at the request of the insured, on the expiration of the policy. Notwithstanding the failure of an insurer to comply with this section, the policy shall terminate on the effective date of any replacement or succeeding insurance policy with another carrier with respect to the insured (a) personal automobile, (b) home, farm, ranch, dwelling, duplex, or apartment, or (c) other real or personal property.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.
Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 527 (H.B. 2382), Sec. 1, eff. September 1, 2011.

Acts 2011, 82nd Leg., R.S., Ch. 1018 (H.B. 2655), Sec. 2, eff. September 1, 2011.

Acts 2023, 88th Leg., R.S., Ch. 428 (H.B. 1900), Sec. 2, eff. September 1, 2023.

Sec. 551.1053. MANDATORY NONRENEWAL OF PRIVATE PASSENGER AUTOMOBILE INSURANCE POLICIES. (a) If an insured under a private passenger automobile insurance policy fails or refuses to cooperate with an insurer in the investigation, settlement, or defense of a third-party liability claim or action or the insurer is unable to contact the insured using reasonable efforts for those purposes, the

insurer shall provide written notice to the named insured that states:

- (1) how the insured failed or refused to cooperate, including failure as a result of the insurer's inability to contact the insured;
- (2) the claim or action for which the insurer is requesting cooperation; and
- (3) the insurer will not renew the policy if the insured continues to fail or refuse to cooperate.

(b) Notwithstanding Sections 551.105 and 551.106, an insurer may not renew a private passenger automobile insurance policy if the insured fails or refuses to cooperate with the insurer in the investigation, settlement, or defense of the third-party liability claim or action described by the notice provided under Subsection (a).

Added by Acts 2021, 87th Leg., R.S., Ch. 886 (S.B. [1602](#)), Sec. 1, eff. September 1, 2021.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 496 (H.B. [2065](#)), Sec. 1, eff. September 1, 2023.

Sec. 551.1055. CHANGES TO POLICY ON RENEWAL. (a) In this section, "material change" means a change to a policy that, with respect to a prior or existing policy:

- (1) reduces coverage;
- (2) changes conditions of coverage; or
- (3) changes the duties of the insured.

(b) Notwithstanding Section 551.103, a change to a policy provision on renewal is not a nonrenewal or cancellation under this subchapter if the insurer provides the insured with written notice in accordance with this section of any material change in each form of the policy offered to the insured on renewal from the form of the policy held immediately before renewal.

(c) Notice provided under Subsection (b) must:

- (1) appear in a conspicuous place in the notice of renewal;
- (2) clearly indicate each material change to the policy being made on renewal;
- (3) be written in plain language; and

(4) be provided to the insured not later than the 30th day before the renewal date.

(d) In addition to the notice to the insured provided under Subsection (b), if an insurer elects to make a material change to a policy form on renewal, not later than the 30th day before the earliest renewal date on which the new policy form is used, the insurer shall provide written notice to each agent of the insurer that clearly indicates each material change being made to the policy form. An insurer may provide the notice to the agents in a single notice given to each agent of the insurer that summarizes substantially similar material changes to more than one policy form.

(e) Notwithstanding this section, for a personal automobile insurance policy, an insurer must comply with Sections 551.105 and 551.106(b).

Added by Acts 2017, 85th Leg., R.S., Ch. 60 (S.B. 417), Sec. 2, eff. September 1, 2017.

Sec. 551.106. RENEWAL AND REINSTATEMENT OF PERSONAL AUTOMOBILE INSURANCE POLICIES. (a) An insurer may not refuse to renew a personal automobile insurance policy solely because of the age of the person covered by the policy.

(b) An insurer shall renew a personal automobile insurance policy that was written for a term of less than one year, except that the insurer may refuse to renew the policy on any 12-month anniversary of the original effective date of the policy.

(c) An insurer may reinstate a personal automobile insurance policy canceled for nonpayment of premium if the premium owed is paid not later than the 60th day after date of cancellation. Coverage under the policy lapses on the date of cancellation and is not again effective until the date the payment is received by the insurer. Premium is not owed for any period in which the policy is not in effect.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 1159 (H.B. 3300), Sec. 1, eff. June 18, 2005.

Acts 2005, 79th Leg., Ch. 1159 (H.B. 3300), Sec. 2, eff. June 18, 2005.

Sec. 551.107. RENEWAL OF CERTAIN POLICIES; PREMIUM SURCHARGE AUTHORIZED; NOTICE. (a) This section applies only to a standard fire, homeowners, or farm or ranch owners insurance policy.

(b) A claim under this section does not include a claim:

- (1) resulting from a loss caused by natural causes;
- (2) that is filed but is not paid or payable under the

policy; or

(3) that an insurer is prohibited from using under Section 544.353.

(c) An insurer may assess a premium surcharge at the time an insurance policy is renewed if the insured has filed two or more claims in the preceding three policy years. The amount of the surcharge must be based on sound actuarial principles.

(d) Subject to Subsection (e), an insurer may refuse to renew an insurance policy if the insured has filed three or more claims under the policy in any three-year period.

(e) An insurer may notify an insured who has filed two claims in a period of less than three years that the insurer may refuse to renew the policy if the insured files a third claim during the three-year period. If the insurer does not notify the insured in accordance with this subsection, the insurer may not refuse to renew the policy because of claims. The notice form must:

(1) list the policyholder's claims; and

(2) contain the sentence: "The filing by you of another claim, except for a claim resulting from a loss caused by natural causes, a claim filed but not paid or payable under the policy under which it was filed, or an appliance-related claim that we are prohibited from using under Section 544.353, Texas Insurance Code, could cause us to refuse to renew your policy."

(f) In this section, "premium surcharge" means an additional amount that is added to the base rate. The term does not include a reduction or elimination of a discount previously received by an insured, reassignment of an insured from one rating tier to another, re-rating an insured, or re-underwriting an insured by using multiple affiliates.

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

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.
Amended by:

Acts 2005, 79th Leg., Ch. 291 (S.B. 14), Sec. 5, eff. September 1, 2005.

Acts 2007, 80th Leg., R.S., Ch. 252 (S.B. 978), Sec. 1, eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2D.013, eff. April 1, 2009.

Sec. 551.108. INSURER RECORDS. (a) An insurer shall maintain information regarding cancellation or nonrenewal of insurance policies in accordance with the insurer's ordinary practices for maintaining records of expired policies.

(b) The insurer shall make the information available to the department on request.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 551.109. INSURER STATEMENT. An insurer shall, at the request of an applicant for insurance or an insured, provide a written statement of the reason for a declination, cancellation, or nonrenewal of an insurance policy. The statement must comply with:

- (1) Sections 551.002(b) and (c); and
- (2) rules adopted under Section 551.002(d).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 551.110. LIABILITY FOR DISCLOSURE. An insurer or agent or an employee of an insurer or agent is not liable for a notice, statement, or disclosure made in good faith under this subchapter unless the notice, statement, or disclosure was:

- (1) known to be false; or
- (2) made with malice or wilful intent to injure any person.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.
Amended by:

Acts 2017, 85th Leg., R.S., Ch. 60 (S.B. 417), Sec. 3, eff. September 1, 2017.

Sec. 551.111. EFFECT OF NONCOMPLIANCE. A cancellation of an insurance policy made in violation of this subchapter has no effect.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 551.112. RULES. The commissioner may adopt rules relating to the cancellation and nonrenewal of insurance policies.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 551.113. DECLINATION, NONRENEWAL, OR CANCELLATION PROHIBITED; CONSIDERATION OF CONSUMER INQUIRY. (a) This section applies only to:

(1) a standard fire, homeowners, or farm and ranch owners insurance policy; or

(2) a personal automobile insurance policy.

(b) When deciding to issue or to decline to issue an insurance policy to an applicant for insurance, an insurer may not consider a customer inquiry as a basis for declination.

(b-1) An insurer may not consider a customer inquiry as a basis for nonrenewal or cancellation of an insurance policy.

(c) For purposes of this section, "customer inquiry" means a telephone call or other communication made to an insurer that does not result in an investigation or claim and that is in regard to the general terms or conditions of or coverage offered under an insurance policy. The term includes a question concerning the process for filing a claim, and whether a policy will cover a loss, unless the question concerns specific damage that has occurred and that results in an investigation or claim.

Added by Acts 2005, 79th Leg., Ch. 922 (H.B. 363), Sec. 2, eff. September 1, 2005.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 570 (S.B. 736), Sec. 2, eff. September 1, 2013.

Acts 2013, 83rd Leg., R.S., Ch. 570 (S.B. 736), Sec. 3, eff. September 1, 2013.

Acts 2015, 84th Leg., R.S., Ch. 1137 (S.B. 189), Sec. 2, eff. September 1, 2015.

**SUBCHAPTER D. CANCELLATION OR NONRENEWAL OF CERTAIN POLICIES ISSUED
TO ELECTED OFFICIALS**

Sec. 551.151. DEFINITION. In this subchapter, "insurer" has the meaning assigned by Section 551.101.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 551.152. ELECTED OFFICIALS. An insurer may not cancel or refuse to renew an insurance policy based solely on the fact that the policyholder is an elected official.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

SUBCHAPTER E. PORTABLE ELECTRONICS INSURANCE

Sec. 551.201. DEFINITIONS. In this subchapter, "customer," "portable electronic devices," and "vendor" have the meanings assigned by Section 4055.251.

Added by Acts 2013, 83rd Leg., R.S., Ch. 1174 (S.B. 839), Sec. 1, eff. September 1, 2013.

Sec. 551.202. REQUIRED NOTICE OF TERMINATION OR CHANGE TO POLICY. (a) Except as otherwise provided by this subchapter, an insurer may terminate or change the terms and conditions of a policy of portable electronics insurance only after notice to the master or group policyholder and each enrolled customer. Notice under this section must be provided not later than the 30th day before the date of the termination or change.

(b) If the insurer changes the terms and conditions of the policy, the insurer shall:

(1) provide to the master or group policyholder a revised policy or endorsement; and

(2) provide to each enrolled customer:

(A) a revised certificate, revised endorsement, updated

brochure, or other document indicating that a change in the terms and conditions has occurred;

(B) a summary of the material changes; and

(C) a disclosure, in a font that is capitalized, boldfaced, italicized, or underlined or is larger than or set off from the remainder of the document, that enrollment in coverage is optional and that provides information on how to discontinue enrollment.

Added by Acts 2013, 83rd Leg., R.S., Ch. 1174 (S.B. 839), Sec. 1, eff. September 1, 2013.

Sec. 551.203. TERMINATION FOR FRAUD OR MISREPRESENTATION. (a) An insurer may terminate the coverage of an enrolled customer under a portable electronics insurance policy for fraud or material misrepresentation in obtaining coverage or in the presentation of a claim under the coverage.

(b) Termination of coverage under this section may not be effective before the 15th day after the date the insurer provides the customer notice of the termination.

Added by Acts 2013, 83rd Leg., R.S., Ch. 1174 (S.B. 839), Sec. 1, eff. September 1, 2013.

Sec. 551.204. TERMINATION WITHOUT NOTICE. (a) An insurer may terminate the coverage of an enrolled customer under a portable electronics insurance policy without notice:

(1) for nonpayment of premium;

(2) if the enrolled customer ceases to have an active service with the vendor of portable electronics; or

(3) if the enrolled customer exhausts the aggregate limit of liability, if any, under the terms of the portable electronics insurance policy.

(b) If a portable electronics insurance policy is terminated under Subsection (a)(3), the insurer must send notice of termination to the enrolled customer not later than the 30th day after the date of exhaustion of the limit. If the notice is not timely sent, the insurer shall continue the customer's coverage, and the aggregate limit of liability is waived, until the insurer sends the notice of

termination to the enrolled customer.

Added by Acts 2013, 83rd Leg., R.S., Ch. 1174 (S.B. 839), Sec. 1, eff. September 1, 2013.

Sec. 551.205. TERMINATION BY POLICYHOLDER. A master or group policyholder who terminates a portable electronics insurance policy shall provide notice to each enrolled customer advising the enrolled customer of the termination of the policy and the effective date of termination. The notice must be provided to the enrolled customer not later than the 30th day before the date the termination becomes effective.

Added by Acts 2013, 83rd Leg., R.S., Ch. 1174 (S.B. 839), Sec. 1, eff. September 1, 2013.

Sec. 551.206. FORM OF NOTICE OR CORRESPONDENCE. (a) A notice required by this subchapter, or another notice or correspondence with respect to a portable electronics insurance policy that is required by law, must be:

(1) in writing; and

(2) sent within the notice period, if any, specified by the statute or rule requiring the notice or correspondence.

(b) Notwithstanding any other law, the notice or correspondence may be sent by mail or by electronic means.

(c) If the notice or correspondence is mailed:

(1) it must be sent to the master or group policyholder at the policyholder's mailing address specified for this purpose and to each affected enrolled customer's last known mailing address on file with the insurer; and

(2) the insurer or master or group policyholder shall maintain proof of mailing in a form authorized or accepted by the United States Postal Service or other commercial mail delivery service.

(d) If the notice or correspondence is sent by electronic means:

(1) it must be sent to the master or group policyholder at the policyholder's e-mail address specified for this purpose and to each affected enrolled customer's last known e-mail address as

provided by the customer to the insurer or master or group policyholder; and

(2) the insurer or master or group policyholder shall maintain proof that the notice or correspondence was sent.

(e) For purposes of Subsection (d), an enrolled customer's provision of an e-mail address to the insurer or master or group policyholder is considered consent to receive notices and correspondence by electronic means.

(f) A notice or correspondence described by this section may be sent on behalf of an insurer or master or group policyholder by a licensed agent or agency appointed by the insurer.

Added by Acts 2013, 83rd Leg., R.S., Ch. 1174 (S.B. 839), Sec. 1, eff. September 1, 2013.

CHAPTER 552. ILLEGAL PRICING PRACTICES

Sec. 552.001. APPLICABILITY OF CHAPTER. (a) This chapter does not apply to the provision of a health care service to a:

(1) Medicaid or Medicare patient or a patient who is covered by a federal, state, or local government-sponsored indigent health care program;

(2) financially or medically indigent person who qualifies for indigent health care services based on:

(A) a sliding fee scale; or

(B) a written charity care policy established by a health care provider; or

(3) person who is not covered by a health insurance policy or other health benefit plan that provides benefits for the services and qualifies for services for the uninsured based on a written policy established by a health care provider.

(b) This chapter does not permit the establishment of health care provider policies or contracts that violate any other state or federal law.

(c) This chapter does not prohibit a health care provider from entering into a contract to provide services covered by a health insurance policy or other health benefit plan with:

(1) the issuer of the health insurance policy or other health benefit plan; or

(2) a preferred provider organization that contracts with

the issuer of the health insurance policy or other health benefit plan.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.
Amended by:

Acts 2005, 79th Leg., Ch. 724 (S.B. 500), Sec. 1, eff. June 17, 2005.

Sec. 552.002. FRAUDULENT INSURANCE ACT. An offense under Section 552.003 is a fraudulent insurance act under Chapter 701.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 552.003. CHARGING DIFFERENT PRICES; OFFENSE. (a) A person commits an offense if:

- (1) the person knowingly or intentionally charges two different prices for providing the same product or service; and
 - (2) the higher price charged is based on the fact that an insurer will pay all or part of the price of the product or service.
- (b) An offense under this section is a Class B misdemeanor.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

CHAPTER 553. ENFORCEMENT OF INSURANCE POLICIES REGARDING HOLOCAUST VICTIMS

Sec. 553.001. DEFINITIONS. In this chapter:

(1) "Holocaust victim" means a person who was killed or injured, or who lost financial assets or other property, as the result of discriminatory laws, policies, or actions directed against any discrete group of which the person was a member, during the period of 1920 to 1945, inclusive, in Germany, areas occupied by Germany, or countries allied with Germany.

(2) "Insurance policy" includes:

(A) a life insurance policy, an annuity, a property insurance policy, a casualty insurance policy, and a liability insurance policy; and

(B) reinsurance on a risk covered under a policy described by Paragraph (A).

(3) "Insurer" means an insurance company or other entity engaged in the business of insurance or reinsurance in this state. The term includes:

(A) a capital stock company, a mutual company, or a Lloyd's plan; and

(B) any parent, subsidiary, or affiliated company, at least 50 percent of the stock of which is in common ownership with an insurer engaged in the business of insurance in this state.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 553.002. SUSPENSION OF LIMITATIONS PERIOD. (a) Notwithstanding any other law, a Holocaust victim, or the heir, assignee, beneficiary, or successor of a Holocaust victim, who resides in this state and has a claim arising out of an insurance policy purchased or in effect in Europe before 1946 that was delivered, issued for delivery, or renewed by an insurer may bring an action in this state against an insurer to recover on that claim.

(b) An action brought under this section before December 31, 2012, may not be dismissed for failure to comply with any applicable limitations period.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 553.003. VIOLATION BY INSURER. An insurer violates this chapter if the insurer fails to comply with a claim brought under this chapter by:

(1) denying the claim on the grounds that the claim is not timely; or

(2) asserting a statute of limitations defense in an action brought under Section 553.002.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 553.004. EXAMINATION; ENFORCEMENT. (a) If the commissioner considers it necessary, the commissioner may initiate an examination of an insurer under Sections 401.051, 401.052, and 401.054-401.062.

(b) If the commissioner believes that an insurer is violating or has violated this chapter, the commissioner may:

- (1) impose a sanction under Chapter 82;
- (2) issue a cease and desist order under Chapter 83;
- (3) assess an administrative penalty under Chapter 84; or
- (4) refer the matter to the attorney general for appropriate enforcement.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2D.014, eff. April 1, 2009.

CHAPTER 554. BURDEN OF PROOF AND PLEADING

Sec. 554.001. APPLICABILITY OF CHAPTER. This chapter applies to each insurer or health maintenance organization engaged in the business of insurance or the business of a health maintenance organization in this state, regardless of form and however organized, including:

- (1) a stock life, health, or accident insurance company;
- (2) a mutual life, health, or accident insurance company;
- (3) a stock fire or casualty insurance company;
- (4) a mutual fire or casualty insurance company;
- (5) a Mexican casualty insurance company;
- (6) a Lloyd's plan;
- (7) a reciprocal or interinsurance exchange;
- (8) a fraternal benefit society;
- (9) a title insurance company;
- (10) a stipulated premium company;
- (11) a nonprofit legal services corporation;
- (12) a statewide mutual assessment company;
- (13) a local mutual aid association;
- (14) a local mutual burial association;
- (15) an association exempt under Section 887.102;
- (16) a nonprofit hospital, medical, or dental service corporation, including a corporation subject to Chapter 842;
- (17) a county mutual insurance company;
- (18) a farm mutual insurance company; and
- (19) an insurer or health maintenance organization engaged

in the business of insurance or the business of a health maintenance organization in this state that does not hold a certificate of authority issued by the department or is not otherwise authorized to engage in business in this state.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.
Amended by:

Acts 2017, 85th Leg., R.S., Ch. 967 (S.B. 2065), Sec. 5.004, eff. September 1, 2017.

Sec. 554.002. BURDEN OF PROOF AND PLEADING. In a suit to recover under an insurance or health maintenance organization contract, the insurer or health maintenance organization has the burden of proof as to any avoidance or affirmative defense that the Texas Rules of Civil Procedure require to be affirmatively pleaded. Language of exclusion in the contract or an exception to coverage claimed by the insurer or health maintenance organization constitutes an avoidance or an affirmative defense.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

CHAPTER 555. FAILURE TO SATISFY JUDGMENT

Sec. 555.001. APPLICABILITY OF CHAPTER. This chapter does not apply to an insurer subject to Chapter 841.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 555.002. REVOCATION OF CERTIFICATE OF AUTHORITY. If an execution issued on a final judgment rendered against an insurer is not satisfied and discharged before the 31st day after the date of notice of the execution's issuance, the insurer's certificate of authority shall be revoked, and the insurer may not engage in the business of insurance in this state until the execution is satisfied.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

CHAPTER 556. UNFAIR METHODS OF COMPETITION AND UNFAIR PRACTICES BY

FINANCIAL INSTITUTIONS**SUBCHAPTER A. GENERAL PROVISIONS**

Sec. 556.001. DEFINITIONS. In this chapter:

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

(2) "Depository institution" has the meaning assigned by Section 4001.003.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 556.002. RULES. The commissioner may adopt reasonable rules to comply with federal law applicable to the sale of insurance and for the implementation and administration of this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

SUBCHAPTER B. UNFAIR METHODS OR PRACTICES

Sec. 556.051. UNFAIR METHOD OF COMPETITION OR UNFAIR PRACTICE: TYING. (a) A depository institution engages in an unfair method of competition or an unfair practice in the sale of insurance by the depository institution if the depository institution:

(1) is an agent and, as a condition of extending or renewing credit, leasing or selling property, or furnishing services, requires the purchase of insurance from the depository institution or a subsidiary or affiliate of the depository institution, or from or through a particular agent, insurer, or any other person or entity;

(2) conditions the terms of credit or the sale or lease of property on acquisition of insurance from or through the depository institution, a subsidiary or affiliate of the depository institution, or any other particular person or entity;

(3) rejects a required policy solely because the policy has been issued or underwritten by a person or entity that is not associated with the depository institution; or

(4) imposes a requirement on an agent or broker who is not associated with the depository institution that is not imposed on an agent or broker who is associated with the depository institution or a subsidiary or affiliate of the depository institution.

(b) This section does not prevent a person who lends money or

extends credit from placing insurance on property if the mortgagor, borrower, or purchaser fails to provide required insurance in accordance with the terms of the loan or credit document.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 556.052. UNFAIR METHOD OF COMPETITION OR UNFAIR PRACTICE: FAILURE TO DISCLOSE. A depository institution engages in an unfair method of competition or an unfair practice in the sale of insurance by the depository institution if, on the premises of the depository institution or in connection with a product offering of the depository institution, the depository institution sells or solicits the purchase of insurance or a person sells or solicits the purchase of insurance recommended or sponsored by the depository institution and the depository institution or person fails to clearly disclose in all promotional materials relating to an insurance product distributed to customers and potential customers that:

(1) an insurance product sold through or in the depository institution or a subsidiary or affiliate of the depository institution is not insured by the Federal Deposit Insurance Corporation;

(2) the insurance product is not issued, guaranteed, or underwritten by the depository institution or the Federal Deposit Insurance Corporation; and

(3) the insurance product involves investment risk, if appropriate, including potential loss of principal.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

SUBCHAPTER C. REGULATION OF PRACTICES

Sec. 556.101. PROHIBITION ON CERTAIN REFERRALS OR SOLICITATIONS TO PURCHASE INSURANCE. (a) An individual who is an employee or agent of a depository institution or a subsidiary or affiliate of a depository institution may not directly or indirectly make a referral related to insurance to, or solicit the purchase of any insurance by, a customer knowing that the customer has applied for a loan or other extension of credit from a financial institution, before:

(1) the customer receives a written commitment relating to that loan or extension of credit; or

(2) if a written commitment has not been or will not be issued in connection with the loan or extension of credit, the customer receives notification of approval of that loan or extension of credit by the financial institution and the financial institution creates a written record of the approval.

(b) This section does not prohibit a depository institution from:

(1) informing a customer that insurance is required in connection with a loan;

(2) contacting a person in the course of a direct or mass mailing to a group of persons in a manner that is not related to the person's loan application or credit decision; or

(3) selling credit life, credit disability, credit property, or involuntary unemployment insurance that is:

(A) specifically authorized by this code;

(B) approved for sale in this state; and

(C) sold in connection with a credit transaction.

(c) This section does not apply to an insurance policy described by Section 556.151.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 556.102. INSURANCE SALE WITH LOAN TRANSACTION. (a) If insurance is offered or sold to a depository institution's customer in connection with a loan transaction by the depository institution, the insurance salesperson involved in that insurance transaction may not be involved in that loan transaction and may not be the person making that loan.

(b) This section does not apply to:

(1) a depository institution that has \$40 million or less in total assets, as reported in the most recent Consolidated Report of Condition and Income by the Federal Financial Institutions Examination Council or any successor report required by federal or state law; or

(2) a credit life, credit disability, credit property, or involuntary unemployment insurance product that is:

(A) specifically authorized by this code;

(B) approved for sale in this state; and

(C) sold in connection with a credit transaction.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 556.103. DESIGNATION OF PLACE OF INSURANCE ACTIVITIES.

(a) The place where a depository institution sells or solicits the purchase of insurance or the place on the premises of a depository institution where insurance is sold or solicited for purchase shall be clearly and conspicuously indicated by signs so that the public can readily distinguish the sale or solicitation as separate from the lending and deposit-taking activities of the depository institution.

(b) The commissioner may grant a waiver from the requirements of this section to a person who files a written request that:

(1) demonstrates that, due to the size of the physical premises of the person, compliance with the requirements is not possible; and

(2) identifies other steps that will be taken to minimize customer confusion.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 556.104. USE OF CUSTOMER INFORMATION. (a) In this section:

(1) "Customer" means a person with an investment, security, deposit, trust, or credit relationship with a financial institution.

(2) "Nonpublic customer information" means information relating to an individual that is derived from a bank record, including information concerning insurance premiums, the terms and conditions of insurance coverage, insurance expirations, insurance claims, and insurance history of the individual. The term does not include a customer's name, address, or telephone number.

(b) A person may not use nonpublic customer information for the purpose of selling or soliciting the purchase of insurance, or provide nonpublic customer information to a third party for the purpose of another's selling or soliciting the purchase of insurance, unless:

(1) it is clearly and conspicuously disclosed that the nonpublic customer information may be used for that purpose; and

(2) the customer has been provided an opportunity to object before the time the information is used.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

SUBCHAPTER D. DISCLOSURES

Sec. 556.151. APPLICABILITY OF SUBCHAPTER. This subchapter does not apply to a credit life, credit accident and health, credit property, or credit involuntary unemployment insurance policy that is:

- (1) specifically authorized by this code;
- (2) approved for sale in this state; and
- (3) sold in connection with a credit transaction.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 556.152. PROMOTIONAL MATERIALS DISCLOSURE. (a) This section applies to each agent that is a depository institution or that, on the premises of a depository institution or in connection with a product offering of a depository institution, sells or solicits the purchase of insurance recommended or sponsored by the depository institution.

(b) Promotional materials relating to an insurance product distributed to a customer or potential customer must clearly disclose that an insurance product sold through an agent affiliated with a depository institution:

- (1) is not insured by the Federal Deposit Insurance Corporation;
- (2) is not issued, guaranteed, or underwritten by the depository institution or the Federal Deposit Insurance Corporation; and
- (3) involves investment risk, if appropriate, including potential loss of principal.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 556.153. DISCLOSURE AT TIME OF LOAN APPLICATION. (a) At the time a loan application is made, a depository institution shall provide to the customer a written disclosure as required by this section and Section 556.154.

- (b) The disclosure must be separate from any loan application

or loan document.

(c) The depository institution employee who presents the disclosure and the customer shall sign and date the disclosure.

(d) The depository institution shall maintain one copy of the disclosure in the loan file and shall provide one copy to the customer.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 556.154. FORM OF DISCLOSURE. (a) The disclosure required by Section 556.153 must be in substantially the following form:

"CUSTOMER DISCLOSURE

"You have applied for a loan with the depository institution. As permitted by Title 4, Finance Code, the depository institution is requiring that collateral used to secure the loan be insured to cover the amount of the loan to the extent insurance is available on the property to be insured, against the usual and customary casualty losses.

"You have the right to provide this insurance either through existing policies already owned or controlled by you or by obtaining the insurance through any insurance agent or insurer authorized to engage in business in Texas.

"The depository institution, through its own insurance agency, can also make this insurance available to you. However, federal and state laws provide that the depository institution cannot require you to obtain insurance through the depository institution, its subsidiary, an affiliate, or any particular unaffiliated third party, either as a condition to obtaining this credit or to obtain special terms or consideration.

"Insurance products sold through or in the depository institution or its affiliate or subsidiary are not insured by the Federal Deposit Insurance Corporation and are not issued, guaranteed, or underwritten by the depository institution or the Federal Deposit Insurance Corporation.

"You are not required or obligated to purchase insurance from the depository institution or any subsidiary, affiliate, or particular unaffiliated third party as a condition to obtaining your loan, and your decision as to insurance agents will not affect your credit terms in any way.

Customer

Date

 Employee of Depository
 Institution"

(b) The commissioner may amend the disclosure form as necessary to comply with federal or state law.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

**CHAPTER 557. INSURED PROPERTY SUBJECT TO SECURITY INTEREST
 SUBCHAPTER A. INSURANCE PROCEEDS HELD BY LENDER PENDING REPAIR OF
 RESIDENTIAL REAL PROPERTY**

Sec. 557.001. DEFINITIONS. In this subchapter:

(1) "Lender" means a person holding a mortgage, lien, deed of trust, or other security interest in property.

(2) "Residential real property" means:

(A) a single-family house;

(B) a duplex, triplex, or quadraplex; or

(C) a unit in a multi-unit residential structure in which title to an individual unit is transferred to the owner of the unit under a condominium or cooperative system.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 557.002. NOTIFICATION BY LENDER TO INSURED CONCERNING INSURANCE PROCEEDS. (a) If a claim under an insurance policy for damage to residential real property is paid to the insured and a lender, and the lender holds all or part of the proceeds from the insurance claim payment pending completion of all or part of the repairs to the property, the lender shall notify the insured of each requirement with which the insured must comply for the lender to release the insurance proceeds.

(b) The notice required under this section must be provided not later than the 10th day after the date the lender receives payment of the insurance proceeds.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 557.003. LENDER'S RELEASE OR REFUSAL TO RELEASE INSURANCE PROCEEDS. Not later than the 10th day after the date a lender receives from the insured a request for release of all or part of the insurance proceeds held by the lender, the lender shall:

(1) if the lender has received sufficient evidence of the insured's compliance with the requirements specified by the lender under Section 557.002 for release of the proceeds, release to the insured, as requested, all or part of the proceeds; or

(2) provide notice to the insured that explains specifically:

(A) the reason for the lender's refusal to release the proceeds to the insured; and

(B) each requirement with which the insured must comply for the lender to release the proceeds.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 557.004. PAYMENT OF INTEREST; RATE. A lender who fails to provide notice as required by Section 557.002 or 557.003 or to release insurance proceeds as required by Section 557.003 shall pay to the insured interest at the rate of 10 percent a year on the proceeds held by the lender.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 557.005. ACCRUAL OF INTEREST. (a) If a lender fails to provide notice as required by Section 557.002 or 557.003, interest begins to accrue on the date the lender received the insurance proceeds.

(b) If a lender fails to release insurance proceeds as required by Section 557.003, interest begins to accrue on the date the lender receives sufficient evidence of the insured's compliance with the requirements specified by the lender under Section 557.002 or 557.003 for release of the proceeds.

(c) Interest stops accruing on the date the lender complies with Section 557.002 or 557.003, as applicable.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 557.006. INTEREST NOT REQUIRED ON INSURANCE PROCEEDS APPLIED TO REDUCE NOTE. A lender is not required to pay interest on insurance proceeds applied, in accordance with the terms and conditions of a deed of trust or other security agreement, to reduce a note.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

SUBCHAPTER B. LIENHOLDER APPROVAL OF INSURANCE CLAIM PAYMENT RELATING TO PERSONAL PROPERTY

Sec. 557.051. LIENHOLDER APPROVAL OF PAYMENT. If payment of an insurance claim relating to personal property requires the endorsement of a check or draft by a holder of a lien on the property or otherwise requires approval of the lienholder, not later than the 14th business day after the date the lienholder receives a request for the endorsement or other approval, the lienholder shall provide:

- (1) the endorsement or approval; or
- (2) a written statement of the reason for denial of the endorsement or approval to the person who requested the endorsement or approval.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 557.052. CIVIL PENALTY. (a) A lienholder who violates Section 557.051 is liable for a civil penalty not to exceed \$500 for each violation.

(b) The attorney general may bring an action to collect a civil penalty under this section.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

CHAPTER 558. REFUND OF UNEARNED PREMIUM

Sec. 558.001. DEFINITION. In this chapter, "insurer" means an insurance company or other entity authorized to engage in the business of insurance in this state. The term includes:

- (1) a stock life, health, or accident insurance company;
- (2) a mutual life, health, or accident insurance company;
- (3) a stock fire or casualty insurance company;

- (4) a mutual fire or casualty insurance company;
- (5) a Mexican casualty insurance company;
- (6) a farm mutual insurance company;
- (7) a county mutual insurance company;
- (8) a Lloyd's plan;
- (9) a reciprocal or insurance exchange;
- (10) a fraternal benefit society;
- (11) a stipulated premium company;
- (12) a nonprofit legal services corporation;
- (13) a statewide mutual assessment company;
- (14) a local mutual aid association;
- (15) a local mutual burial association;
- (16) an association exempt under Section 887.102;
- (17) a nonprofit hospital, medical, or dental service corporation, including a corporation subject to Chapter 842;
- (18) a risk retention group;
- (19) a purchasing group;
- (20) an eligible surplus lines insurer; and
- (21) a guaranty association operating under Chapter 462 or 463.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2D.015,
eff. April 1, 2009.

Sec. 558.002. APPLICABILITY OF CHAPTER; REFUND OF UNEARNED PREMIUM. (a) This chapter applies to an insurer that issues an insurance policy that requires the insurer to maintain an unearned premium reserve for the portion of the written policy premium applicable to the unexpired or unused part of the policy period for which the premium has been paid.

(b) An insurer shall promptly refund the appropriate portion of any unearned premium to the policyholder if the policy:

- (1) has a remaining unearned premium reserve; and
- (2) is canceled or terminated by the insured or the insurer before the end of its term.

(c) A guaranty association shall promptly refund any unearned premium as described by Subchapter E, Chapter 462, or Sections

463.003(9) and 463.259.

(d) An insurer shall refund the appropriate portion of any unearned premium to the policyholder not later than the 15th business day after the effective date of cancellation or termination of a policy of personal automobile or residential property insurance, as those terms are defined by Section 2301.051.

(e) Notwithstanding Subsection (d), a guaranty association shall refund any unearned premium as described by Subchapter E, Chapter 462, not later than the 30th business day after the date the guaranty association receives any necessary and accurate financial information, including supporting accounting information, required to determine unearned premium under a policy of personal automobile or residential property insurance, as those terms are defined by Section 2301.051.

(f) For purposes of this section, "business day" means a day other than a Saturday, Sunday, or holiday recognized by this state.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2D.016, eff. April 1, 2009.

Acts 2013, 83rd Leg., R.S., Ch. 94 (S.B. 698), Sec. 1, eff. May 18, 2013.

Sec. 558.003. RULES AND GUIDELINES. The commissioner shall:

- (1) adopt rules necessary to implement this chapter; and
- (2) establish appropriate guidelines to determine the portion of an unearned premium that must be refunded to a policyholder under this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 558.004. EFFECT ON INSURANCE PREMIUM FINANCE COMPANY.

This chapter does not affect the obligation of an insurer to pay an unearned premium to an insurance premium finance company in accordance with Section 651.162.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

CHAPTER 559. CREDIT SCORING AND CREDIT INFORMATION**SUBCHAPTER A. GENERAL PROVISIONS**

Sec. 559.001. DEFINITIONS. In this chapter:

(1) "Adverse effect" means an action taken by an insurer in connection with the underwriting of insurance for a consumer that results in the denial of coverage, the cancellation or nonrenewal of coverage, or the offer to and acceptance by a consumer of a policy form, premium rate, or deductible other than the policy form, premium rate, or deductible for which the consumer specifically applied.

(2) "Agent" means a person licensed or required to be licensed as a general property and casualty insurance agent or a personal lines property and casualty agent under Chapter 4051.

(3) "Applicant for insurance coverage" means an individual who has applied to an insurer for coverage under a personal insurance policy.

(4) "Consumer" means an individual whose credit information is used or whose credit score is computed in the underwriting or rating of a personal insurance policy. The term includes an applicant for insurance coverage.

(5) "Consumer reporting agency" means any person that, for monetary fees or dues or on a cooperative nonprofit basis, regularly engages in the practice of assembling or evaluating consumer credit information or other information on consumers for the purpose of furnishing consumer reports to third parties.

(6) "Credit information" means any credit-related information derived from a credit report, found in a credit report itself, or provided in an application for personal insurance. The term does not include information that is not credit-related, regardless of whether that information is contained in a credit report or in an application for insurance coverage or is used to compute a credit score.

(7) "Credit report" means any written, oral, or other communication of information by a consumer reporting agency that:

(A) bears on a consumer's creditworthiness, credit standing, or credit capacity; and

(B) is used or expected to be used or collected in whole or in part to serve as a factor to determine personal insurance premiums, eligibility for coverage, or tier placement.

(8) "Credit score" or "insurance score" means a number or rating derived from an algorithm, computer application, model, or

other process that is:

(A) based on credit information; and

(B) used to predict the future insurance loss exposure of a consumer.

(9) "Insured" means a consumer who has purchased an insurance policy from an insurer.

(10) "Insurer" means an insurer authorized to write property and casualty insurance in this state, including an insurance company, reciprocal or interinsurance exchange, mutual insurance company, capital stock company, county mutual insurance company, association, Lloyd's plan, or other entity writing personal insurance in this state. The term includes an affiliate, as described by this code, if that affiliate is authorized to write personal insurance in this state. The term does not include a farm mutual insurance company or an eligible surplus lines insurer under this code.

(11) "Personal insurance" means:

(A) a personal automobile insurance policy;

(B) a residential property insurance policy;

(C) a residential fire and allied lines insurance policy; or

(D) a noncommercial insurance policy covering a boat, personal watercraft, snowmobile, or recreational vehicle.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.020(a), eff. September 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 548 (S.B. 1263), Sec. 2.05, eff. September 1, 2007.

Sec. 559.002. APPLICABILITY OF CHAPTER. This chapter applies to an insurer that writes personal insurance coverage and uses credit information or credit reports for the underwriting or rating of that coverage.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.020(a), eff. September 1, 2005.

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

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

(2) post the report required under former Section 15, Article 21.49-2U, on the department's Internet website.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.020(a), eff. September 1, 2005.

Sec. 559.004. RULES. (a) The commissioner may adopt rules necessary to implement this chapter.

(b) The commissioner shall adopt rules that prescribe the allowable differences in rates charged by insurers due solely to the difference in credit scores.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.020(a), eff. September 1, 2005.

SUBCHAPTER B. USE OF CREDIT SCORING AND CREDIT INFORMATION

Sec. 559.051. PERMISSIBLE USE OF CREDIT SCORING. An insurer may use credit scoring, except for factors that constitute unfair discrimination, to develop rates, rating classifications, or underwriting criteria regarding lines of insurance subject to this chapter.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.020(a), eff. September 1, 2005.

Sec. 559.052. PROHIBITED USE OF CREDIT INFORMATION. (a) An insurer may not:

(1) use a credit score that is computed using factors that constitute unfair discrimination;

(2) deny, cancel, or nonrenew a policy of personal insurance solely on the basis of credit information without considering any other applicable underwriting factor independent of credit information; or

(3) take an action that results in an adverse effect against a consumer because the consumer does not have a credit card

account without considering any other applicable factor independent of credit information.

(b) An insurer may not consider an absence of credit information or an inability to determine credit information for an applicant for insurance coverage or for an insured as a factor in underwriting or rating an insurance policy unless the insurer:

(1) has statistical, actuarial, or reasonable underwriting information that:

(A) is reasonably related to actual or anticipated loss experience; and

(B) shows that the absence of credit information could result in actual or anticipated loss differences;

(2) treats the consumer as if the applicant for insurance coverage or insured had neutral credit information, as defined by the insurer; or

(3) excludes the use of credit information as a factor in underwriting and uses only other underwriting criteria.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.020(a), eff. September 1, 2005.

Sec. 559.053. DISCLOSURE TO CONSUMER REGARDING USE OF CREDIT SCORING. (a) An insurer that uses credit scoring in the underwriting or rating of insurance subject to this chapter shall disclose to each applicant for insurance coverage that the applicant's credit report may be used in the underwriting or rating of the applicant's policy. The disclosure must be provided at the time of application by the insurer or agent and may be given orally, in writing, or electronically.

(b) If a policy is issued to the applicant for insurance coverage, an insurer or agent is not required to make the disclosure required under Subsection (a) on any subsequent renewal of the coverage.

(c) An insurer or its agent shall disclose to its customers, on a form adopted by the commissioner, whether credit information will be obtained on an applicant for insurance coverage or insured or on any other member or members of the applicant's or insured's household and used as part of the insurance credit scoring process.

(d) If credit information is obtained or used on an applicant

for insurance coverage or insured, or on any member of the applicant's or insured's household, the insurer shall disclose to the applicant or insured the name of each person on whom credit information was obtained or used and how each person's credit information was used to underwrite or rate the policy.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.020(a), eff. September 1, 2005.

Sec. 559.054. NOTICE OF ACTION RESULTING IN ADVERSE EFFECT.

(a) If, based in whole or in part on information contained in a credit report, an insurer takes an action resulting in an adverse effect with respect to an applicant for insurance coverage or insured, the insurer shall provide to the applicant or insured within 30 days:

(1) written or electronic notice of the action resulting in an adverse effect and the reasons for that action;

(2) the name, address, and telephone number of the consumer reporting agency, including a toll-free number established by the agency and the agency's Internet website, if applicable;

(3) written or electronic notice that the consumer reporting agency did not make the decision to take the action resulting in an adverse effect and will be unable to provide the applicant or insured the specific reasons why the action was taken; and

(4) written or electronic notice of the applicant's or insured's right to:

(A) obtain a free copy of the consumer's credit report from the consumer reporting agency during the 60-day period after the date of the notice; and

(B) dispute with the consumer reporting agency the accuracy or completeness of any information in the consumer's credit report furnished by the agency.

(b) In the notice described by Subsection (a)(1), an insurer shall include a description of not more than four factors that were the primary influences of the action resulting in the adverse effect.

(c) The use by an insurer of a generalized term such as "poor credit history," "poor credit rating," or "poor credit score" does not constitute sufficient notice under this section of the action

resulting in the adverse effect.

(d) Standardized credit explanations provided by a consumer reporting agency or other third-party vendor are also sufficient to comply with this section.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.020(a), eff. September 1, 2005.

Sec. 559.055. DISPUTE RESOLUTION; ERROR CORRECTION. (a) If it is determined through the dispute resolution process established under Section 611(a)(5), Fair Credit Reporting Act (15 U.S.C. Section 1681i), as amended, that the credit information of a current insured was inaccurate or incomplete or could not be verified and the insurer receives notice of that determination from the consumer reporting agency or from the insured, the insurer shall re-underwrite and re-rate the insured not later than the 30th day after the date the insurer receives the notice.

(b) After re-underwriting or re-rating an insured under Subsection (a), an insurer shall make any adjustments necessary within 30 days, consistent with the insurer's underwriting and rating guidelines. If an insurer determines that the insured has overpaid premium, the insurer shall credit the insured the amount of overpayment. The insurer shall compute the overpayment back to the shorter of:

- (1) the last 12 months of coverage; or
- (2) the actual policy period.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.020(a), eff. September 1, 2005.

Sec. 559.056. INDEMNIFICATION OF AGENT. (a) An insurer shall indemnify, defend, and hold its agent harmless from and against all liability, fees, and costs that arise out of or relate to the actions, errors, or omissions of an agent who obtains or uses credit information or credit scores for the insurer if the agent:

- (1) follows the instructions of or procedures established by the insurer; and
- (2) complies with any applicable law or rule.

(b) This section may not be construed to establish a cause of

action that does not exist in the absence of this section.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.020(a), eff. September 1, 2005.

Sec. 559.057. SALE OF POLICY TERM INFORMATION BY CONSUMER REPORTING AGENCY PROHIBITED. (a) A consumer reporting agency may not provide or sell data or lists that include any information that, in whole or in part, was submitted in conjunction with an insurance inquiry about a consumer's credit information or a request for a credit report or credit score, including:

- (1) the expiration dates of an insurance policy or any other information that may identify periods during which a consumer's insurance may expire; and
- (2) the terms and conditions of the consumer's insurance coverage.

(b) The restriction under Subsection (a) does not apply to data or lists that the consumer reporting agency provides to:

- (1) the agent from whom information was received;
- (2) the insurer on whose behalf the agent acted; or
- (3) that insurer's affiliates.

(c) This section may not be construed to restrict the ability of an insurer to obtain a claims history report or a report regarding a motor vehicle.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.020(a), eff. September 1, 2005.

SUBCHAPTER C. COMPUTING CREDIT SCORE; EVALUATING CREDIT INFORMATION

Sec. 559.101. NEGATIVE FACTORS. An insurer may not use any of the following as a negative factor in any credit scoring methodology or in reviewing credit information to underwrite or rate a policy of personal insurance:

- (1) a credit inquiry that is not initiated by the consumer;
- (2) an inquiry relating to insurance coverage, if so identified on a consumer's credit report; or
- (3) a collection account with a medical industry code, if so identified on the consumer's credit report.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.020(a), eff. September 1, 2005.

Sec. 559.102. MULTIPLE LENDER INQUIRIES. (a) An insurer shall consider multiple lender inquiries made within 30 days of a prior inquiry, if coded by the consumer reporting agency on the consumer's credit report as from the home mortgage industry, as only one inquiry.

(b) An insurer shall consider multiple lender inquiries made within 30 days of a prior inquiry, if coded by the consumer reporting agency on the consumer's credit report as from the motor vehicle lending industry, as only one inquiry.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.020(a), eff. September 1, 2005.

Sec. 559.103. EXTRAORDINARY EVENTS. (a) Notwithstanding any other law, an insurer shall, on written request from an applicant for insurance coverage or an insured, provide reasonable exceptions to the insurer's rates, rating classifications, or underwriting rules for a consumer whose credit information has been directly influenced by:

- (1) a catastrophic illness or injury;
- (2) the death of a spouse, child, or parent;
- (3) temporary loss of employment;
- (4) divorce; or
- (5) identity theft.

(b) In a situation described by Subsection (a), an insurer:

- (1) may consider only credit information not affected by the event; or
- (2) shall assign a neutral credit score.

(c) An insurer may require reasonable written and independently verifiable documentation of the event and the effect of the event on the person's credit before granting an exception. An insurer is not required to consider repeated events or events the insurer reconsidered previously as an extraordinary event.

(d) An insurer may also consider granting an exception to an applicant for insurance coverage or an insured for an extraordinary

event not listed in Subsection (a).

(e) An insurer is not out of compliance with any law or rule relating to underwriting, rating, or rate filing as a result of granting an exception under this section.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.020(a), eff. September 1, 2005.

SUBCHAPTER D. FILING OF CREDIT SCORING MODELS

Sec. 559.151. FILING REQUIRED. (a) An insurer that uses credit scores to underwrite and rate risks shall file the insurer's credit scoring models or other credit scoring processes with the department.

(b) Another entity may file credit scoring models on behalf of an insurer.

(c) A filing that includes credit scoring may include loss experience justifying the use of credit information.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.020(a), eff. September 1, 2005.

Sec. 559.152. PUBLIC INFORMATION. A credit scoring model filed to comply with this chapter, as of the date the filing is received by the department:

- (1) is public information;
- (2) is not subject to any exceptions to disclosure under Chapter 552, Government Code; and
- (3) cannot be withheld from disclosure under any other law.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.020(a), eff. September 1, 2005.

SUBCHAPTER E. ENFORCEMENT

Sec. 559.201. VIOLATION. An insurer that violates this chapter or a rule adopted under this chapter commits an unfair practice in violation of Chapter 541 and is subject to sanctions under Chapter 82.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.020(a), eff. September 1, 2005.

CHAPTER 560. PROHIBITED RATES

Sec. 560.001. DEFINITION OF INSURER. In this chapter, "insurer" means an insurance company, reciprocal or interinsurance exchange, mutual insurance company, farm mutual insurance company, capital stock insurance company, county mutual insurance company, Lloyd's plan, surplus lines insurer, or other legal entity engaged in the business of insurance in this state. The term includes:

- (1) an affiliate described by Section 823.003(a);
- (2) the Texas Windstorm Insurance Association established under Chapter 2210;
- (3) the FAIR Plan Association established under Chapter 2211; and
- (4) the Texas Automobile Insurance Plan Association established under Chapter 2151.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1D.002, eff. April 1, 2009.

Sec. 560.002. USE OF CERTAIN RATES PROHIBITED; RATE REQUIREMENTS. (a) An insurer may not use a rate that violates this chapter.

(b) A rate used under this code:

- (1) must be just, fair, reasonable, and adequate; and
- (2) may not be:
 - (A) confiscatory;
 - (B) excessive for the risks to which the rate applies;

or

(C) unfairly discriminatory.

(c) For purposes of this section, a rate is:

- (1) inadequate if the rate is insufficient to sustain projected losses and expenses to which the rate applies, and continued use of the rate:
 - (A) endangers the solvency of an insurer using the rate; or
 - (B) has the effect of substantially lessening

competition or creating a monopoly in any market;

(2) excessive if the rate is likely to produce a long-term profit that is unreasonably high in relation to the insurance coverage provided; or

(3) unfairly discriminatory if the rate:

(A) is not based on sound actuarial principles;

(B) does not bear a reasonable relationship to the expected loss and expense experience among risks; or

(C) is based wholly or partly on the race, creed, color, ethnicity, or national origin of the policyholder or an insured.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1D.002, eff. April 1, 2009.

**CHAPTER 562. UNFAIR METHODS OF COMPETITION AND
UNFAIR OR DECEPTIVE ACTS OR PRACTICES REGARDING**

DISCOUNT HEALTH CARE PROGRAMS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 562.001. PURPOSE. The purpose of this chapter is to regulate trade practices in the business of discount health care programs by:

(1) defining or providing for the determination of trade practices in this state that are unfair methods of competition or unfair or deceptive acts or practices; and

(2) prohibiting those unfair or deceptive trade practices.

Added by Acts 2009, 81st Leg., R.S., Ch. 1331 (H.B. 4341), Sec. 1, eff. September 1, 2009.

Sec. 562.002. DEFINITIONS. In this chapter:

(1) "Advertisement, solicitation, or marketing material" means material that is made, published, disseminated, circulated, or placed before the public:

(A) in a newspaper, magazine, or other publication;

(B) in a notice, circular, pamphlet, letter, or poster;

(C) over a radio or television station;

(D) through the Internet;

(E) in a telephone sales script; or

(F) in any other manner.

(2) "Discount health care program" means a business arrangement or contract in which an entity, in exchange for fees, dues, charges, or other consideration, offers its members access to discounts on health care services provided by health care providers. The term does not include an insurance policy, certificate of coverage, or other product otherwise regulated by the department or a self-funded or self-insured employee benefit plan.

(3) "Discount health care program operator" means a person who, in exchange for fees, dues, charges, or other consideration, operates a discount health care program and contracts with providers, provider networks, or other discount health care program operators to offer access to health care services at a discount and determines the charge to members.

(4) "Health care services" includes physician care, inpatient care, hospital surgical services, emergency services, ambulance services, laboratory services, audiology services, dental services, vision services, mental health services, substance abuse services, chiropractic services, and podiatry services, and the provision of medical equipment and supplies, including prescription drugs.

(5) "Marketer" means a person who sells or distributes, or offers to sell or distribute, a discount health care program, including a private label entity that places its name on and markets or distributes a discount health care program, but does not operate a discount health care program.

(6) "Member" means a person who pays fees, dues, charges, or other consideration for the right to participate in a discount health care program.

(7) "Person" means an individual, corporation, association, partnership, or other legal entity.

(8) "Program operator" means a discount health plan program operator.

(9) "Provider" means a person who is licensed or otherwise authorized to provide health care services in this state.

Added by Acts 2009, 81st Leg., R.S., Ch. 1331 (H.B. [4341](#)), Sec. 1, eff. September 1, 2009.

Sec. 562.003. VENUE FOR ACTIONS INVOLVING DEPARTMENT OR COMMISSIONER. An action under this chapter in which the department or commissioner is a party must be brought in a district court in Travis County.

Added by Acts 2009, 81st Leg., R.S., Ch. 1331 (H.B. 4341), Sec. 1, eff. September 1, 2009.

Sec. 562.004. APPLICABILITY. Except as otherwise provided by this chapter, a program operator, including the operator of a freestanding discount health care program or a discount health care program marketed by an insurer or a health maintenance organization, shall comply with this chapter.

Added by Acts 2009, 81st Leg., R.S., Ch. 1331 (H.B. 4341), Sec. 1, eff. September 1, 2009.

Sec. 562.0041. EXEMPTION. This chapter does not apply to a health care sharing ministry operated under Chapter 1681.

Added by Acts 2013, 83rd Leg., R.S., Ch. 455 (S.B. 874), Sec. 2, eff. June 14, 2013.

Sec. 562.005. LIBERAL CONSTRUCTION. This chapter shall be liberally construed and applied to promote the underlying purposes as provided by Section 562.001.

Added by Acts 2009, 81st Leg., R.S., Ch. 1331 (H.B. 4341), Sec. 1, eff. September 1, 2009.

**SUBCHAPTER B. UNFAIR METHODS OF COMPETITION AND
UNFAIR OR DECEPTIVE ACTS OR PRACTICES DEFINED**

Sec. 562.051. MISREPRESENTATION REGARDING DISCOUNT HEALTH CARE PROGRAM. It is an unfair method of competition or an unfair or deceptive act or practice in the business of discount health care programs to:

- (1) misrepresent the price range of discounts offered by

the discount health care program;

(2) misrepresent the size or location of the program's network of providers;

(3) misrepresent the participation of a provider in the program's network;

(4) suggest that a discount card offered through the program is a federally approved Medicare prescription discount card;

(5) use the term "insurance," except as:

(A) a disclaimer of any relationship between the discount health care program and insurance; or

(B) a description of an insurance product connected with a discount health care program; or

(6) use the term "health plan," "coverage," "copay," "copayments," "deductible," "preexisting conditions," "guaranteed issue," "premium," "PPO," or "preferred provider organization," or another similar term, in a manner that could reasonably mislead an individual into believing that the discount health care program is health insurance or provides coverage similar to health insurance.

Added by Acts 2009, 81st Leg., R.S., Ch. 1331 (H.B. [4341](#)), Sec. 1, eff. September 1, 2009.

Sec. 562.052. FALSE INFORMATION AND ADVERTISING. It is an unfair method of competition or an unfair or deceptive act or practice in the business of discount health care programs to make, publish, disseminate, circulate, or place before the public or directly or indirectly cause to be made, published, disseminated, circulated, or placed before the public an advertisement, solicitation, or marketing material containing an untrue, deceptive, or misleading assertion, representation, or statement regarding the discount health care program.

Added by Acts 2009, 81st Leg., R.S., Ch. 1331 (H.B. [4341](#)), Sec. 1, eff. September 1, 2009.

Sec. 562.053. FAILURE TO REGISTER OR RENEW REGISTRATION; FALSE REGISTRATION OR RENEWAL STATEMENT. (a) It is an unfair method of competition or an unfair or deceptive act or practice in the business of discount health care programs to:

- (1) fail to register or renew registration as required under Chapter 7001; or
- (2) with intent to deceive:
 - (A) file with the department a false statement in connection with an application for registration as a program operator under Chapter 7001; or
 - (B) file with the department a false statement in connection with an application for renewal of a registration as a program operator under Chapter 7001.
- (b) The commissioner may impose on a person operating a discount health care program for the person's failure to register or renew registration as required under Chapter 7001 any remedy that the commissioner is authorized to impose under Chapter 101 for the unauthorized business of insurance.

Added by Acts 2009, 81st Leg., R.S., Ch. 1331 (H.B. [4341](#)), Sec. 1, eff. September 1, 2009.

Sec. 562.054. MISREPRESENTATION OF DISCOUNT HEALTH CARE PROGRAMS. It is an unfair method of competition or an unfair or deceptive act or practice in the business of discount health care programs to misrepresent a discount health care program by:

- (1) making an untrue statement of material fact;
- (2) failing to state a material fact necessary to make other statements made not misleading, considering the circumstances under which the statements were made;
- (3) making a statement in a manner that would mislead a reasonably prudent person to a false conclusion of a material fact;
- (4) making a material misstatement of law; or
- (5) failing to disclose a matter required by law to be disclosed, including failing to make an applicable disclosure required by this code.

Added by Acts 2009, 81st Leg., R.S., Ch. 1331 (H.B. [4341](#)), Sec. 1, eff. September 1, 2009.

Sec. 562.055. NETWORK PARTICIPATION REQUIREMENTS. (a) It is an unfair method of competition or an unfair or deceptive act or practice in the business of discount health care programs for a

discount health care program operator or an affiliate or agent of a discount health care program operator to require a pharmacy or pharmacist to:

(1) participate in a specified provider network as a condition of processing a claim for prescription drugs under the discount health care program; or

(2) participate in, or process claims under, a discount health care program as a condition of participation in a provider network.

(b) A discount health care program operator is not legally liable for any act or omission of an agent of the operator in violation of Subsection (a).

Added by Acts 2015, 84th Leg., R.S., Ch. 573 (H.B. 3028), Sec. 1, eff. September 1, 2015.

Sec. 562.056. CERTAIN METHODS OF PROMOTIONS. (a) It is an unfair method of competition or an unfair or deceptive act or practice in the business of discount health care programs for a discount health care program operator to pay any consideration to a health care services provider or employee of a health care services provider:

(1) to encourage an individual to claim a discount for prescription drugs under a discount health care program; or

(2) to include discount health care program information on a prescription for a drug or in materials accompanying the prescription.

(b) It is an unfair method of competition or an unfair or deceptive act or practice in the business of discount health care programs for a discount health care program operator to provide a person with written prescription forms that could reasonably mislead an individual to believe that the discount health care program is health insurance or provides coverage similar to health insurance.

Added by Acts 2015, 84th Leg., R.S., Ch. 573 (H.B. 3028), Sec. 1, eff. September 1, 2015.

SUBCHAPTER C. REGULATION OF PRACTICES

Sec. 562.101. UNFAIR METHODS OF COMPETITION AND UNFAIR OR

DECEPTIVE ACTS OR PRACTICES PROHIBITED. A person may not engage in this state in a trade practice that is defined in this chapter as or determined under this chapter to be an unfair method of competition or an unfair or deceptive act or practice in the business of discount health care programs.

Added by Acts 2009, 81st Leg., R.S., Ch. 1331 (H.B. 4341), Sec. 1, eff. September 1, 2009.

Sec. 562.102. PROHIBITED CONTENT OF CERTAIN DISCOUNT HEALTH CARE PROGRAM ADVERTISING, SOLICITATION, OR MARKETING.

Notwithstanding any other provision of this code, it is unlawful for a program operator or marketer to advertise, solicit, or market a discount health care program containing the words "approved by the Texas Department of Insurance" or words with a similar meaning.

Added by Acts 2009, 81st Leg., R.S., Ch. 1331 (H.B. 4341), Sec. 1, eff. September 1, 2009.

Sec. 562.103. PROGRAM OPERATOR DUTIES. (a) A program operator shall:

(1) provide a toll-free telephone number and Internet website for members to obtain information about the discount health care program and confirm or find providers currently participating in the program; and

(2) remove a provider from the discount health care program not later than the 30th day after the date the program operator learns that the provider is no longer participating in the program or has lost the authority to provide services or products.

(b) A program operator shall issue at least one membership card to serve as proof of membership in the discount health care program that must:

(1) contain a clear and conspicuous statement that the discount health care program is not insurance; and

(2) if the discount health care program includes discount prescription drug benefits, include:

(A) the name or logo of the entity administering the prescription drug benefits;

(B) the international identification number assigned by

the American National Standards Institute for the entity administering the prescription drug benefits;

(C) the group number applicable to the member; and

(D) a telephone number to be used to contact an appropriate person to obtain information relating to the prescription drug benefits provided under the program.

(c) Not later than the 15th day after the date of enrollment, a program operator shall issue at least one set of disclosure materials describing the terms and conditions of the discount health care program to each household in which a person is a member, including a statement that:

(1) the discount health care program is not insurance, with the word "not" capitalized;

(2) the member is required to pay the entire amount of the discounted rate;

(3) the discount health care program does not guarantee the quality of the services or products offered by individual providers; and

(4) if the member remains dissatisfied after completing the discount health care program's complaint system, the member may contact the member's state insurance department.

(d) A program operator shall ensure that an application form or other membership agreement:

(1) clearly and conspicuously discloses the duration of membership and the amount of payments the member is obligated to make for the membership; and

(2) contains a clear and conspicuous statement that the discount health care program is not insurance.

(e) A program operator shall allow any member who cancels a membership in the discount health care program not later than the 30th day after the date the person becomes a member to receive a refund, not later than the 30th day after the date the program operator receives a valid cancellation notice and returned membership card, of all periodic membership charges paid by that member to the program operator and the amount of any one-time enrollment fee that exceeds \$50.

(f) A program operator shall:

(1) maintain a surety bond, payable to the department for the use and benefit of members in a manner prescribed by the department, in the principal amount of \$50,000, except that a program

operator that is an insurer that holds a certificate of authority under Title 6 is not required to maintain the surety bond;

(2) maintain an agent for service of process in this state; and

(3) establish and operate a fair and efficient procedure for resolution of complaints regarding the availability of contracted discounts or services or other matters relating to the contractual obligations of the discount health care program to its members.

Added by Acts 2009, 81st Leg., R.S., Ch. 1331 (H.B. 4341), Sec. 1, eff. September 1, 2009.

Sec. 562.104. MARKETING OF PROGRAM. (a) A program operator may market directly or contract with marketers for the distribution of the program operator's discount health care programs.

(b) A program operator shall enter into a written contract with a marketer before the marketer begins marketing, promoting, selling, or distributing the program operator's discount health care program. The contract must prohibit the marketer from using an advertisement, solicitation, or other marketing material or a discount card that has not been approved in advance and in writing by the program operator.

(c) A program operator must approve in writing before their use all advertisements, solicitations, or other marketing materials and all discount cards used by marketers to market, promote, sell, or distribute the discount health care program.

(d) Each advertisement, solicitation, or marketing material of a discount health care program must clearly and conspicuously state that the discount health care program is not insurance.

Added by Acts 2009, 81st Leg., R.S., Ch. 1331 (H.B. 4341), Sec. 1, eff. September 1, 2009.

Sec. 562.105. CONTRACT REQUIREMENTS. (a) A program operator shall contract, directly or indirectly, with a provider offering discounted health care services or products under the discount health care program. The written contract must contain all of the following provisions:

(1) a description of the discounts to be provided to a member;

(2) a provision prohibiting the provider from charging a member more than the discounted rate agreed to in the written agreement with the provider; and

(3) a provision requiring the provider to promptly notify the program operator if the provider no longer participates in the program or loses the authority to provide services or products.

(b) The program operator may not charge or receive from a provider any fee or other compensation for entering into the agreement.

(c) If the program operator contracts with a network of providers, the program operator shall obtain written assurance from the network that:

(1) the network has a written agreement with each network provider that includes a discounted rate that is applicable to a program operator's discount health care program and contains all of the terms described in Subsection (a); and

(2) the network is authorized to obligate the network providers to provide services to members of the discount health care program.

(d) The program operator shall require the network to:

(1) maintain and provide the program operator on a monthly basis an up-to-date list of providers in the network; and

(2) promptly remove a provider from its network if the provider no longer participates or loses the authority to provide services or products.

(e) The program operator shall maintain a copy of each written agreement the program operator has with a provider or a network for at least two years following termination of the agreement.

Added by Acts 2009, 81st Leg., R.S., Ch. 1331 (H.B. [4341](#)), Sec. 1, eff. September 1, 2009.

Sec. 562.106. SUBMISSION OF MATERIALS. If the commissioner reasonably believes that a program operator or a marketer may not be operating in compliance with this chapter, the commissioner by order may require the program operator or the marketer to submit to the commissioner any advertisement, solicitation, or marketing material, disclosure material, discount card, agreement, or other document requested by the commissioner.

Added by Acts 2009, 81st Leg., R.S., Ch. 1331 (H.B. 4341), Sec. 1, eff. September 1, 2009.

Redesignated from Insurance Code, Section 561.106 by Acts 2011, 82nd Leg., R.S., Ch. 91 (S.B. 1303), Sec. 27.001(40), eff. September 1, 2011.

SUBCHAPTER D. DETERMINATION OF UNFAIR METHODS OF COMPETITION AND UNFAIR OR DECEPTIVE ACTS OR PRACTICES; ENFORCEMENT; SANCTIONS AND PENALTIES

Sec. 562.151. EXAMINATION AND INVESTIGATION. The department may examine and investigate the affairs of a person engaged in the business of discount health care programs in this state to determine whether the person:

- (1) has or is engaged in an unfair method of competition or unfair or deceptive act or practice prohibited by this chapter; or
- (2) has violated Subchapter B or C.

Added by Acts 2009, 81st Leg., R.S., Ch. 1331 (H.B. 4341), Sec. 1, eff. September 1, 2009.

Sec. 562.152. STATEMENT OF CHARGES; NOTICE OF HEARING. (a) When the department has reason to believe that a person engaged in the business of discount health care programs in this state has engaged or is engaging in this state in an unfair method of competition or unfair or deceptive act or practice defined by Subchapter B or has violated Subchapter B or C and that a proceeding by the department regarding the charges is in the interest of the public, the department shall issue and serve on the person:

- (1) a statement of the charges; and
- (2) a notice of the hearing on the charges, including the time and place for the hearing.

(b) The department may not hold the hearing before the sixth day after the date the notice required by Subsection (a)(2) is served.

Added by Acts 2009, 81st Leg., R.S., Ch. 1331 (H.B. 4341), Sec. 1, eff. September 1, 2009.

Sec. 562.153. HEARING. A person against whom charges are made under Section 562.152 is entitled at the hearing on the charges to have an opportunity to be heard and show cause why the department should not issue an order requiring the person to cease and desist from:

- (1) performing the unfair method of competition or unfair or deceptive act or practice described in the charges; or
- (2) violating Subchapter B or C.

Added by Acts 2009, 81st Leg., R.S., Ch. 1331 (H.B. 4341), Sec. 1, eff. September 1, 2009.

Sec. 562.154. HEARING PROCEDURES. (a) Nothing in this chapter requires the observance of formal rules of pleading or evidence at a hearing under this subchapter.

(b) At a hearing under this subchapter, the department, on a showing of good cause, shall permit any person to intervene, appear, and be heard by counsel or in person.

Added by Acts 2009, 81st Leg., R.S., Ch. 1331 (H.B. 4341), Sec. 1, eff. September 1, 2009.

Sec. 562.155. RECORD OF HEARING. (a) At a hearing under this subchapter, the department may, and at the request of a party to the hearing shall, make a record of the proceedings and the evidence presented at the hearing.

(b) If the department does not make a record and a person seeks judicial review of the decision made at the hearing, the department shall prepare a statement of the evidence and proceeding for use on review.

Added by Acts 2009, 81st Leg., R.S., Ch. 1331 (H.B. 4341), Sec. 1, eff. September 1, 2009.

Sec. 562.156. COMPLIANCE WITH SUBPOENA. (a) If a person refuses to comply with a subpoena issued in connection with a hearing under this subchapter or refuses to testify with respect to a matter about which the person may be lawfully interrogated, on application

of the department, a district court in Travis County or in the county in which the person resides may order the person to comply with the subpoena or testify.

(b) A court may punish as contempt a person's failure to obey an order under this section.

Added by Acts 2009, 81st Leg., R.S., Ch. 1331 (H.B. 4341), Sec. 1, eff. September 1, 2009.

Sec. 562.157. DETERMINATION OF VIOLATION. After a hearing under this subchapter to determine whether a person has engaged in an unfair method of competition or unfair or deceptive act or practice prohibited by this chapter, the department shall determine whether:

(1) the method of competition or the act or practice considered in the hearing is defined as:

(A) an unfair method of competition or deceptive act or practice under Subchapter B; or

(B) a false, misleading, or deceptive act or practice under Section 17.46, Business & Commerce Code; and

(2) the person against whom the charges were made engaged in the method of competition or act or practice in violation of:

(A) this chapter; or

(B) Subchapter E, Chapter 17, Business & Commerce Code, as specified in Section 17.46, Business & Commerce Code.

Added by Acts 2009, 81st Leg., R.S., Ch. 1331 (H.B. 4341), Sec. 1, eff. September 1, 2009.

Sec. 562.158. CEASE AND DESIST ORDER. On determining that a person committed a violation described by Section 562.157 or committed a violation of Subchapter B or C, the department shall:

(1) make written findings; and

(2) issue and serve on the person an order requiring the person to cease and desist from engaging in the method of competition or act or practice determined to be a violation or the violation of Subchapter B or C, as applicable.

Added by Acts 2009, 81st Leg., R.S., Ch. 1331 (H.B. 4341), Sec. 1, eff. September 1, 2009.

Sec. 562.159. MODIFICATION OR SETTING ASIDE OF ORDER. On the notice and in the manner the department determines proper, the department may modify or set aside wholly or partly a cease and desist order issued under Section 562.158 at any time before a petition appealing the order is filed in accordance with Subchapter D, Chapter 36.

Added by Acts 2009, 81st Leg., R.S., Ch. 1331 (H.B. 4341), Sec. 1, eff. September 1, 2009.

Sec. 562.160. ADMINISTRATIVE PENALTY FOR VIOLATION OF CEASE AND DESIST ORDER. (a) A person who violates a cease and desist order issued under Section 562.158 is subject to an administrative penalty under Chapter 84.

(b) In determining whether a person has violated a cease and desist order, the department shall consider the maintenance of procedures reasonably adapted to ensure compliance with the order.

(c) An administrative penalty imposed under this section may not exceed:

- (1) \$1,000 for each violation; or
- (2) \$5,000 for all violations.

(d) An order of the department imposing an administrative penalty under this section applies only to a violation of the cease and desist order committed before the date the order imposing the penalty is issued.

Added by Acts 2009, 81st Leg., R.S., Ch. 1331 (H.B. 4341), Sec. 1, eff. September 1, 2009.

Sec. 562.161. CIVIL PENALTY FOR VIOLATION OF CEASE AND DESIST ORDER. (a) A person who is found by a court to have violated a cease and desist order issued under Section 562.158 is liable to the state for a penalty. The state may recover the penalty in a civil action.

(b) The penalty may not exceed \$50 unless the court finds the violation to be wilful, in which case the penalty may not exceed \$500.

Added by Acts 2009, 81st Leg., R.S., Ch. 1331 (H.B. 4341), Sec. 1, eff. September 1, 2009.

SUBCHAPTER E. ENFORCEMENT BY ATTORNEY GENERAL

Sec. 562.201. INJUNCTIVE RELIEF. (a) The attorney general may bring an action under this section if the attorney general has reason to believe that:

(1) a person engaged in the business of discount health care programs in this state is engaging in, has engaged in, or is about to engage in an act or practice defined as unlawful under:

- (A) this chapter; or
- (B) Section 17.46, Business & Commerce Code; and

(2) the action is in the public interest.

(b) The attorney general may bring the action in the name of the state to restrain by temporary or permanent injunction the person's use of the method, act, or practice.

Added by Acts 2009, 81st Leg., R.S., Ch. 1331 (H.B. 4341), Sec. 1, eff. April 1, 2010.

Sec. 562.202. VENUE FOR INJUNCTIVE ACTION. An action for an injunction under this subchapter may be commenced in a district court in:

(1) the county in which the person against whom the action is brought:

- (A) resides;
- (B) has the person's principal place of business; or
- (C) is engaging in business;

(2) the county in which the transaction or a substantial portion of the transaction occurred; or

(3) Travis County.

Added by Acts 2009, 81st Leg., R.S., Ch. 1331 (H.B. 4341), Sec. 1, eff. April 1, 2010.

Sec. 562.203. ISSUANCE OF INJUNCTION. (a) The court may issue an appropriate temporary or permanent injunction.

(b) The court shall issue the injunction without bond.

Added by Acts 2009, 81st Leg., R.S., Ch. 1331 (H.B. 4341), Sec. 1, eff. April 1, 2010.

Sec. 562.204. CIVIL PENALTY. In addition to requesting a temporary or permanent injunction under Section 562.201, the attorney general may request a civil penalty of not more than \$20,000 for each violation on a finding by the court that the defendant has engaged in or is engaging in an act or practice defined as unlawful under this chapter or Section 17.46, Business & Commerce Code.

Added by Acts 2009, 81st Leg., R.S., Ch. 1331 (H.B. 4341), Sec. 1, eff. April 1, 2010.

Sec. 562.205. COMPENSATION OR RESTORATION. The court may make an additional order or judgment as necessary to compensate an identifiable person for actual damages or for restoration of money or property that may have been acquired by means of an enjoined act or practice.

Added by Acts 2009, 81st Leg., R.S., Ch. 1331 (H.B. 4341), Sec. 1, eff. April 1, 2010.

Sec. 562.206. CIVIL PENALTY FOR VIOLATION OF INJUNCTION. (a) A person who violates an injunction issued under this subchapter is liable for and shall pay to the state a civil penalty of not more than \$10,000 for each violation.

(b) The attorney general may, in the name of the state, petition the court for recovery of the civil penalty against the person who violates the injunction.

(c) The court shall consider the maintenance of procedures reasonably adapted to ensure compliance with the injunction in determining whether a person has violated an injunction.

(d) The court issuing the injunction retains jurisdiction and the cause is continued for the purpose of assessing a civil penalty under this section.

Added by Acts 2009, 81st Leg., R.S., Ch. 1331 (H.B. 4341), Sec. 1, eff. April 1, 2010.

Sec. 562.207. REMEDIES NOT EXCLUSIVE. The remedies provided by this subchapter:

- (1) are not exclusive; and
- (2) are in addition to any other remedy or procedure provided by another law or at common law.

Added by Acts 2009, 81st Leg., R.S., Ch. 1331 (H.B. 4341), Sec. 1, eff. April 1, 2010.

SUBCHAPTER F. ASSURANCE OF VOLUNTARY COMPLIANCE

Sec. 562.251. ACCEPTANCE OF ASSURANCE. (a) In administering this chapter, the department may accept assurance of voluntary compliance from a person who is engaging in, has engaged in, or is about to engage in an act or practice in violation of this chapter or Section 17.46, Business & Commerce Code.

(b) The assurance must be in writing and be filed with the department.

(c) The department may condition acceptance of an assurance of voluntary compliance on the stipulation that the person offering the assurance restore to a person in interest money that may have been acquired by the act or practice described in Subsection (a).

Added by Acts 2009, 81st Leg., R.S., Ch. 1331 (H.B. 4341), Sec. 1, eff. September 1, 2009.

Sec. 562.252. EFFECT OF ASSURANCE. (a) An assurance of voluntary compliance is not an admission of a prior violation of this chapter or Section 17.46, Business & Commerce Code.

(b) Unless an assurance of voluntary compliance is rescinded by agreement, a subsequent failure to comply with the assurance is prima facie evidence of a violation of this chapter or Section 17.46, Business & Commerce Code.

Added by Acts 2009, 81st Leg., R.S., Ch. 1331 (H.B. 4341), Sec. 1, eff. September 1, 2009.

Sec. 562.253. REOPENING. A matter closed by the filing of an assurance of voluntary compliance may be reopened at any time.

Added by Acts 2009, 81st Leg., R.S., Ch. 1331 (H.B. 4341), Sec. 1, eff. September 1, 2009.

SUBCHAPTER G. CONSTRUCTION OF CHAPTER WITH OTHER LAWS

Sec. 562.301. LIABILITY UNDER OTHER LAW. An order of the department under this chapter, or an order by a court to enforce that order, does not relieve or absolve a person affected by either order from liability under another law of this state.

Added by Acts 2009, 81st Leg., R.S., Ch. 1331 (H.B. 4341), Sec. 1, eff. September 1, 2009.

Sec. 562.302. POWERS IN ADDITION TO OTHER POWERS AUTHORIZED BY LAW. The powers vested in the department and the commissioner by this chapter are in addition to any other powers to enforce a penalty, fine, or forfeiture authorized by law with respect to a method of competition or act or practice defined as unfair or deceptive.

Added by Acts 2009, 81st Leg., R.S., Ch. 1331 (H.B. 4341), Sec. 1, eff. September 1, 2009.

Sec. 562.303. DOUBLE RECOVERY PROHIBITED. A person may not recover damages and penalties for the same act or practice under both this chapter and another law.

Added by Acts 2009, 81st Leg., R.S., Ch. 1331 (H.B. 4341), Sec. 1, eff. September 1, 2009.

CHAPTER 563. PRACTICES RELATING TO CLAIMS REPORTING

Sec. 563.001. DEFINITIONS. In this chapter:

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

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

Added by Acts 2011, 82nd Leg., R.S., Ch. 1147 (H.B. 1951), Sec. 13.001, eff. September 1, 2011.

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

Added by Acts 2011, 82nd Leg., R.S., Ch. 1147 (H.B. 1951), Sec. 13.001, eff. September 1, 2011.

CHAPTER 564. DISCLOSURES FOR THE SALE OF CERTAIN OCCUPATIONAL INSURANCE POLICIES

Sec. 564.001. SCOPE OF CHAPTER; PURPOSE. (a) This chapter is intended to require disclosures on policy forms for certain occupational insurance policies designed or marketed to provide coverage to an employer that elects not to maintain workers' compensation insurance coverage under Chapter 406, Labor Code.

(b) Nothing in this chapter prohibits an employer that is not required to maintain workers' compensation insurance coverage and has elected not to obtain workers' compensation insurance coverage from obtaining occupational accident, disease, or death insurance coverage for the employer or the employer's employees.

Added by Acts 2021, 87th Leg., R.S., Ch. 281 (H.B. 3769), Sec. 1, eff. September 1, 2021.

Sec. 564.002. APPLICABILITY OF CHAPTER. This chapter applies to an insurance company authorized to write accident and health insurance or liability insurance, including:

- (1) a surplus lines insurer;
- (2) a Lloyd's plan; and

(3) a reciprocal or interinsurance exchange.

Added by Acts 2021, 87th Leg., R.S., Ch. 281 (H.B. 3769), Sec. 1, eff. September 1, 2021.

Sec. 564.003. EXCEPTIONS. This chapter does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease or another limited benefit;

(B) only for dental or vision care; or

(C) only for hospital indemnity for hospital confinement;

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

(3) long-term care coverage or benefits, home health care coverage or benefits, community-based care coverage or benefits, or any combination of those coverages or benefits;

(4) an individual or group life insurance policy; or

(5) individual or group credit life, accident, or disability insurance.

Added by Acts 2021, 87th Leg., R.S., Ch. 281 (H.B. 3769), Sec. 1, eff. September 1, 2021.

Sec. 564.004. OCCUPATIONAL POLICY DEFINED. In this chapter, "occupational policy" means:

(1) an individual or group accident or health insurance policy that explicitly provides coverage or benefits for an employer or the employer's employees for an employee's occupational bodily injury, disease, or death;

(2) an employer's insurance policy that explicitly provides liability coverage to an employer that elects not to maintain workers' compensation insurance coverage under Chapter 406, Labor Code, for an employee's occupational bodily injury, disease, or death in:

(A) a general liability insurance policy;

(B) a commercial multiple peril insurance policy; or

(C) any other type of insurance policy designated by the department as intended to provide liability coverage to an

employer that elects not to maintain workers' compensation insurance coverage under Chapter 406, Labor Code, for an employee's occupational bodily injury, disease, or death;

(3) an accident, health, or liability insurance policy that does not expressly include coverage for occupational injuries, disease, or death, but is marketed or sold to or through an employer as an alternative to coverage for benefits or liability provided by a workers' compensation insurance policy; or

(4) a policy that includes occupational accident and health and liability coverage in the same policy.

Added by Acts 2021, 87th Leg., R.S., Ch. 281 (H.B. 3769), Sec. 1, eff. September 1, 2021.

Sec. 564.005. REQUIRED DISCLOSURES FOR OCCUPATIONAL POLICIES. An occupational policy shall include the following disclosure statement in 10-point boldface type on the first page of the policy and on the first page of all materials used in advertising or marketing the occupational policy to an employer that elects not to maintain workers' compensation insurance coverage under Chapter 406, Labor Code:

"THIS IS NOT A WORKERS' COMPENSATION INSURANCE POLICY. THE EMPLOYER DOES NOT OBTAIN WORKERS' COMPENSATION INSURANCE COVERAGE BY PURCHASING THIS POLICY, AND IF THE EMPLOYER HAS NOT ELECTED TO OBTAIN WORKERS' COMPENSATION INSURANCE COVERAGE, THE EMPLOYER DOES NOT OBTAIN THOSE BENEFITS THAT WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS IN THIS STATE. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAWS IN THIS STATE AS THEY PERTAIN TO EMPLOYERS THAT ELECT NOT TO MAINTAIN WORKERS' COMPENSATION INSURANCE COVERAGE AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED."

Added by Acts 2021, 87th Leg., R.S., Ch. 281 (H.B. 3769), Sec. 1, eff. September 1, 2021.

Sec. 564.006. RULES. The commissioner shall adopt rules as necessary to implement this chapter.

Added by Acts 2021, 87th Leg., R.S., Ch. 281 (H.B. 3769), Sec. 1, eff. September 1, 2021.

CHAPTER 565. PROHIBITED RATING CRITERIA

Sec. 565.001. PURPOSE. (a) The purpose of this chapter is to regulate the use of environmental, social, or governance models, scores, factors, or standards to define acts or practices that may be unfair discrimination in the business of insurance in this state.

(b) The legislature finds that there are numerous entities that have developed different environmental, social, or governance models, scores, factors, or standards that are used to:

(1) evaluate financial risks for investments in certain businesses or industries; or

(2) encourage or discourage business dealings or investments with certain types of businesses or industries.

(c) To the extent that the use of such models, scores, factors, or standards are not based on sound actuarial principles, or do not bear a reasonable relationship to the expected loss and expense experience related to insurance risks, the rating of certain businesses or risks in this state without an ordinary insurance business purpose may adversely affect the economy, a sector of the economy, productivity, competition, jobs, the environment, or the public health and safety of this state or a portion of this state.

Added by Acts 2023, 88th Leg., R.S., Ch. 1144 (S.B. 833), Sec. 1, eff. September 1, 2023.

Sec. 565.002. DEFINITION. In this chapter, "insurer" means an insurance company or other entity authorized to engage in the business of insurance in this state. The term includes:

(1) a stock or mutual property and casualty insurance company;

(2) a Lloyd's plan;

(3) a reciprocal or interinsurance exchange;

(4) a county mutual insurance company;

(5) a farm mutual insurance company;

(6) any insurer writing a line of insurance regulated by Title 10;

(7) all life, health, and accident insurance companies regulated by the department, including:

- (A) a stock or mutual life, health, or accident insurance company;
 - (B) a fraternal benefit society;
 - (C) a nonprofit hospital, medical, or dental service corporation, including a group hospital service corporation operating under Chapter 842; and
 - (D) a stipulated premium company; and
- (8) a health maintenance organization operating under Chapter 843.

Added by Acts 2023, 88th Leg., R.S., Ch. 1144 (S.B. 833), Sec. 1, eff. September 1, 2023.

Sec. 565.003. APPLICABILITY OF CHAPTER. (a) Except as provided by this section, this chapter applies only to insurance policies issued and delivered by an insurer in this state.

(b) This chapter does not require the filing of rates for any line, type of insurer, or type of insurance business that is not specifically required by statute to file rates with the department.

(c) This chapter does not apply to:

- (1) fidelity, guaranty, and surety bonds; or
- (2) crop insurance.

Added by Acts 2023, 88th Leg., R.S., Ch. 1144 (S.B. 833), Sec. 1, eff. September 1, 2023.

Sec. 565.004. CONSTRUCTION OF CHAPTER. (a) This chapter shall be construed and applied to promote the underlying purposes as provided by Section 565.001.

(b) This chapter may not be construed or applied to require:

- (1) an insurer to write any line or type of business that the insurer does not write; or
- (2) a material change in the insurer's current business plans.

(c) Nothing in this chapter is intended to create any type of private cause of action or independent basis in a civil or criminal proceeding.

(d) Nothing in this chapter is intended to prohibit the use of information that is relevant and related to the risk being insured

even if that information may also be used or considered in developing an environmental, social, or governance model, score, factor, or standard.

Added by Acts 2023, 88th Leg., R.S., Ch. 1144 (S.B. 833), Sec. 1, eff. September 1, 2023.

Sec. 565.005. PROHIBITED CRITERIA. Except as provided by Section 565.006, an insurer may not use an environmental, social, or governance model, score, factor, or standard to charge a rate different than the rate charged to another business or risk in the same class for essentially the same hazard.

Added by Acts 2023, 88th Leg., R.S., Ch. 1144 (S.B. 833), Sec. 1, eff. September 1, 2023.

Sec. 565.006. EXCEPTION. An insurer does not violate Section 565.005 if the insurer's actions are based on an ordinary insurance business purpose, including the use of sound actuarial principles, or financial solvency considerations reasonably related to loss experience for the different types of risks and coverages made available by a particular insurer.

Added by Acts 2023, 88th Leg., R.S., Ch. 1144 (S.B. 833), Sec. 1, eff. September 1, 2023.

Sec. 565.007. REGULATORY ACTION. Nothing in this chapter is intended to authorize the department to adopt any rule, model, or standard requiring an insurer to use any environmental, social, or governance model law, regulation, or other standard that has not been specifically authorized by statute, including:

(1) a rule, model, or standard required under any federal law that does not preempt state law under the McCarran-Ferguson Act (15 U.S.C. Section 1012(b)); or

(2) a rule, model, or standard required by any national organization, including the National Association of Insurance Commissioners, that has not been specifically authorized by statute.

Added by Acts 2023, 88th Leg., R.S., Ch. 1144 (S.B. 833), Sec. 1, eff. September 1, 2023.

SUBTITLE D. PRIVACY
CHAPTER 601. PRIVACY
SUBCHAPTER A. GENERAL PROVISIONS

Sec. 601.001. DEFINITIONS. In this chapter:

(1) "Affiliate" means a company that controls, is controlled by, or is under common control with another company. For the purposes of this subdivision, "control" has the meaning described by Sections 823.005 and 823.151.

(2) "Authorization" has the meaning assigned by Section 82.001.

(3) "Covered entity" means an individual or entity that receives an authorization from the department. The term includes an individual or entity described by Section 82.002.

(4) "Nonaffiliated third party" means an entity that is not an affiliate of, or related to by common ownership or affiliated by corporate control with, the covered entity. The term does not include a joint employee of the entity.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 601.002. COMPLIANCE WITH FEDERAL LAW REQUIRED. (a) A covered entity shall comply with 15 U.S.C. Sections 6802 and 6803, as amended, in the same manner as a financial institution is required to comply under those sections.

(b) An entity that is a nonaffiliated third party in relation to a covered entity shall comply with 15 U.S.C. Section 6802(c), as amended.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 601.003. EXEMPTION. Section 601.002(a) does not apply to a covered entity to the extent that the entity is acting solely as an insurance agent, employee, or other authorized representative for another covered entity.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 601.004. TREATMENT OF CERTAIN HEALTH INFORMATION; STRICTER RULES NOT PRECLUDED. This chapter does not affect the authority of the department or another state agency to adopt stricter rules governing the treatment of health information by a covered entity if another law gives the department or agency that authority, including a law or rule of this state related to the privacy of individually identifiable health information under Subtitle F, Title II, Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. Section 1320d et seq.), as amended.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

SUBCHAPTER B. DEPARTMENT POWERS AND DUTIES

Sec. 601.051. RULES. (a) The commissioner shall adopt:

(1) rules to implement this chapter; and

(2) any other rules necessary to carry out Subtitle A, Title V, Gramm-Leach-Bliley Act (15 U.S.C. Section 6801 et seq.), as amended, to make this state eligible to override federal regulations as described by 15 U.S.C. Section 6805(c), as amended.

(b) In adopting rules under this chapter, the commissioner shall attempt to keep state privacy requirements consistent with federal regulations adopted under Subtitle A, Title V, Gramm-Leach-Bliley Act (15 U.S.C. Section 6801 et seq.), as amended.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 601.052. IMPLEMENTATION OF CERTAIN STANDARDS. The department shall implement standards as required by 15 U.S.C. Section 6805(b), as amended.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

SUBCHAPTER C. ENFORCEMENT

Sec. 601.101. ENFORCEMENT BY DEPARTMENT. The department shall enforce 15 U.S.C. Sections 6801-6805, as amended, to the extent

required by 15 U.S.C. Section 6805, as amended, and this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 601.102. INJUNCTIVE OR DECLARATORY RELIEF; CIVIL PENALTY.

(a) The attorney general, after conferring with the commissioner, may institute an action for injunctive or declaratory relief to restrain a violation of this chapter.

(b) In addition to instituting an action for injunctive relief under Subsection (a), the attorney general, after conferring with the commissioner, may institute an action for civil penalties against a covered entity or nonaffiliated third party for a violation of this chapter. A civil penalty assessed under this section may not exceed \$3,000 for each violation.

(c) If the court in which an action under Subsection (b) is pending finds that violations of this chapter have occurred with a frequency that constitutes a pattern or practice, the court may assess a civil penalty not to exceed \$250,000.

(d) If the attorney general substantially prevails in an action for injunctive relief or a civil penalty under this section, the attorney general may recover reasonable attorney's fees, costs, and expenses incurred obtaining the relief or penalty, including court costs and witness fees.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

CHAPTER 602. PRIVACY OF HEALTH INFORMATION

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 602.001. DEFINITIONS. In this chapter:

(1) "Covered entity" means a person who holds or is required to hold a license, registration, certificate of authority, or other authorization under this code or another insurance law of this state. The term includes:

- (A) an insurance company, including:
 - (i) a county mutual insurance company;
 - (ii) a farm mutual insurance company;
 - (iii) a fraternal benefit society;
 - (iv) a group hospital service corporation;
 - (v) a Lloyd's plan;

- (vi) a local mutual aid association;
 - (vii) a mutual insurance company;
 - (viii) a reciprocal or interinsurance exchange;
 - (ix) a statewide mutual assessment company; and
 - (x) a stipulated premium company;
- (B) a health maintenance organization; and
 - (C) an insurance agent.

(2) "Health information" means information regarding an individual, other than the individual's age or gender, whether provided orally or recorded in any medium or form, that is created by or derived from the individual or a health care provider and that relates to:

- (A) the past, present, or future physical, mental, or behavioral health or condition of the individual;
- (B) the provision of health care to the individual; or
- (C) payment for the provision of health care to the individual.

(3) "Nonpublic personal health information" means health information:

- (A) that identifies an individual who is the subject of the information; or
- (B) with respect to which there is a reasonable basis to believe that the information could be used to identify an individual.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 602.002. APPLICABILITY OF CHAPTER TO COVERED ENTITY REQUIRED TO COMPLY WITH CERTAIN FEDERAL STANDARDS. This chapter does not apply to a covered entity that is required to comply with the standards governing the privacy of individually identifiable health information adopted by the United States secretary of health and human services under Section 262(a), Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. Section 1320d et seq.).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 602.003. CONSTRUCTION OF CHAPTER. (a) This chapter does not preempt or supersede state law in effect on July 1, 2002, that

relates to the privacy of medical records, health information, or insurance information.

(b) This chapter may not be construed to modify, limit, or supersede the operation of the federal Fair Credit Reporting Act (15 U.S.C. Section 1681 et seq.).

(c) This chapter may not be used as a basis for drawing an inference that information is or is not transaction or experience information under Section 603 of the federal Fair Credit Reporting Act (15 U.S.C. Section 1681a).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 602.004. RULES. The commissioner may adopt rules as necessary to implement this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

SUBCHAPTER B. AUTHORIZED DISCLOSURE OF CERTAIN HEALTH INFORMATION

Sec. 602.051. AUTHORIZATION FOR DISCLOSURE OF CERTAIN HEALTH INFORMATION. (a) Except as provided by Section 602.053, a covered entity must obtain authorization to disclose nonpublic personal health information before disclosing the information.

(b) A request for authorization to disclose nonpublic personal health information may be in written or electronic form and must:

(1) state the identity of the consumer or customer who is the subject of the information;

(2) describe:

(A) each type of information to be disclosed;

(B) each party to whom the covered entity intends to disclose the information;

(C) the purpose of the disclosure;

(D) how the information will be used; and

(E) the procedure for revoking the authorization;

(3) include the signature of:

(A) the consumer or customer who is the subject of the information; or

(B) the individual who is legally empowered to grant authorization;

(4) state the date the authorization is signed; and

(5) provide notice of:

(A) the period for which the authorization is valid;

and

(B) the consumer's or customer's right to revoke the authorization at any time.

(c) The period for which the authorization is valid may not exceed 24 months.

(d) The right of a consumer or customer to revoke an authorization at any time is subject to the rights of an individual who, before receiving notice of a revocation, acted in reliance on the authorization.

(e) The covered entity shall retain the original or a copy of the authorization in the records of the individual who is the subject of the nonpublic personal health information.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 602.052. DELIVERY OF AUTHORIZATION FORM AND REQUEST FOR AUTHORIZATION. (a) A covered entity may deliver to a consumer or customer a request for authorization and an authorization form only if the request and form are clear and conspicuous.

(b) A covered entity is required to include delivery of the authorization form in a notice to a consumer or customer only if the covered entity intends to disclose health information protected under this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 602.053. EXCEPTIONS. A covered entity may disclose nonpublic personal health information to the extent that the disclosure is necessary to perform the following insurance or health maintenance organization functions on behalf of the covered entity:

(1) the investigation or reporting of actual or potential fraud, misrepresentation, or criminal activity;

(2) underwriting;

(3) the placement or issuance of an insurance policy or evidence of coverage;

(4) loss control services;

(5) ratemaking or guaranty fund functions;

- (6) reinsurance or excess loss insurance;
- (7) risk management;
- (8) case management;
- (9) disease management;
- (10) quality assurance;
- (11) quality improvement;
- (12) performance evaluation;
- (13) health care provider credentialing verification;
- (14) utilization review;
- (15) peer review activities;
- (16) actuarial, scientific, medical, or public policy research;
- (17) grievance procedures;
- (18) the internal administration of compliance, managerial, and information systems;
- (19) policyholder or enrollee services;
- (20) auditing;
- (21) reporting;
- (22) database security;
- (23) the administration of consumer disputes and inquiries;
- (24) external accreditation standards;
- (25) the replacement of a group benefit plan or workers' compensation policy or program;
- (26) activities in connection with a sale, merger, transfer, or exchange of all or part of a business or operating unit;
- (27) any activity that permits disclosure without authorization under the federal Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. Section 1320d et seq.), as amended;
- (28) disclosure that is required, or that is a lawful or appropriate method to enforce the covered entity's rights or the rights of other persons engaged, in carrying out a transaction or providing a product or service that the consumer requests or authorizes;
- (29) claims administration, adjustment, and management;
- (30) any activity that is:
 - (A) otherwise permitted by law;
 - (B) required by a governmental reporting authority; or
 - (C) required to comply with legal process; and
- (31) any other insurance or health maintenance organization

functions the commissioner approves that are:

- (A) necessary for appropriate performance of insurance or health maintenance organization functions; and
- (B) fair and reasonable to the interests of consumers.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 602.054. COMPLIANCE WITH OTHER LAW. A covered entity shall comply with:

- (1) Subchapter D, Chapter 181, Health and Safety Code, except as otherwise provided by that subchapter; and
- (2) the standards adopted under Section 182.108, Health and Safety Code.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1126 (H.B. 300), Sec. 18, eff. September 1, 2012.

SUBCHAPTER C. PENALTIES AND ENFORCEMENT

Sec. 602.101. PROHIBITION. A covered entity may not knowingly or wilfully violate this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 602.102. INJUNCTION. The attorney general may bring an action for injunctive relief to restrain a violation of this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 602.103. CIVIL PENALTY. (a) The attorney general may bring an action for a civil penalty against a covered entity or health care entity for a violation of this chapter.

(b) A civil penalty assessed under this section may not be less than \$3,000 for each violation.

(c) If the court in which an action under this section is pending finds that the violations have occurred with a frequency as to constitute a pattern or practice, the court may assess a civil penalty not to exceed \$250,000.

(d) A civil penalty authorized by this section is in addition to any other civil, administrative, or criminal action provided by law, including an action for injunctive relief provided by Section 602.102.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 602.104. DISCIPLINARY ACTION. (a) In addition to a penalty prescribed by this subchapter, a covered entity that violates this chapter is subject to investigation, disciplinary proceedings, and probation or suspension of the covered entity's license or other form of authorization to engage in business.

(b) If there is evidence that a covered entity has engaged in a pattern or practice of violating this chapter, the covered entity's license or other form of authorization to engage in business may be revoked.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 602.105. EXCLUSION FROM STATE PROGRAMS. If there is evidence that a covered entity has engaged in a pattern or practice of violating this chapter, in addition to the other penalties prescribed by this subchapter, the covered entity shall be excluded from participating in any state-funded health care program.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 602.106. REMEDIES AVAILABLE. This subchapter does not affect any right of a person under other law to bring a cause of action or otherwise seek relief with respect to conduct that violates this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

SUBTITLE E. PREMIUM FINANCING
CHAPTER 651. FINANCING OF INSURANCE PREMIUMS
SUBCHAPTER A. GENERAL PROVISIONS

Sec. 651.001. DEFINITIONS. In this chapter:

(1) "Annual percentage rate" means the annual percentage rate of finance charge determined under the Consumer Credit Protection Act and Regulation Z.

(2) "Consumer Credit Protection Act" means the Consumer Credit Protection Act of 1970 (15 U.S.C. Section 1601 et seq.; 18 U.S.C. Section 891 et seq.).

(2-a) "Insurance agent" means a person licensed under Subchapter E, Chapter 981 or Chapter 4051, 4052, 4053, 4054, 4055, 4056, or 4153.

(3) "Insurance premium finance company" means:

(A) a person engaged in the business of making loans under this chapter by entering into premium finance agreements with insureds or prospective insureds;

(B) a person engaged in the business of acquiring premium finance agreements from insurance agents or brokers or from other insurance premium finance companies; or

(C) an insurance agent or broker making loans under this chapter who holds premium finance agreements made and delivered by insureds that are payable to the agent or broker or to the agent's or broker's order.

(4) "Insured" means a person who enters into a premium finance agreement with an insurance premium finance company.

(5) "Insurer" means an entity organized or authorized to engage in the business of insurance under this code as a capital stock insurance company, title insurance company, reciprocal or interinsurance exchange, Lloyd's plan, fraternal benefit society, mutual or mutual assessment company of any kind, statewide mutual assessment company, local mutual aid association, burial association, county or farm mutual insurance company, fidelity, guaranty, or surety company, or trust company.

(6) "License holder" means an insurance premium finance company that holds a license issued under Subchapter B.

(7) "Person" means an individual, partnership, corporation, joint venture, trust, association, or other legal entity, regardless of organization.

(8) "Premium finance agreement" means an agreement by which an insured or prospective insured promises to pay to an insurance premium finance company the amount advanced or to be advanced under the agreement to an insurer or to an insurance agent in payment of

the premiums on an insurance contract.

(8-a) "Premium finance agreement servicer" means a person who provides a premium finance company with collection, billing, or other services related to the administration of premium finance agreements.

(9) "Regulation Z" means the federal regulations adopted under the Consumer Credit Protection Act as 12 C.F.R. Section 226.1 et seq.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 757 (H.B. 2965), Sec. 1, eff. June 17, 2005.

Sec. 651.002. CERTAIN CONDUCT NOT ENGAGING IN BUSINESS AS INSURANCE PREMIUM FINANCE COMPANY. (a) The preparation or delivery by an insurance agent of a premium finance agreement or disclosure statement required by Section 651.155 on behalf of the insured does not constitute engaging in business as an insurance premium finance company.

(b) Subsection (a) does not apply to a premium finance agreement held for the benefit of the insurance agent as provided by Section 651.001(3)(C).

(c) This chapter does not apply to a health care sharing ministry operated under Chapter 1681.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 455 (S.B. 874), Sec. 3, eff. June 14, 2013.

Sec. 651.003. RULES. (a) The commissioner may adopt and enforce rules necessary to administer this chapter.

(b) The rules may contain classifications, differentiations, or other provisions and provide for adjustments or exceptions for any class of transactions necessary to:

- (1) accomplish the purposes of this chapter;
- (2) prevent circumvention or evasion of this chapter; or
- (3) facilitate compliance with this chapter.

(c) A rule adopted by the commissioner may not contain any classification, differentiation, or other provision with respect to any class of transactions or provide for any adjustment or exception for any class of transactions that would result in a less stringent disclosure requirement than required for that class of transactions by the Consumer Credit Protection Act or Regulation Z.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 651.004. EMPLOYMENT OF EXAMINERS AND INVESTIGATORS; PAYMENT OF EXPENSES. The department may:

- (1) employ persons as necessary to examine or investigate and make reports on alleged violations of this chapter and compliance with any other provision of this code by a license holder;
- (2) pay the salaries and expenses of persons described by Subdivision (1) and of all office employees; and
- (3) pay an expense necessary to enforce this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 651.005. DEPOSIT AND USE OF FEES. (a) Except as provided by Subsection (b), each fee collected under this chapter:

- (1) shall be deposited to the credit of the Texas Department of Insurance operating account; and
 - (2) may be used by the department to enforce this chapter.
- (b) An assessment or fee associated with examination costs, as defined by Section 401.251, shall be deposited to the account described by Section 401.156(a).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.
Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 659 (S.B. [1291](#)), Sec. 4, eff. September 1, 2011.

Sec. 651.006. ASSESSMENTS. (a) A license holder shall pay to the department:

- (1) an amount imposed by the department to cover the direct and indirect cost of examinations and investigations made under this

chapter; and

(2) a proportionate share of the general administrative expense attributable to the regulation of license holders.

(b) Each amount required by this section is in addition to any investigation or license fee imposed under Subchapter B.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 651.007. APPLICABILITY OF CONSUMER CREDIT PROTECTION ACT AND REGULATION Z. A transaction that is subject to this chapter is also subject to:

- (1) the Consumer Credit Protection Act; and
- (2) the applicable provisions of Regulation Z.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 651.008. AUTHORITY OF CERTAIN PROPERTY AND CASUALTY AGENTS TO CHARGE INTEREST TO CERTAIN PERSONS. (a) Notwithstanding any other law, a general property and casualty agent or a personal lines property and casualty agent who holds a license under Chapter 4051 may enter into a written agreement with a purchaser of insurance from the agent that provides for the payment of interest to the agent on any amount due to the agent for the insurance purchased. The interest is computed at a rate not to exceed the greater of:

- (1) a rate allowed by Chapter 303, Finance Code; or
- (2) the rate of one percent a month.

(b) A claim or defense of usury may not be raised in connection with a written agreement under this section.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 548 (S.B. 1263), Sec. 2.06, eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 548 (S.B. 1263), Sec. 2.07, eff. September 1, 2007.

SUBCHAPTER B. AUTHORITY TO ENGAGE IN BUSINESS

Sec. 651.051. LICENSE REQUIRED. (a) Unless the person is a

license holder, a person may not:

- (1) negotiate, transact, or engage in the business of insurance premium financing in this state; or
- (2) contract for, charge, or receive directly or indirectly on or in connection with an insurance premium financing any charge, regardless of whether the charge is for interest, compensation, consideration, expense, or otherwise, if in the aggregate the amount of the charge exceeds the amount the person would be permitted by law to charge if the person were not a license holder.

(b) This subchapter does not apply to a person who purchases or otherwise acquires a premium finance agreement from a license holder if the license holder:

- (1) retains the right to service the agreement and to collect payments due under the agreement; and
- (2) remains responsible for servicing the agreement in compliance with this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 757 (H.B. [2965](#)), Sec. 2, eff. June 17, 2005.

Sec. 651.052. LICENSE FEE. (a) The department shall establish the fee for a license under this subchapter in an amount not to exceed \$200.

(b) The fee for a license issued after June 30 may not exceed \$100.

(c) Section 201.001 applies to fees collected under this section.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 651.053. ENTITLEMENT OF BANKS AND SAVINGS AND LOAN ASSOCIATIONS TO LICENSE. (a) A bank or a savings and loan association is entitled to receive a license under this subchapter if the bank or savings and loan association:

- (1) is engaging in business under the laws of this state or the United States; and
- (2) notifies the department of its intention to operate

under this chapter.

(b) On receipt of notice under Subsection (a)(2), the department shall immediately issue a license to the bank or savings and loan association.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 651.054. APPLICATION FOR LICENSE; INVESTIGATION FEE; EXEMPTION. (a) An application for a license to engage in the business of insurance premium financing must:

(1) be in writing on a form prescribed by the commissioner; and

(2) be accompanied by a nonrefundable investigation fee in an amount not to exceed \$400 as established by the department.

(b) A person who on January 1, 1980, held a license under Chapter 3, Title 79, Revised Statutes (Article 5069-3.01 et seq., Vernon's Texas Civil Statutes), is not required to pay an investigation fee.

(c) Section 201.001 applies to fees collected under this section.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 651.055. REFUSAL TO ISSUE LICENSE. The department may refuse to issue a license to an applicant if the department determines that:

(1) the financial responsibility, experience, character, or general fitness of the applicant or any person associated with the applicant does not command the confidence of the community and does not warrant the belief that the applicant will engage in the business of insurance premium financing honestly, fairly, and efficiently; or

(2) the applicant does not have available for the operation of the business net assets of at least \$25,000.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 651.056. NOTICE OF ACTION ON APPLICATION. Not later than the 90th day after the date the department receives an application

under Section 651.054, the department shall notify the applicant that:

- (1) the application has been approved and the department will issue a license to the applicant on payment of the required license fee; or
- (2) the application has been denied.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 651.057. ISSUANCE OF LICENSE. After approval of an application and on receipt of the required license fee, the department shall:

- (1) issue a license authorizing the license holder to engage in business as an insurance premium finance company at the location specified in the license holder's application; and
- (2) send the license to the applicant.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 651.058. RECIPROCAL LICENSE. The department may waive any license requirement for an applicant who holds a valid license from another state that has license requirements substantially equivalent to the requirements prescribed by this state.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 651.059. ISSUANCE OF MULTIPLE LICENSES. The department may issue a person more than one license under this subchapter but may not issue one person more than 60 of those licenses.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 651.060. SINGLE BUSINESS LOCATION AUTHORIZED BY LICENSE. A license authorizes the license holder to maintain only one location where the business of insurance premium financing may be conducted.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 651.061. APPEARANCE OF LICENSE; POSTING. (a) A license must state the name and address of the license holder.

(b) The license must be conspicuously posted at the location where the license holder engages in the business of insurance premium financing.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 651.062. TRANSFER OR ASSIGNMENT OF LICENSE PROHIBITED. A license may not be transferred or assigned.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 651.063. TERM OF LICENSE. Unless a staggered renewal system is adopted under Section 651.065, a license is issued for the calendar year and remains valid until December 31 of that year, unless suspended, revoked, or surrendered in accordance with Section 651.204 or 651.206.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 651.064. PROCEDURE FOR LICENSE RENEWAL. (a) A license holder may renew an unexpired license by paying the required renewal fee to the department.

(b) A person whose license has been expired for 90 days or less may renew the license by paying to the department:

- (1) the required renewal fee; and
- (2) an additional fee equal to one-half of the original license fee.

(c) A person whose license has been expired for more than 90 days but less than two years may renew the license by paying to the department:

- (1) all unpaid renewal fees; and
- (2) an additional fee equal to the original license fee.

(d) A person whose license has been expired for two years or more may not renew the license. The person may obtain a new license

by complying with the requirements and procedures for obtaining an original license.

(e) Not later than the 30th day before the date a person's license expires, the department shall send written notice of the impending license expiration to the person at the person's last known address.

(f) This section may not be construed to prevent the department from denying or refusing to renew a license under an applicable law or a rule adopted by the commissioner.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 651.065. STAGGERED RENEWAL SYSTEM. (a) The commissioner by rule may adopt a system under which licenses expire on various dates during the year.

(b) For a year in which the license expiration date is less than one year from the date of license issuance or the anniversary of that date, the license fee shall be prorated so that each license holder pays only that portion of the license fee allocable to the number of months during which the license is valid. On each subsequent renewal of the license, a license holder must pay the total renewal fee.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

SUBCHAPTER C. REGULATION OF INSURANCE PREMIUM FINANCE COMPANIES AND OTHERS

Sec. 651.101. BOOKS, ACCOUNTS, AND RECORDS. (a) A license holder shall maintain books, accounts, and records in sufficient detail to enable a representative of the department to determine whether the license holder is in compliance with this chapter and rules adopted by the commissioner.

(b) A license holder shall maintain for inspection the license holder's books, accounts, and records, including any cards used in a card system, for at least four years after the date the final entry of any premium finance agreement is recorded in those books, accounts, and records.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 651.102. ANNUAL REPORT. On or before April 1 of each year, a license holder shall file with the department a report containing information required by the department concerning the business and operations of the license holder during the preceding calendar year at each licensed location where the license holder engages in the business of insurance premium financing in this state.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 651.103. BUSINESS NAME. A license holder may not engage in the business of insurance premium financing under any name other than the name stated on the license.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 651.104. BUSINESS LOCATION. A license holder may not engage in the business of insurance premium financing at any location other than the address stated on the license.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 651.105. RELOCATION OF PLACE OF BUSINESS. (a) A license holder who proposes to relocate the place where the holder engages in the business of insurance premium financing shall give written notice of the proposed change to the department.

(b) If the department approves the proposed relocation, the department shall issue an endorsement to the license holder indicating the change and the date of the change.

(c) The endorsement authorizes the license holder to engage in the business of insurance premium financing at the new location. The license holder shall attach the endorsement to the license for that location.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 651.106. BUSINESS PREMISES. (a) Except as provided by Subsection (b), a license holder may engage in the business of insurance premium financing:

(1) in any office, suite, room, or place of business in which any other business is solicited or engaged in; or

(2) in association or in conjunction with any other business.

(b) Subsection (a) does not apply if the department:

(1) determines, after a hearing, that the conduct by the license holder of the other business at the location for which the license was issued has concealed evasions of this chapter; and

(2) orders the license holder in writing to stop engaging in the business of insurance premium financing at that location.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 651.107. ENGAGING IN BUSINESS BY MAIL OR OUTSIDE THE COMMUNITY. This chapter does not prohibit a license holder from engaging in the business of insurance premium financing:

(1) by mail; or

(2) with persons who do not reside in the same community as the licensed location.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 651.108. CERTAIN CHARGES PROHIBITED. In connection with a premium finance agreement entered into under this chapter, an insurance charge or any other charge or fee may not be imposed unless the charge or fee is authorized by this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 651.109. LIMITATIONS ON RATES AND CHARGES. (a) An insurance premium finance company may not take or receive from an insured a greater rate or charge than is authorized by Chapter 342, Finance Code.

(b) For purposes of this section, a charge begins on the earlier of:

(1) the date from which the insurer requires payment of the premium and payment was made to the insurer for the financed policy; or

(2) the effective date of the policy.

(c) The finance charge is computed on the balance of the premiums due after subtracting any down payment made by the insured in accordance with the premium finance agreement.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 651.110. LIMITATIONS ON CERTAIN INDUCEMENTS OR SHARING OF PROFITS AND FEES. (a) This section applies to:

(1) an insurance premium finance company;

(2) an insurance agent;

(3) a premium finance agreement servicer; or

(4) an affiliate, employee, agent, or other representative of an insurance premium finance company or a premium finance agreement servicer.

(a-1) A person, partnership, or other entity described by Subsection (a) and involved in transactions related to the financing of insurance premiums may not:

(1) directly or indirectly pay, allow, give, or offer to pay, allow, or give in any manner to an insurance agent or an employee of an insurance agent any consideration, compensation, or inducement for soliciting, accepting an application for, delivering, or administering premium finance agreements;

(2) pay, allow, or offer to pay or allow an insurance agent or an employee of an insurance agent to share the profits of any person, partnership, or other entity if any portion of the share of profits is determined, either in whole or in part, by the amount of premium dollars financed or premium finance agreements placed; or

(3) pay, allow, or offer to pay or allow an insurance agent or an employee of an insurance agent to share any portion of fees, including late fees, that are related to the premium finance agreement.

(b) Subsection (a-1) does not prohibit the giving or offering of an article of merchandise to an insurance agent or an employee of an insurance agent that has a value of \$10 or less on which there is an advertisement of the insurance premium finance company.

(c) Subsection (a-1) does not prohibit a person, partnership, or other entity described by Subsection (a) from making a payment under a contractual agreement with a validly organized and operating association of insurance agents or a subsidiary of the association if no part of a payment received under the agreement:

(1) is distributed to an insurance agent or an employee of an insurance agent; or

(2) inures directly to the benefit of a member of the association or an employee of the member.

(d) A contractual agreement under Subsection (c):

(1) must be in writing; and

(2) is not valid until commissioner approval is received.

(e) Subsection (a-1) does not prohibit an insurance agent from being the sole owner or sole shareholder of an insurance premium finance company and receiving profits and fees of the insurance premium finance company if the insurance agent discloses in writing the agent's ownership interest in the insurance premium finance company to all insureds placed by the agent with the insurance premium finance company owned by the agent.

(f) Subsections (a-1) and (e) do not apply to a person, partnership, or other entity described by Subsection (a) and involved in transactions related to the financing of insurance premiums for commercial lines of insurance if, with respect to those transactions:

(1) the insurance agent discloses in writing the source of any compensation to be received by the agent as a result of the insured entering into a premium finance agreement;

(2) the agent provides in writing to the insured the amount of compensation, as a percentage of the premiums financed, if the amount of compensation received by the agent exceeds two percent of the premium amount financed; and

(3) the amount of compensation is based only on actual premiums financed and is not paid as:

(A) an advance on future premium finance agreements; or

(B) a form of bonus for the agent agreeing to place finance agreements with the premium finance company.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 757 (H.B. [2965](#)), Sec. 4, eff. June 17, 2005.

Sec. 651.111. DECEPTIVE ADVERTISING PROHIBITED. (a) A license holder may not advertise or cause to be advertised in any manner any false, misleading, or deceptive statement or representation with regard to the rates, terms, or conditions of a premium finance agreement.

(b) If rates or charges are stated in advertising, the license holder must express the rates or charges in terms of a simple annual percentage rate as defined by federal law.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

SUBCHAPTER D. PREMIUM FINANCE AGREEMENTS

Sec. 651.151. REQUIRED FORM AND CONTENTS OF PREMIUM FINANCE AGREEMENT. (a) A premium finance agreement must be in writing on a form approved by the commissioner.

(b) A premium finance agreement must be dated and signed by the insured. An agreement may be signed on behalf of the insured by the insured's agent if:

(1) the agreement contains policies for other than personal, family, or household purposes; and

(2) the premiums for the policies exceed \$1,000.

(c) A premium finance agreement must contain:

(1) the name and business address of the insurance agent or broker negotiating the related insurance contract;

(2) the name and residence or business address of the insured as specified by the insured;

(3) the name and business location of the insurance premium finance company to which payments are to be made;

(4) a description of each insurance contract involved;

(5) the amount of the premium for each insurance contract;

(6) the total amount of the premiums for all insurance contracts;

(7) the amount of any down payment;

(8) the principal balance, which is the difference between the amounts under Subdivisions (6) and (7);

(9) the total amount of the finance charge, which must describe each amount included and use the term "finance charge"; and

(10) the balance payable by the insured, which is the sum of the amounts under Subdivisions (8) and (9).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 651.152. OTHER REQUIRED CONTENTS. In addition to the items required by Section 651.151, a premium finance agreement must contain the following, as applicable:

(1) the finance charge expressed as an annual percentage rate, using the term "annual percentage rate";

(2) the number of installments required under the agreement;

(3) the amount of each installment expressed in dollars;

(4) the due date or period of each installment;

(5) the amount or method of computing the amount of any default or delinquency charge that is payable in the event of late payment; and

(6) the method of computing any unearned portion of the finance charge in the event of prepayment of the obligation.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 651.153. FORM OF DISCLOSURES. (a) The disclosures required by Sections 651.151 and 651.152 must be made clearly, conspicuously, and in meaningful sequence.

(b) If the term "finance charge" or "annual percentage rate" is required to be used, the term must be printed more conspicuously than other required terminology.

(c) Each numerical amount or percentage must be expressed as a figure and:

(1) legibly handwritten; or

(2) printed in not less than the equivalent of 10-point type, 75/1,000-inch computer type, or elite-size typewritten numerals.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 651.154. CONSOLIDATION OF INCREASE ATTRIBUTABLE TO

AMENDMENT OF RATE CLASSIFICATION. (a) If, in a premium finance agreement, a change in an insured's policy that is caused by an amendment of the rate classification by endorsement or otherwise results in an increased principal balance and the amount under the previous contract has not been fully paid, the subsequent increase, at the insured's option, may be consolidated with the previous contract if the agreement provides for consolidation.

(b) A consolidation under this section may be accomplished by a memorandum of agreement between the agent and the insured if, before the first scheduled payment date of the amended transaction, the insurance premium finance company provides to the insured the following information in writing:

- (1) the amount of the premium increase;
- (2) the down payment on the increase;
- (3) the principal amount of the increase;
- (4) the total amount of any finance charge on the increase;
- (5) the total of the additional balance due;
- (6) the outstanding balance due under the original agreement;
- (7) the balance due under the consolidated agreement;
- (8) the annual percentage rate of any finance charge on the additional balance due;
- (9) the revised schedule of payments;
- (10) the amount or method of computing the amount of any default, deferment, or similar charge authorized by Chapter 342, Finance Code, that is payable in the event of late payment; and
- (11) the method of computing any unearned portion of the finance charge in the event of prepayment of the obligation.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 651.155. RESPONSIBILITIES OF INSURANCE AGENT. An insurance agent shall:

- (1) prepare a premium finance agreement; and
- (2) deliver to the insured each disclosure statement required by law.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 651.156. TAKING OF INCOMPLETE PREMIUM FINANCE AGREEMENT PROHIBITED. A license holder may not take a premium finance agreement that has not been fully completed and executed at the time the agreement is executed.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 651.157. PERFECTION OF PREMIUM FINANCE AGREEMENT AS SECURED TRANSACTION: FILING NOT REQUIRED. Filing of a premium finance agreement or a financing statement is not necessary to perfect the agreement as a secured transaction against a creditor, subsequent purchaser, pledgee, encumbrancer, successor, or assign of the insured or any other party.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 651.158. PREPAYMENT AND REFUND. (a) Notwithstanding the provisions of any premium finance agreement to the contrary, an insured may pay the balance due under the agreement in full at any time before the maturity of the final installment of the balance.

(b) If an insured pays a premium finance agreement in full as authorized by this section and the agreement included an amount for a charge, the insured is entitled to receive for the prepayment by cash or renewal a refund credit in accordance with Subchapter H, Chapter 342, Finance Code, and rules adopted under that subchapter. If the amount of the credit for prepayment is less than \$5, the insured is not entitled to a refund credit.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 757 (H.B. [2965](#)), Sec. 5, eff. June 17, 2005.

Sec. 651.159. DEFAULT CHARGE. A premium finance agreement may provide for the payment of a default charge by the insured as provided by Section 342.203, Finance Code, this code, or a rule adopted under those statutes.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 651.160. POWER OF ATTORNEY. A premium finance agreement may contain a power of attorney that enables the insurance premium finance company to cancel any or all of the insurance contracts listed in the agreement as provided by Section 651.161.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 651.161. CANCELLATION OF INSURANCE CONTRACT. (a) An insurance premium finance company may not cancel an insurance contract listed in a premium finance agreement except as provided by this section for an insured's failure to make a payment at the time and in the amount provided in the agreement.

(b) The insurance premium finance company must mail to the insured a written notice that the company will cancel the insurance contract because of the insured's default in payment unless the default is cured at or before the time stated in the notice. The stated time may not be earlier than the 10th day after the date the notice is mailed.

(c) The insurance premium finance company must also mail a copy of the notice to the insurance agent or broker identified in the premium finance agreement.

(d) After the time stated in the notice required by Subsection (b), the insurance premium finance company may cancel each applicable insurance contract by mailing a notice of cancellation to the insurer. Each insurance contract shall be canceled as if the insured had canceled the contract, except that the return of a canceled contract is not required.

(e) The insurance premium finance company must also mail a notice of cancellation to:

- (1) the insured at the insured's last known address; and
- (2) the insurance agent or broker identified in the premium finance agreement.

(f) A statutory, regulatory, or contractual restriction that provides that an insurance contract may not be canceled unless notice is given to a governmental agency, mortgagee, or other third party applies to a cancellation under this section. The insurer shall:

(1) give the prescribed notice on behalf of the insurer or the insured to each governmental agency, mortgagee, or other third party on or before the second business day after the date the insurer receives the notice of cancellation from the insurance premium finance company; and

(2) determine the effective date of cancellation, taking into consideration the number of days' notice required to complete the cancellation.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 651.162. RETURN OF UNEARNED PREMIUMS AND COMMISSIONS. (a) This section applies only to a premium finance agreement that contains an assignment or power of attorney for the benefit of the insurance premium finance company.

(b) If an insurance contract listed in a premium finance agreement is canceled, the insurer shall return all unearned premiums that are due under the contract directly to the insurance premium finance company before the 61st day after the cancellation date.

(c) The insurer may deduct from the unearned premiums returned to the insurance premium finance company the amount of any unearned commission due from the agent writing the insurance if the insurer notifies the agent to return the unearned commission to the insurance premium finance company. If the agent does not return the unearned commission to the insurance premium finance company before the 91st day after the cancellation date, the insurer shall remit the unearned commission to the insurance premium finance company before the 121st day after the cancellation date.

(d) Notwithstanding Subsections (a)-(c), an agent is liable for the return of unearned commissions on an insurance contract written through the Texas Windstorm Insurance Association, the Texas Automobile Insurance Plan Association, or the Texas Medical Liability Insurance Underwriting Association. An agent placing business through one of those plans shall return the unearned commissions to the insurance premium finance company before the 61st day after the date the agent is notified of the cancellation.

(e) An insurer, other than the Texas Windstorm Insurance Association, the Texas Automobile Insurance Plan Association, or the Texas Medical Liability Insurance Underwriting Association, may

return the unearned premiums to the producing agent. The insurer remains liable and shall remit the unearned premiums to the insurance premium finance company before the 121st day after the cancellation date if:

(1) the producing agent does not return the unearned premiums to the insurance premium finance company before the 91st day after the cancellation date; and

(2) the insurance premium finance company complied with Section 651.165.

(f) If the insurance premium finance company failed to comply with Section 651.165, the insurer, including the Texas Windstorm Insurance Association, the Texas Automobile Insurance Plan Association, and the Texas Medical Liability Insurance Underwriting Association, may comply with its legal duty to return the unearned premiums due under the insurance contract to the insurance premium finance company by returning those unearned premiums to the producing agent.

(g) If the crediting of return premiums to the account of an insured results in a surplus over the amount due from the insured, the insurance premium finance company shall refund the excess to the insured. If the amount of the excess is less than \$5, the insured is not entitled to a refund.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.
Amended by:

Acts 2009, 81st Leg., R.S., Ch. 417 (H.B. 1975), Sec. 1, eff. June 19, 2009.

Sec. 651.163. ASSIGNMENT OF PREMIUM FINANCE AGREEMENT. Unless the insured has notice of an actual or intended assignment of a premium finance agreement, payment by an insured under the agreement to the last known holder of the agreement is binding on all subsequent holders or assignees.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 651.164. RESTRICTIONS ON PREMIUM FINANCE AGREEMENTS. (a) A premium finance agreement may not contain any provision under which, absent default by the insured, the insurance premium finance

company holding the agreement may arbitrarily or without reasonable cause accelerate the maturity of all or any part of the amount owing under the agreement.

(b) For purposes of Subsection (a), reasonable cause includes a proceeding in bankruptcy, receivership, or insolvency instituted by or against the insured or the insolvency of or suspension of business or cessation of the right to engage in business by an insurer writing policies that are financed for the insured under the premium finance agreement.

(c) A license holder may not take:

(1) an instrument in which the insured waives any right accruing to the insured under this chapter;

(2) an instrument that has not been fully completed and executed by the insured;

(3) an assignment of wages as security for an insurance premium finance agreement entered into under this chapter;

(4) a lien on real property as security for a premium finance agreement entered into under this chapter, except any lien created by law on the recording of an abstract of judgment; or

(5) a confession of judgment or a power of attorney in favor of the license holder or a third person to confess judgment or to appear for an insured in a judicial proceeding.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 651.165. REQUIRED NOTICE OF CERTAIN PREMIUM FINANCE AGREEMENTS. (a) An insurance premium finance company that enters into a premium finance agreement that includes an assignment or power of attorney shall notify the insurer or the Texas Windstorm Insurance Association, the Texas Automobile Insurance Plan Association, or the Texas Medical Liability Insurance Underwriting Association whose premiums are being financed:

(1) of the existence of the agreement; and

(2) to whom the premium payment has been made.

(b) An insurance premium finance company shall notify and fund all premiums to a county mutual insurance company unless the insurance premium finance company is authorized in writing by the county mutual insurance company to notify or fund an agent or managing general agent.

(c) Notice required under this section must be made before the 31st day after the date the premium finance agreement is accepted by the insurance premium finance company.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 651.166. TAKING, RECEIVING, OR CHARGING UNAUTHORIZED AMOUNT. (a) Taking or receiving from an insured or the charging of an insured by an insurance premium finance company of a charge greater than authorized by this chapter does not invalidate:

- (1) the premium finance agreement; or
- (2) the principal balance payable under the agreement.

(b) An action described by Subsection (a) may be adjudged a forfeiture of all charges that:

- (1) are authorized under the premium finance agreement; or
- (2) the insured has agreed to pay.

(c) A person who pays an unauthorized charge or the person's legal representative may bring an action against the insurance premium finance company to recover twice the total amount of the charge paid. The action must be brought within two years after the date the unauthorized charge is paid.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 651.167. EFFECT OF LICENSE REVOCATION, SUSPENSION, OR SURRENDER ON PREMIUM FINANCE AGREEMENT. The revocation, suspension, or surrender of a license does not affect the obligation of an insured under a lawful premium finance agreement previously acquired or held by the person whose license was revoked, suspended, or surrendered.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

SUBCHAPTER E. DISCIPLINARY PROCEDURES AND PENALTIES; OFFENSES

Sec. 651.201. EXAMINATIONS AND INVESTIGATIONS OF LICENSE HOLDERS. (a) The department may conduct an examination or investigation that is necessary to determine whether a license holder:

(1) is in compliance with this chapter; or
(2) has engaged in conduct that would warrant the revocation or suspension of the license holder's license.

(b) The department or an authorized representative of the department may:

(1) require the attendance of any person;
(2) examine the person under oath; and
(3) compel the production of any relevant book, record, account, or document.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 651.202. CONFIDENTIALITY OF REPORTS AND RELATED MATERIAL.

(a) A report of an examination or investigation under Section 651.201 and any correspondence or memoranda concerning or arising from the examination or investigation:

(1) are confidential communications;
(2) are not subject to subpoena; and
(3) may not be made public, except in connection with a hearing under Section 651.204 or an appearance in connection with the hearing.

(b) Subsection (a) applies to an authenticated copy of a report described by Subsection (a) in the possession of the commissioner, the department, or a license holder.

(c) Information obtained in the course of an examination or investigation may be made available to another governmental agency if the information involves a matter within the scope or jurisdiction of the agency.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 651.203. HEARINGS AND INVESTIGATIONS; SUBPOENA POWER. In conducting a hearing or investigation under this chapter, the department or a person designated by the department may:

(1) administer oaths;
(2) subpoena witnesses;
(3) take depositions of witnesses who reside outside of this state in the manner provided for in a civil action in district court; and

(4) pay to those witnesses a fee and mileage for attendance as provided for a witness in a civil action in district court.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 651.204. REVOCATION OR SUSPENSION OF LICENSE. After notice and hearing, the department may revoke or suspend a license if:

(1) the department finds:

(A) that the license holder has violated this chapter or a rule adopted by the commissioner under this chapter; or

(B) the existence of a fact or condition that, if the fact or condition existed at the time of the original application for the license, clearly would have warranted the refusal of the license; or

(2) the department learns from any source that the license holder has failed to return all amounts due from an insurance premium finance company to the person whose insurance policy has been canceled as required by Section 651.162.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 651.205. ISSUANCE OF REVOCATION OR SUSPENSION ORDER. If the department revokes or suspends a license, the department shall:

(1) immediately issue in duplicate a written order of revocation or suspension;

(2) file one copy of the order in the office of the secretary of state; and

(3) mail one copy of the order to the license holder.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 651.206. SURRENDER OF LICENSE; EFFECT. (a) A license holder may surrender a license by delivering to the department written notice that the license holder surrenders the license.

(b) The surrender of a license does not affect any civil or criminal liability of the person for an act committed before the surrender.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 651.207. LICENSE REINSTATEMENT. The department may reinstate a suspended license or issue a new license to a person whose license has been revoked if no fact or condition exists that clearly would have warranted the refusal to issue the license originally.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 651.208. OFFENSE. (a) A person commits an offense if the person:

(1) intentionally, knowingly, recklessly, or negligently engages in the operation of an insurance premium finance company and does not hold a license issued under this chapter;

(2) intentionally, knowingly, recklessly, or negligently violates this chapter;

(3) intentionally or knowingly omits to state a material fact necessary to give the commissioner or the department information lawfully required of the person; or

(4) refuses to permit an investigation or examination authorized under this chapter.

(b) An offense under this section is a Class B misdemeanor.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 651.209. SANCTIONS; CEASE AND DESIST ORDERS. In addition to each penalty provided by Sections 651.166 and 651.208, the commissioner or a person designated by the commissioner may:

(1) order a sanction under Subchapter B, Chapter 82; or

(2) issue a cease and desist order under Chapter 83.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

SUBTITLE F. INSURANCE FRAUD AND IDENTITY THEFT
CHAPTER 701. INSURANCE FRAUD INVESTIGATIONS
SUBCHAPTER A. GENERAL PROVISIONS

Sec. 701.001. DEFINITIONS. In this chapter:

(1) "Authorized governmental agency" means:

(A) a municipal, county, or state law enforcement agency of this state or another state or a law enforcement agency of the United States; or

(B) the prosecuting attorney of a municipality, county, or judicial district of this state or another state or the prosecuting attorney of the United States.

(2) "Fraudulent insurance act" means an act that is a violation of a penal law and is:

(A) committed or attempted while engaging in the business of insurance;

(B) committed or attempted as part of or in support of an insurance transaction; or

(C) part of an attempt to defraud an insurer.

(3) "Insurer" means a person who is engaged in the business of insurance as a principal or agent. The term includes:

(A) an unauthorized insurer; and

(B) an entity that is self-insured and provides health care benefits to the entity's employees.

(4) "Person" means an individual, corporation, organization, governmental entity, business trust or another trust, estate, partnership, joint venture, association, or any other legal entity.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 701.002. BUSINESS OF INSURANCE. A person is engaged in the business of insurance for purposes of this chapter if the person performs any act described by Subchapter B, Chapter 101.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 701.003. EFFECT OF CHAPTER. This chapter does not:

(1) preempt the authority or relieve the duty of an authorized governmental agency to investigate and prosecute suspected criminal acts;

(2) prevent or prohibit a person from voluntarily disclosing information to an authorized governmental agency;

(3) limit powers or duties granted to the commissioner by any other law; or

(4) prohibit or limit the authority of an insurer to conduct an independent investigation of suspected insurance claim fraud.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 701.004. ANTIFRAUD EDUCATION. The commissioner, through the insurance fraud unit, shall develop fraud prevention educational programs and disseminate materials necessary to educate the public effectively regarding antifraud programs.

Added by Acts 2015, 84th Leg., R.S., Ch. 245 (S.B. 783), Sec. 1, eff. September 1, 2015.

Sec. 701.005. GIFTS, GRANTS, AND DONATIONS. (a) The insurance fraud unit may accept gifts, grants, and donations to enable the fraud unit to perform its duties under this chapter.

(b) The insurance fraud unit may not accept gifts, grants, or donations from a regulated entity.

(c) All gifts, grants, or donations to the insurance fraud unit shall be:

(1) deposited to the credit of the department's operating account; and

(2) distributed to the insurance fraud unit to be used to perform its duties under this chapter.

Added by Acts 2015, 84th Leg., R.S., Ch. 245 (S.B. 783), Sec. 1, eff. September 1, 2015.

SUBCHAPTER B. REPORTING FRAUDULENT INSURANCE ACTS

Sec. 701.051. DUTY TO REPORT. (a) Not later than the 30th day after the date the person makes the determination or reasonably suspects that a fraudulent insurance act has been or is about to be committed in this state, the person:

(1) shall report the information in writing to the insurance fraud unit of the department, in the format prescribed by

the fraud unit or by the National Association of Insurance Commissioners; and

(2) may also report the information to another authorized governmental agency.

(b) A report made to the insurance fraud unit constitutes notice to each other authorized governmental agency.

(c) A person who is a member of an organization primarily dedicated to the detection, investigation, and prosecution of insurance fraud fully complies with the person's obligations under Subsection (a) by authorizing the organization to report on the person's behalf information required to be reported under Subsection (a). The person retains any liability resulting from the failure of the organization to report in a manner that complies with Subsection (a).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.
Amended by:

Acts 2005, 79th Leg., Ch. 1282 (H.B. [2388](#)), Sec. 1, eff.
September 1, 2005.

Sec. 701.052. IMMUNITY FOR FURNISHING INFORMATION RELATING TO A FRAUDULENT INSURANCE ACT. (a) A person is not liable in a civil action, including an action for libel or slander, and a civil action may not be brought against the person, for furnishing information relating to a suspected, anticipated, or completed fraudulent insurance act if the information is provided to:

- (1) an authorized governmental agency or the department;
- (2) a law enforcement officer or an agent or employee of the officer;
- (3) the National Association of Insurance Commissioners or an employee of the association;
- (4) a state or federal governmental agency established to detect and prevent fraudulent insurance acts or to regulate the business of insurance or an employee of the agency;
- (5) a special investigative unit of an insurer, including a person who contracts to provide special investigative unit services to the insurer or an employee of the insurer who is responsible for the investigation of suspected fraudulent insurance acts; or
- (6) an organization described by Section 701.051(c), if the

person is a member of the organization and:

(A) the person has reported the information as required by Section 701.051(a); or

(B) the organization has reported the information to the insurance fraud unit as required by Section 701.051(c) on behalf of the person and in a manner that fully complies with the person's obligations under Section 701.051(a).

(b) A person may furnish information as described in Subsection (a) orally or in writing, including through publishing, disseminating, or filing a bulletin or report.

(c) Subsection (a) does not apply to a person who acts with malice, fraudulent intent, or bad faith.

(d) A person to whom Subsection (a) applies who prevails in a civil action arising from furnishing information as described in Subsection (a) is entitled to attorney's fees and costs.

(e) This section does not affect any common law or statutory privilege or immunity.

(f) Repealed by Acts 2005, 79th Leg., Ch. 1282, Sec. 3, eff. September 1, 2005.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.
Amended by:

Acts 2005, 79th Leg., Ch. 1282 (H.B. 2388), Sec. 3, eff. September 1, 2005.

Acts 2011, 82nd Leg., R.S., Ch. 88 (S.B. 918), Sec. 1, eff. September 1, 2011.

SUBCHAPTER C. INVESTIGATIONS

Sec. 701.101. INSURANCE FRAUD UNIT. (a) The purpose of the department's insurance fraud unit is to enforce laws relating to fraudulent insurance acts.

(b) The insurance fraud unit may receive, review, and investigate in a timely manner insurer antifraud reports submitted under Chapter 704.

(c) The insurance fraud unit shall report annually to the commissioner in writing regarding:

(1) the number of cases completed by the insurance fraud unit; and

(2) recommendations for regulatory and statutory responses

to the types of fraudulent activities encountered by the insurance fraud unit.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 701.102. INVESTIGATION OF CERTAIN ACTS OF FRAUD. If the commissioner has reason to believe a person has engaged in, is engaging in, has committed, or is about to commit a fraudulent insurance act, the commissioner may conduct any investigation necessary inside or outside this state to:

- (1) determine whether the act occurred; or
- (2) aid in enforcing laws relating to fraudulent insurance acts, including by providing technical or litigation assistance to other governmental agencies.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 244 (S.B. 782), Sec. 1, eff. September 1, 2015.

Sec. 701.103. DISCIPLINARY ACTION; REPORT TO OTHER AGENCIES. (a) The commissioner shall take appropriate disciplinary action as provided by this code if the commissioner believes a fraudulent insurance act has occurred. The commissioner shall report information concerning the commissioner's belief that a person has committed a fraudulent insurance act to an authorized governmental agency.

- (b) The commissioner shall:
 - (1) provide all material, documents, reports, complaints, or other evidence to an authorized governmental agency on request; and
 - (2) assist the authorized governmental agency as requested.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 701.104. DEPARTMENT INVESTIGATORS. (a) The commissioner may:

- (1) employ investigators as necessary to enforce this

chapter; and

(2) commission those investigators as peace officers.

(b) If the commissioner commissions investigators as peace officers, the commissioner shall appoint a chief investigator who:

(1) is commissioned as a peace officer; and

(2) is qualified by training and experience in law enforcement to supervise, direct, and administer the activities of the commissioned investigators.

(c) An investigator employed by the department as a peace officer must meet the requirements for a peace officer under Chapter 1701, Occupations Code.

(d) The commissioner shall ensure that a peace officer commissioned under Subsection (a) is compensated according to Schedule C of the position classification salary schedule prescribed by the General Appropriations Act.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.
Amended by:

Acts 2019, 86th Leg., R.S., Ch. 1143 (H.B. [2816](#)), Sec. 3, eff. September 1, 2019.

Sec. 701.105. ASSISTANCE FROM LAW ENFORCEMENT. An investigator employed by the department may request assistance from local law enforcement officers in conducting an investigation authorized by this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 701.106. SUBPOENA AUTHORITY. (a) The commissioner may issue a subpoena to compel the attendance and testimony of a witness or, except as provided by Subsection (b), the production of materials relevant to an investigation under this chapter.

(b) A person is not required to produce an item subpoenaed under Subsection (a) if the item can only be identified by writing and executing a special computer program for that purpose.

(c) A person possessing materials located outside this state that are requested by the commissioner may make the materials available to the commissioner or a representative of the commissioner for examination at the place where the materials are located. The

commissioner may designate a representative, including an official of the state in which the materials are located, to examine the materials. The commissioner may respond to a similar request from an official of another state or the United States.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 701.107. CERTAIN AGENCIES' DUTY TO PROVIDE INFORMATION.

(a) On the insurance fraud unit's request, an authorized governmental agency or a state licensing agency shall provide material, documents, reports, complaints, or other evidence to the insurance fraud unit.

(b) Compliance with Subsection (a) by an authorized governmental agency or a state licensing agency does not constitute waiver of any otherwise applicable privilege or confidentiality requirement.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 701.108. INSURER'S DUTY TO PROVIDE INFORMATION. (a) On the written request of an authorized governmental agency, an insurer shall provide to the agency any relevant information or material relating to a matter under investigation.

(b) An insurer must respond to a request under Subsection (a) from the department not later than the 15th day after the date the request is received. On written request of the insurer, the department shall extend the period 10 days.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 82 (S.B. [411](#)), Sec. 1, eff. September 1, 2013.

Sec. 701.109. REQUEST FOR INVESTIGATION BY INSURER. (a) An insurer who conducts an independent investigation of suspected insurance fraud is not required to complete that investigation before requesting that the commissioner conduct an investigation.

(b) When requesting the commissioner to conduct an

investigation, the insurer shall draft a report of the insurer's findings and submit the report and any related investigation file to the commissioner as soon as practicable on the conclusion of the insurer's independent investigation.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 1282 (H.B. 2388), Sec. 2, eff. September 1, 2005.

SUBCHAPTER D. INSURANCE FRAUD INFORMATION; CONFIDENTIALITY

Sec. 701.151. CONFIDENTIALITY OF DEPARTMENT INFORMATION. (a) Information or material acquired by the department that is relevant to an investigation by the insurance fraud unit is not a public record for the period the commissioner considers reasonably necessary to:

- (1) complete the investigation;
- (2) protect the person under investigation from unwarranted injury; or
- (3) serve the public interest.

(b) The information or material is not subject to a subpoena by another governmental entity, other than a grand jury subpoena, until:

- (1) the information or material is released for public inspection by the commissioner; or
- (2) after notice and a hearing a district court determines that obeying the subpoena would not jeopardize the public interest and any investigation by the commissioner.

(c) This section does not affect the conduct of a contested case under Chapter 2001, Government Code.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 701.152. CONFIDENTIALITY OF AUTHORIZED GOVERNMENTAL AGENCY INFORMATION. Information or material acquired under this chapter by an authorized governmental agency is privileged and is not a public record. The information or material is not subject to a subpoena, other than a grand jury subpoena, unless, after reasonable notice to the insurer and agency and a hearing, a district court determines that obeying the subpoena would not jeopardize the public interest

and any investigation by the agency.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 701.153. DISCLOSURE OF INFORMATION TO CERTAIN AGENCIES.

An authorized governmental agency may release to another authorized governmental agency or the department and the department may release to an authorized governmental agency information or material provided under this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 701.154. DISCLOSURE OF INFORMATION TO PUBLIC. (a) Except as otherwise provided by law, an authorized governmental agency or an insurer that possesses or receives information or material under this chapter may not release that information or material to the public.

(b) Information provided under this chapter by an insurer to the insurance fraud unit or an authorized governmental agency is not subject to public disclosure. The information may be used by the insurance fraud unit or authorized governmental agency only in performing duties described by this chapter.

(c) Notwithstanding Section 701.151, the commissioner may not release evidence obtained under Section 701.107 for public inspection if releasing the evidence would violate a privilege held by or a confidentiality requirement imposed on the agency from which the evidence was obtained.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

CHAPTER 703. COVERED ENTITY'S ANTIFRAUD ACTION

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 703.001. DEFINITION. In this chapter, "covered entity" means a health maintenance organization or insurer regulated by the department, including:

- (1) a stock life, health, or accident insurance company;
- (2) a mutual life, health, or accident insurance company;
- (3) a stock fire or casualty insurance company;
- (4) a mutual fire or casualty insurance company;

- (5) a Mexican casualty insurance company;
- (6) a Lloyd's plan;
- (7) a reciprocal or interinsurance exchange;
- (8) a fraternal benefit society;
- (9) a title insurance company;
- (10) a stipulated premium company;
- (11) a nonprofit legal services corporation;
- (12) a statewide mutual assessment company;
- (13) a local mutual aid association;
- (14) a local mutual burial association;
- (15) an association exempt under Section 887.102;
- (16) a nonprofit hospital, medical, or dental service corporation, including a corporation subject to Chapter 842;
- (17) a county mutual insurance company; and
- (18) a farm mutual insurance company.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 967 (S.B. [2065](#)), Sec. 5.005, eff. September 1, 2017.

Sec. 703.002. RIGHT OF INTERVENTION. This chapter does not affect the right of any person, including a state agency, to intervene in an antifraud action brought under this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

SUBCHAPTER B. ANTIFRAUD ACTION; CERTIFICATION

Sec. 703.051. ANTIFRAUD ACTION AUTHORIZED. (a) A covered entity acting alone or through a person, corporation, or legal entity affiliated with the covered entity may bring an action in a court, including a counter-action or cross-action, to:

(1) prevent a person from fraudulently engaging in the business of insurance or the business of a health maintenance organization in this state; or

(2) redress the effects of a person who has fraudulently engaged in the business of insurance or the business of a health maintenance organization in this state.

(b) An action may be brought under this section if:

(1) the acts of the person may adversely affect or have adversely affected at least 10 residents of this state; and

(2) the department has not brought an antifraud action in a court against the person.

(c) An action may be brought under this section regardless of whether the covered entity is directly affected by the person's acts.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 703.052. REQUEST FOR CERTIFICATION. A covered entity may request the court to certify that the action is an antifraud action under this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 703.053. NOTICE OF REQUEST FOR CERTIFICATION. (a) When a covered entity files a request for certification, the covered entity shall provide at least 10 days' notice of the request to the department and the attorney general by serving each with a copy of the request in the manner provided for service of notice under Rule 21a, Texas Rules of Civil Procedure.

(b) The covered entity shall provide the notice regardless of whether the department or the state is a party to the action.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 703.054. HEARING ON REQUEST FOR CERTIFICATION. As soon as practicable after a covered entity files a request for certification, the court shall hold a hearing to determine whether the action is an antifraud action under this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 703.055. CERTIFICATION. The court shall certify that the action is an antifraud action if the court determines that:

(1) the requirements of Section 703.051 are met; and

(2) the pleadings and evidence demonstrate that the covered

entity has a probable right of recovery.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

SUBCHAPTER C. EXPENSES OF ANTIFRAUD ACTION

Sec. 703.101. DETERMINATION OF EXPENSES. (a) The court that certifies an action as an antifraud action by order may determine the amount of reasonable and necessary expenses incurred in bringing the action, including court costs, reasonable attorney's fees, witness fees, fees of experts, and deposition expenses.

(b) In making the determination, the court may consider the contribution to the action of any person, including a state agency, that has intervened in the action.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 703.102. DEDUCTION OR OFFSET FOR EXPENSES; REIMBURSEMENT.

(a) Subject to Subsection (b), a covered entity has a deduction or offset against any obligation, assessment, or debt owed by the covered entity to this state in the amount of the reasonable and necessary expenses determined by the court order.

(b) The covered entity shall reimburse the state the amount of any expenses actually recovered from the parties to the private antifraud action under a final judgment awarding, wholly or partly, expenses to or for the covered entity's benefit. The amount of reimbursement may not exceed the actual amount of deductions or offsets taken by the covered entity.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 703.103. ASSIGNMENT OF DEDUCTION OR OFFSET. The covered entity may assign the covered entity's deduction or offset to any other covered entity or reinsurer.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 703.104. TREATMENT OF DEDUCTION OR OFFSET AS ADMITTED

ASSET. A covered entity or a covered entity's assignee entitled to an offset or deduction that has not been used may show, in the covered entity's or assignee's books and records, the balance of the deduction or offset as an admitted asset for any purpose.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

CHAPTER 704. ANTIFRAUD PROGRAMS
SUBCHAPTER A. GENERAL PROVISIONS

Sec. 704.001. DEFINITION. In this chapter, "plan issuer" means:

(1) a health insurer, including a life, health, and accident insurer, a health and accident insurer, a health maintenance organization, and any other person operating under Chapter 841, 842, 843, 884, 885, 982, or 1501 who is authorized to issue, issue for delivery, or deliver insurance policies, certificates, contracts, or evidences of coverage in this state;

(2) an approved nonprofit health corporation that holds a certificate of authority issued under Chapter 844; or

(3) an insurer authorized by the department to write workers' compensation insurance in this state.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 704.002. NOTICE RELATING TO FALSE OR FRAUDULENT CLAIMS REQUIRED. (a) A plan issuer who provides a form for a person to make a claim against or to give notice of the person's intent to make a claim against a policy, certificate, contract, or evidence of coverage issued by the issuer must include on the form, in comparative prominence with the other content on the form, a statement that is substantially similar to the following: "Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison."

(b) This section does not apply to a form provided to make a claim against a policy issued by a reinsurer.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

SUBCHAPTER B. ANTIFRAUD PLANS

Sec. 704.051. ANTIFRAUD PLAN REQUIRED FOR CERTAIN PLAN ISSUERS. A plan issuer who collects direct written premium shall adopt an antifraud plan under this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 704.052. ANTIFRAUD PLAN REQUIREMENTS. An antifraud plan adopted by a plan issuer under this subchapter must include a description of the issuer's procedures for:

- (1) detecting and investigating possible fraudulent insurance acts; and
- (2) reporting possible fraudulent insurance acts to the insurance fraud unit.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 704.053. FILING OF ANTIFRAUD PLAN. A plan issuer may annually file the issuer's antifraud plan adopted under this subchapter with the insurance fraud unit.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 704.054. FRAUD AND ABUSE PLANS UNDER CERTAIN STATE PROGRAMS; ENFORCEMENT. (a) A fraud and abuse plan put in place by a plan issuer participating in the Medicaid STAR or STAR + Plus program or the child health plan program under Chapter 62, Health and Safety Code, and approved by a health and human services agency meets the requirements of this subchapter.

(b) If a plan issuer described by Subsection (a) is required by law to report possible fraudulent insurance acts to a health and human services agency or the office of the attorney general, the issuer is not required to report those acts to the insurance fraud unit.

(c) The insurance fraud unit, the office of the attorney general, and the health and human services agencies shall coordinate enforcement efforts with respect to fraudulent insurance acts covered by this chapter relating to the Medicaid program or the child health

plan program.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

CHAPTER 705. MISREPRESENTATIONS BY POLICYHOLDERS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 705.001. DEFINITION. In this subchapter, "insurance policy" means a contract or policy of insurance.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 705.002. APPLICABILITY OF SUBCHAPTER. Except as provided by Section 705.005, this subchapter applies to each insurance policy issued or contracted for in this state.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 705.003. POLICY PROVISION: MISREPRESENTATION IN PROOF OF LOSS OR DEATH. (a) An insurance policy provision that states that a misrepresentation, including a false statement, made in a proof of loss or death makes the policy void or voidable:

- (1) has no effect; and
- (2) is not a defense in a suit brought on the policy.

(b) Subsection (a) does not apply if it is shown at trial that the misrepresentation:

- (1) was fraudulently made;
- (2) misrepresented a fact material to the question of the insurer's liability under the policy; and
- (3) misled the insurer and caused the insurer to waive or lose a valid defense to the policy.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 705.004. POLICY PROVISION: MISREPRESENTATION IN POLICY APPLICATION. (a) An insurance policy provision that states that false statements made in the application for the policy or in the policy make the policy void or voidable:

- (1) has no effect; and
- (2) is not a defense in a suit brought on the policy.

(b) Subsection (a) does not apply if it is shown at trial that the matter misrepresented:

- (1) was material to the risk; or
- (2) contributed to the contingency or event on which the policy became due and payable.

(c) It is a question of fact whether a misrepresentation made in the application for the policy or in the policy itself was material to the risk or contributed to the contingency or event on which the policy became due and payable.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 705.005. NOTICE TO INSURED OF MISREPRESENTATIONS. (a) This section applies to any suit brought on an insurance policy issued or contracted for after June 29, 1903.

(b) A defendant may use as a defense a misrepresentation made in the application for or in obtaining an insurance policy only if the defendant shows at trial that before the 91st day after the date the defendant discovered the falsity of the representation, the defendant gave notice that the defendant refused to be bound by the policy:

- (1) to the insured, if living; or
- (2) to the owners or beneficiaries of the insurance policy, if the insured was deceased.

(c) This section does not:

- (1) make available as a defense an immaterial misrepresentation; or
- (2) affect the provisions of Section 705.004.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

SUBCHAPTER B. SPECIAL PROVISIONS RELATED TO LIFE, ACCIDENT, AND HEALTH INSURANCE POLICIES

Sec. 705.051. IMMATERIAL MISREPRESENTATION IN LIFE, ACCIDENT, OR HEALTH INSURANCE APPLICATION. A misrepresentation in an application for a life, accident, or health insurance policy does not defeat recovery under the policy unless the misrepresentation:

- (1) is of a material fact; and
- (2) affects the risks assumed.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

SUBCHAPTER C. SPECIAL PROVISIONS RELATED TO LIFE INSURANCE POLICIES

Sec. 705.101. DEFINITION. In this subchapter, "insurance policy" means a contract or policy of insurance.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 705.102. APPLICABILITY OF SUBCHAPTER. This subchapter applies to any insurance policy issued or contracted for in this state.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 705.103. DOCUMENTS TO ACCOMPANY POLICY. Except as otherwise provided by this code, a life insurance policy must be accompanied by a copy of:

- (1) the policy application; and
- (2) any questions and answers given in connection with the application.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 705.104. MISREPRESENTATION IN APPLICATION FOR LIFE INSURANCE. A defense based on a misrepresentation in the application for, or in obtaining, a life insurance policy on the life of a person in or residing in this state is not valid or enforceable in a suit brought on the policy on or after the second anniversary of the date of issuance of the policy if premiums due on the policy during the two years have been paid to and received by the insurer, unless:

- (1) the insurer has notified the insured of the insurer's intention to rescind the policy because of the misrepresentation; or
- (2) it is shown at the trial that the misrepresentation

was:

- (A) material to the risk; and
- (B) intentionally made.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

Sec. 705.105. APPLICABILITY OF OTHER LAW. Subchapter A does not apply to a life insurance policy:

- (1) that contains a provision making the policy incontestable after two years or less; and
- (2) on which premiums have been duly paid.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 2, eff. April 1, 2005.

CHAPTER 706. IDENTITY THEFT INSURANCE

Sec. 706.001. DEFINITIONS. (a) The definitions adopted under Sections 2251.002 and 2301.002 and the terms described by Sections 2251.003 and 2301.003 apply to this chapter.

(b) In this chapter, "identity theft" means a criminal offense described by Section 32.51, Penal Code, or a substantially similar federal law or law in another state.

Added by Acts 2005, 79th Leg., Ch. 102 (S.B. 99), Sec. 3, eff. September 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2D.017, eff. April 1, 2009.

Sec. 706.002. COVERAGE AUTHORIZED. (a) An insurer authorized to write property and casualty insurance in this state may offer and issue insurance coverage for a loss suffered by a policyholder as a result of the policyholders' being a victim of identity theft or attempted identity theft.

(b) Coverage authorized by Subsection (a) may be:

(1) offered as a separate insurance policy or as a rider or endorsement to:

- (A) a residential and commercial property insurance policy; or
- (B) a personal or commercial casualty insurance policy;

and

(2) underwritten and issued as an individual or group insurance policy.

Added by Acts 2005, 79th Leg., Ch. 102 (S.B. 99), Sec. 3, eff. September 1, 2005.

Sec. 706.003. ELIGIBLE POLICYHOLDERS. (a) An insurer may issue coverage authorized under Section 706.002 to:

(1) an individual; or
(2) a group, business, employer, association, trustee, or other entity for the benefit of its members, customers, employees, members, or beneficiaries.

(b) An entity described by Subsection (a)(2) may be a group that:

(1) is formed solely for the purpose of obtaining insurance coverage under this chapter; or
(2) has already been formed for a purpose other than for obtaining insurance coverage under this chapter and that is described by Subsection (a)(2).

Added by Acts 2005, 79th Leg., Ch. 102 (S.B. 99), Sec. 3, eff. September 1, 2005.

Sec. 706.004. RATES AND FORMS. Notwithstanding any other law, rates and forms for insurance coverage issued under this chapter are governed by:

- (1) Subchapters A-E, Chapter 2251;
- (2) Subchapter A, Chapter 2301; and
- (3) Article 5.13-2.

Added by Acts 2005, 79th Leg., Ch. 102 (S.B. 99), Sec. 3, eff. September 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2D.018, eff. April 1, 2009.

Sec. 706.005. RULES. The commissioner may adopt rules as

necessary to implement this chapter.

Added by Acts 2005, 79th Leg., Ch. 102 (S.B. 99), Sec. 3, eff. September 1, 2005.

CHAPTER 707. PAYMENT OF INSURANCE DEDUCTIBLE

Sec. 707.001. DEFINITIONS. In this chapter:

(1) "Person" means an individual, corporation, association, partnership, limited liability company, or other legal entity.

(2) "Property insurance policy" means an insurance policy issued by an insurer, including a county mutual insurance company, farm mutual insurance company, Lloyd's plan, or reciprocal or interinsurance exchange, that provides first-party coverage for loss of or damage to real property.

Added by Acts 2019, 86th Leg., R.S., Ch. 1099 (H.B. 2102), Sec. 1, eff. September 1, 2019.

Sec. 707.002. PAYMENT OF DEDUCTIBLE REQUIRED. A person insured under a property insurance policy shall pay any deductible applicable to a first-party claim made under the policy.

Added by Acts 2019, 86th Leg., R.S., Ch. 1099 (H.B. 2102), Sec. 1, eff. September 1, 2019.

Sec. 707.003. CONSUMER EDUCATION. The department, in coordination with other state agencies and stakeholders as necessary, shall develop and implement an education program related to the payment of property insurance policy deductibles. The program must:

(1) provide reasonable methods to educate insurance consumers and providers of goods or services that are regularly paid for from proceeds of property insurance claims; and

(2) include information regarding:

(A) the requirements of this chapter and Section 27.02, Business & Commerce Code; and

(B) the conduct prohibited by Section 27.02, Business & Commerce Code.

Added by Acts 2019, 86th Leg., R.S., Ch. 1099 (H.B. 2102), Sec. 1, eff. September 1, 2019.

Sec. 707.004. REASONABLE PROOF OF PAYMENT. An insurer that issues a property insurance policy with replacement cost coverage may refuse to pay a claim for withheld recoverable depreciation or a replacement cost holdback under the policy until the insurer receives reasonable proof of payment by the policyholder of any deductible applicable to the claim. Reasonable proof of payment includes a canceled check, money order receipt, credit card statement, or copy of an executed installment plan contract or other financing arrangement that requires full payment of the deductible over time.

Added by Acts 2019, 86th Leg., R.S., Ch. 1099 (H.B. 2102), Sec. 1, eff. September 1, 2019.

Sec. 707.005. RULEMAKING. The commissioner may adopt rules as necessary to implement this chapter. Section 2001.0045, Government Code, does not apply to rules adopted under this section.

Added by Acts 2019, 86th Leg., R.S., Ch. 1099 (H.B. 2102), Sec. 1, eff. September 1, 2019.

SUBTITLE G. REGULATION OF INSURER MARKET CONDUCT

CHAPTER 751. MARKET CONDUCT SURVEILLANCE

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 751.001. SHORT TITLE. This chapter may be cited as the Insurance Market Conduct Surveillance Act.

Added by Acts 2005, 79th Leg., Ch. 291 (S.B. 14), Sec. 3, eff. September 1, 2005.

Sec. 751.002. PURPOSE AND SCOPE. (a) The purpose of this chapter is to establish a framework for department market conduct actions, including:

(1) processes and systems for identifying, assessing, and prioritizing market conduct problems that have a substantial adverse

impact on consumers, policyholders, and claimants;

(2) development of appropriate market conduct actions by the commissioner as required to:

- (A) substantiate market conduct problems; and
- (B) remedy significant market conduct problems; and

(3) procedures to communicate and coordinate market conduct actions with other states to foster the most efficient and effective use of resources.

(b) Notwithstanding any other law of this state, the department or commissioner, as applicable, may undertake market analysis or market conduct action only as provided by this chapter.

Added by Acts 2005, 79th Leg., Ch. 291 (S.B. 14), Sec. 3, eff. September 1, 2005.

Sec. 751.003. DEFINITIONS. (a) In this chapter:

(1) "Complaint" means a written or documented oral communication, the primary intent of which is to express a grievance or an expression of dissatisfaction.

(2) "Desk examination" means a targeted examination conducted by an examiner at a location other than an insurer's premises. The term includes an examination performed at the department's offices during which the insurer provides requested documents for department review by hard copy or by microfiche, disk, or other electronic media.

(3) "Market analysis" means a process under which market conduct surveillance personnel collect and analyze information from filed schedules, surveys, required reports, and other sources as necessary to:

- (A) develop a baseline understanding of the marketplace; and
- (B) identify insurer patterns or practices that:
 - (i) deviate significantly from the norm; or
 - (ii) pose a potential risk to the insurance consumer.

(4) "Market analysis handbook" means the outline of the elements and objectives of market analysis as developed and adopted by the National Association of Insurance Commissioners, and used to establish a uniform process by which states may establish and

implement market analysis programs.

(5) "Market conduct action" means any activity that the commissioner may initiate to assess and address insurer market practices before conducting a targeted examination. The term does not include a commissioner action taken to resolve:

(A) an individual consumer complaint; or

(B) another report relating to a specific instance of insurer misconduct.

(6) "Market conduct examination" means a review of one or more lines of business of an insurer domiciled in this state that is not conducted for cause. The term includes a review of rating, tier classification, underwriting, policyholder service, claims, marketing and sales, producer licensing, complaint handling practices, or compliance procedures and policies.

(7) "Market conduct examiners handbook" means the set of guidelines, developed and adopted by the National Association of Insurance Commissioners, that document established practices to be used by market conduct surveillance personnel in developing and executing an examination under this chapter.

(8) "Market conduct surveillance personnel" means those individuals employed by or under contract with the department who collect, analyze, review, or act on information regarding insurer patterns or practices.

(9) "Market conduct uniform examination procedures" means the set of guidelines developed and adopted by the National Association of Insurance Commissioners designed to be used by market conduct surveillance personnel in conducting an examination under this chapter.

(10) "On-site examination" means a targeted examination that is conducted at:

(A) the insurer's home office; or

(B) another location at which the records under review are stored.

(11) "Qualified contract examiner" means a person qualified by education, experience, and any applicable professional designations who is under contract with the commissioner to perform market conduct actions.

(12) "Standard data request" means the set of field names and descriptions developed and adopted by the National Association of Insurance Commissioners for use by market conduct surveillance

personnel in an examination.

(13) "Targeted examination" means a limited review and analysis, conducted through a desk examination or an on-site examination and in accordance with the market conduct uniform examination procedures, of specific insurer conduct, practices, or risks identified through market analysis that have not been remedied by the insurer, including:

- (A) underwriting and rating;
- (B) marketing and sales;
- (C) complaint handling operations and management;
- (D) advertising materials;
- (E) licensing;
- (F) policyholder services;
- (G) claims handling;
- (H) policy forms and filings; or
- (I) tier classification.

(14) "Third-party model or product" means a model or product provided by an entity that is separate from and not under direct or indirect corporate control of the insurer using the model or product.

(b) In this chapter, "affiliate" and "subsidiary" have the meanings described by Section 823.003.

Added by Acts 2005, 79th Leg., Ch. 291 (S.B. 14), Sec. 3, eff. September 1, 2005.

Sec. 751.004. IMMUNITY. (a) A cause of action does not arise, and liability may not be imposed, for any statements made or conduct performed in good faith while implementing this chapter, against:

- (1) the commissioner;
- (2) an authorized representative of the commissioner; or
- (3) an examiner appointed by the commissioner.

(b) A cause of action does not arise, and liability may not be imposed, against any person for the act of communicating or delivering information or data to the commissioner or the commissioner's authorized representative or examiner under an examination made under this chapter, if the act of communication or delivery was performed in good faith and without fraudulent intent or the intent to deceive.

(c) A person identified in Subsection (a) is entitled to attorney's fees and costs if the person is the prevailing party in a civil cause of action for libel, slander, or any other relevant tort arising out of activities conducted in implementing this chapter, and the party bringing the action was not substantially justified in doing so. For purposes of this subsection, an action is "substantially justified" if the action had a reasonable basis in law or fact at the time that it was initiated.

(d) This section does not abrogate or modify any common law or statutory privilege or immunity.

Added by Acts 2005, 79th Leg., Ch. 291 (S.B. 14), Sec. 3, eff. September 1, 2005.

SUBCHAPTER B. GENERAL POWERS AND DUTIES OF COMMISSIONER

Sec. 751.051. PARTICIPATION IN NATIONAL MARKET CONDUCT DATABASES. (a) The commissioner shall collect and report market data to the National Association of Insurance Commissioners' market information systems, including the complaint database system, the examination tracking system, the regulatory information retrieval system, or other successor systems of that association, as determined by the commissioner.

(b) Information collected and maintained by the department shall be compiled in a manner that meets the requirements of the National Association of Insurance Commissioners.

Added by Acts 2005, 79th Leg., Ch. 291 (S.B. 14), Sec. 3, eff. September 1, 2005.

Sec. 751.052. COORDINATION WITH OTHER STATES; REGISTRATION OF CONTRACT EXAMINER. (a) The commissioner shall coordinate the department's market analysis and examination efforts with other states through the National Association of Insurance Commissioners.

(b) A person with whom another state contracts to perform any market analysis or examination initiated by the other state of an insurer domiciled in this state shall register with and provide the following information to the department's chief examiner:

- (1) the person's name;
- (2) if the person is not an individual, the identity of

each examiner or other person who will perform any part of the market analysis or examination;

(3) the name of the state that contracted with the person;

(4) the identity of the insurer to be examined;

(5) a description of each issue that the person has been contracted to examine;

(6) an estimate of the examination costs to be charged to the insurer to be examined;

(7) a copy of any contract between the person and the state regulatory body that initiated the examination and the letter authorizing the examination; and

(8) a list of the previous examinations conducted on the same insurer on behalf of any state within the last three years.

(b-1) On accepting a person's registration under Subsection (b), the department shall send written confirmation of the acceptance to:

(1) the person;

(2) the insurer to be examined; and

(3) the state regulatory body that initiated the examination.

(c) It is a violation of this code for a person to accept compensation from multiple states for the same examination, if doing so results in duplicative costs to the insurer being examined. It is not a violation of this code for:

(1) an examiner to conduct an examination of an insurer for the benefit of multiple states in a coordinated examination; and

(2) the examiner to accept compensation from the states participating in the coordinated examination to reduce the examination costs to the insurer being examined.

Added by Acts 2005, 79th Leg., Ch. 291 (S.B. 14), Sec. 3, eff. September 1, 2005.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1030 (H.B. 4359), Sec. 1, eff. June 19, 2009.

Acts 2011, 82nd Leg., R.S., Ch. 185 (S.B. 1229), Sec. 2, eff. May 28, 2011.

Sec. 751.053. INFORMATION FROM COMMISSIONER. (a) At least

once annually or more frequently if determined necessary by the commissioner, the commissioner shall provide in an appropriate manner to insurers and other entities subject to this code information regarding new laws and rules, enforcement actions, and other information the commissioner considers relevant to ensure compliance with market conduct requirements.

(b) The commissioner may provide the notice required under Subsection (a) in an electronic format that is designed to give insurers and other entities adequate notice.

(c) Failure by the commissioner to provide the information described by Subsection (a) does not constitute a defense for an insurer who fails to comply with an insurance law of this state.

Added by Acts 2005, 79th Leg., Ch. 291 (S.B. 14), Sec. 3, eff. September 1, 2005.

Sec. 751.054. REPORT OF VIOLATIONS. (a) The commissioner shall designate an individual within the department whose responsibilities shall include the receipt of information from employees of insurers and other entities regulated by the department regarding violations of laws or rules by their employers. The commissioner's designee shall be properly trained in the handling of that information.

(b) Information received under this section is a confidential communication and is not public information.

Added by Acts 2005, 79th Leg., Ch. 291 (S.B. 14), Sec. 3, eff. September 1, 2005.

Sec. 751.055. EXERCISE OF SUBPOENA AUTHORITY. The commissioner has the subpoena power authorized by Subchapter C, Chapter 36, for the production of documents under this chapter and enforcement of this subtitle.

Added by Acts 2005, 79th Leg., Ch. 291 (S.B. 14), Sec. 3, eff. September 1, 2005.

SUBCHAPTER C. RELATIONS WITH OTHER STATES

Sec. 751.101. COMMISSIONER AUTHORITY; INTERACTIONS WITH OTHER INSURANCE COMMISSIONERS OF OTHER STATES. (a) The commissioner has responsibility for conducting market conduct examinations on domestic insurers. The commissioner may delegate that responsibility to the insurance commissioner of another state, if that insurance commissioner agrees to accept the delegated responsibility. If the commissioner elects to delegate responsibility for examining an insurer, the commissioner shall accept a report of the examination prepared by the insurance commissioner to whom the responsibility has been delegated.

(b) If the insurer to be examined is part of an insurance holding company system, the commissioner may also seek to simultaneously examine any affiliate of the insurer that is authorized to write the same types of insurance in this state as the insurer if the insurance commissioner of the state in which the affiliate is organized consents and delegates responsibility for that examination.

(c) In lieu of conducting a targeted examination of an insurer that holds a certificate of authority in this state but is not a domestic insurer, the commissioner shall accept a report of a market conduct examination regarding that insurer prepared by the insurance commissioner of the state in which the insurer is organized or by another state if:

(1) the laws of the examining state that are applicable to the subject of the examination are substantially similar to those of this state; and

(2) the examining state has a market conduct surveillance system that the commissioner deems comparable to the market conduct surveillance system required under this chapter.

(d) The commissioner's determination under Subsection (c)(2) is discretionary with the commissioner and is not subject to appeal.

(e) Subject to a determination under Subsection (c), if a market conduct examination conducted by another state results in a finding that an insurer should modify a specific practice or procedure, the commissioner shall accept documentation that the insurer has made a similar modification in this state in lieu of initiating a market conduct action or examination related to that practice or procedure. The commissioner may require other or additional practice or procedure modifications.

Added by Acts 2005, 79th Leg., Ch. 291 (S.B. 14), Sec. 3, eff. September 1, 2005.

SUBCHAPTER D. MARKET ANALYSIS PROCEDURES

Sec. 751.151. COLLECTION OF INFORMATION; COMMISSIONER ANALYSIS.

(a) Subject to Subsection (d), the commissioner shall gather insurance market information from:

- (1) data available to the department, including survey results and information required to be reported to the department;
- (2) information collected by the National Association of Insurance Commissioners and other public and private sources; and
- (3) information from within and outside the insurance industry.

(b) The commissioner shall analyze the information compiled under Subsection (a) as necessary to:

- (1) develop a baseline understanding of the insurance marketplace; and
- (2) identify for further review insurers or insurance practices that deviate significantly from the norm or that pose a potential risk to the insurance consumer.

(c) The commissioner shall use the market analysis handbook as a resource in performing the analysis required under this section.

(d) Except as otherwise specifically provided, the department or the commissioner, as applicable, may not require an insurer to report information in a manner that is inconsistent with the records the insurer maintains in the ordinary course of business or can create at a reasonable expense or effort.

Added by Acts 2005, 79th Leg., Ch. 291 (S.B. 14), Sec. 3, eff. September 1, 2005.

Sec. 751.152. ADDITIONAL ANALYSIS OF MARKET ACTIONS. (a) If, as a result of the market analysis, the commissioner determines that further inquiry into a particular insurer or insurance practice is needed, the commissioner shall consider taking one or more of the market conduct actions described by Subsection (b) before conducting a targeted examination. If a market conduct action selected by the commissioner requires the participation of or a response by the

affected insurer, the commissioner shall notify the insurer of the action selected in writing.

(b) Market conduct actions described by Subsection (a) may include:

- (1) correspondence with the insurer;
- (2) insurer interviews;
- (3) information gathering;
- (4) policy and procedure reviews;
- (5) interrogatories; and
- (6) review of insurer self-evaluation and compliance programs, including insurer membership in a best-practice organization.

(c) The commissioner shall select market conduct actions that are efficient and cost-effective for the department and the insurer while protecting the interests of the insurance consumer.

(d) The commissioner shall take steps reasonably necessary to:

- (1) eliminate requests for information that duplicates or conflicts with information provided as part of an insurer's annual financial statement, the annual market conduct statement of the National Association of Insurance Commissioners, or other required schedules, surveys, or reports that are regularly submitted to the commissioner, or with data requests made by other states if that information is available to the commissioner, unless the information is state specific; and
- (2) coordinate the market conduct actions and findings of this state with those of other states.

Added by Acts 2005, 79th Leg., Ch. 291 (S.B. 14), Sec. 3, eff. September 1, 2005.

Sec. 751.153. PROTOCOLS FOR MARKET CONDUCT ACTIONS. (a) Each market conduct action taken as a result of a market analysis:

- (1) must focus on the general business practices and compliance activities of insurers, rather than identifying infrequent or unintentional random errors that do not cause significant consumer harm; and
- (2) may not result in a market conduct examination, unless the head of the insurance regulatory agency in the insurer's state of domicile determines that a market conduct examination is needed.

(b) The commissioner may determine the frequency and timing of the market conduct actions. The timing of an action depends on the specific market conduct action to be initiated unless extraordinary circumstances indicating a risk to consumers require immediate action.

(c) If the commissioner has information that more than one insurer is engaged in practices that may violate statutes or rules, the commissioner may schedule and coordinate multiple examinations simultaneously.

(d) The commissioner shall provide an insurer with an opportunity to resolve to the satisfaction of the commissioner any matter that arises as a result of a market analysis before any additional market conduct actions are taken against the insurer. If the insurer has modified a practice or procedure as a result of a market conduct action taken or examination conducted by the insurance commissioner of another state, and the commissioner deems that state's market conduct surveillance system comparable to the system required under this chapter, the commissioner may accept the modified practice or procedure and may require other or additional practice or procedure modifications.

(e) For an application by the department of a handbook, guideline, or other product referenced in this chapter that is the work product of the National Association of Insurance Commissioners that changes the way in which market conduct actions are conducted, the commissioner shall give notice and provide interested parties with an opportunity for a public hearing as provided by Chapter 2001, Government Code, if the change:

- (1) necessitates a change in a statute or rule; or
- (2) deviates from the applicable handbook, guideline, or other product most recently adopted by the National Association of Insurance Commissioners.

(f) Except as otherwise provided by law, each insurer or person from whom information is sought, and each officer, director, or agent of that insurer or person, shall provide the commissioner with convenient and free access to all books, records, accounts, papers, documents, and any computer or other recordings relating to the property, assets, business, and affairs of the insurer or person.

(g) Each officer, director, employee, insurance producer, and agent of an insurer or person described by Subsection (f) shall, to the extent of that individual's ability, facilitate and aid in a

department market conduct action.

Added by Acts 2005, 79th Leg., Ch. 291 (S.B. 14), Sec. 3, eff. September 1, 2005.

SUBCHAPTER E. EXAMINATIONS

Sec. 751.201. EXAMINATION. (a) If the commissioner determines that a market conduct action described by Section 751.152(b) is not appropriate, the commissioner may conduct a targeted examination in accordance with the market conduct uniform examination procedures and the market conduct examiners handbook.

(b) A targeted examination may be conducted through a desk examination or an on-site examination. To the extent feasible, the department shall conduct a market conduct examination through desk examinations and data requests before conducting an on-site examination.

(c) The department shall conduct an examination in accordance with the market conduct examiners handbook and the market conduct uniform examinations procedures.

(d) The department shall use the standard data request or a successor product that is substantially similar to the standard data request as adopted by the commissioner by rule.

(e) If the insurer to be examined is not a domestic insurer, the commissioner shall coordinate the examination with the insurance commissioner of the state in which the insurer is organized.

Added by Acts 2005, 79th Leg., Ch. 291 (S.B. 14), Sec. 3, eff. September 1, 2005.

Sec. 751.202. WORK PLAN. Before beginning an examination, market conduct surveillance personnel shall prepare a work plan that includes:

- (1) the name and address of the insurer to be examined;
- (2) the name and contact information of the examiner-in-charge;
- (3) a statement of the reasons for the examination;
- (4) a description of the scope of the examination;
- (5) the date the examination is scheduled to begin;
- (6) notice to any non-insurance department personnel who

will assist in the examination;

(7) a time estimate for the examination; and

(8) if the cost of the examination is billed to the affected insurer:

(A) a budget for the examination; and

(B) an identification of factors that will be included in the billing.

Added by Acts 2005, 79th Leg., Ch. 291 (S.B. 14), Sec. 3, eff. September 1, 2005.

Sec. 751.203. NOTICE OF EXAMINATION. (a) Unless the examination is conducted in response to extraordinary circumstances as described by Section 751.153(b), the department shall notify an affected insurer of an examination not later than the 60th day before the scheduled date of the beginning of the examination. The notice must include the examination work plan and a request that the insurer name an examination coordinator for the insurer.

(b) In addition to the notice required under Subsection (a), the commissioner shall post notice that a market conduct examination has been scheduled on the National Association of Insurance Commissioners examination tracking system.

(c) If a targeted examination is expanded beyond the reasons provided to the insurer in the notice of the examination required under Subsection (a), the commissioner shall provide written notice to the insurer, explaining the extent of the expansion and the reasons for the expansion. The department shall provide a revised work plan to the insurer before the beginning of any significantly expanded examination.

Added by Acts 2005, 79th Leg., Ch. 291 (S.B. 14), Sec. 3, eff. September 1, 2005.

Sec. 751.204. PRE-EXAMINATION CONFERENCE. Not later than the 30th day before the scheduled date of the examination, the commissioner shall conduct a pre-examination conference with the insurer's examination coordinator and key personnel to clarify expectations.

Added by Acts 2005, 79th Leg., Ch. 291 (S.B. 14), Sec. 3, eff. September 1, 2005.

Sec. 751.205. EXIT CONFERENCE. Before the conclusion of an examination, the member of the market conduct surveillance personnel who is designated as the examiner-in-charge shall schedule an exit conference with the insurer.

Added by Acts 2005, 79th Leg., Ch. 291 (S.B. 14), Sec. 3, eff. September 1, 2005.

Sec. 751.206. EXAMINATION REPORT. (a) Unless the commissioner and the insurer agree to a different schedule, the commissioner shall follow the time line established under this section.

(b) The commissioner shall deliver the draft examination report to the insurer not later than the 60th day after the date the examination is completed. For purposes of this section, the date the examination is completed is the date on which the exit conference is conducted.

(c) Not later than the 30th day after the date on which the insurer receives the draft examination report, the insurer shall provide any written comments regarding the report to the department.

(d) The department shall make a good faith effort to resolve issues with the insurer informally and shall prepare a final examination report not later than the 30th day after the date of receipt of the insurer's written comments on the draft report unless a mutual agreement is reached to extend the deadline.

(e) The department shall include the insurer's responses in the final examination report. The responses may be included as an appendix or in the text of the examination report. An insurer is not obligated to submit a response. An individual involved in the examination may not be named in either the report or the insurer response except to acknowledge the individual's involvement.

(f) The commissioner may make corrections and other changes to the final examination report as appropriate, and shall issue the report to the insurer. Not later than the 30th day after receipt of the final examination report under this subsection, the insurer shall accept the report, accept the findings of the report, or request a

hearing. The commissioner and the insurer by mutual agreement may extend the period for an additional 30 days. A request for a hearing must be made in writing and must follow the requirements of Chapter 2001, Government Code.

Added by Acts 2005, 79th Leg., Ch. 291 (S.B. 14), Sec. 3, eff. September 1, 2005.

Sec. 751.207. CONFIDENTIALITY OF EXAMINATION REPORT INFORMATION. (a) A final or preliminary market conduct examination report, and any information obtained during the course of an examination, is confidential and is not subject to disclosure under Chapter 552, Government Code. This section may not be construed to limit the commissioner's authority to use any final or preliminary market conduct examination report, any examiner or company work papers or other documents, or any other information discovered or developed during the course of an examination in the furtherance of any legal or regulatory action that the commissioner, in the commissioner's sole discretion, may deem appropriate.

(b) This chapter does not prevent the commissioner from disclosing at any time the contents of a final market conduct examination report to the department, the insurance department of any other state, or an agency of the federal government, if the department or agency receiving the report agrees in writing to maintain the information as confidential and in a manner consistent with this chapter.

(c) The commissioner shall provide to an insurer subject to a final market conduct examination a written agreement described by Subsection (b) not later than the fifth day after the date the final market conduct examination is released under Subsection (b).

Added by Acts 2005, 79th Leg., Ch. 291 (S.B. 14), Sec. 3, eff. September 1, 2005.

Sec. 751.208. ASSESSMENT OF COSTS OF EXAMINATION. (a) Subject to Subsection (d), if the reasonable and necessary cost of a market conduct examination is to be assessed against the affected insurer, fees for that cost must be consistent with those otherwise authorized by law. The fees must be itemized and bills for the fees must be

provided to the insurer on a monthly basis for review prior to submission for payment.

(b) The commissioner shall actively manage and oversee examination costs, including costs associated with the use of department examiners and with retaining qualified contract examiners necessary to perform an on-site examination. To the extent the commissioner retains outside assistance, the commissioner shall adopt by rule written protocols that:

(1) clearly identify the types of functions to be subject to outsourcing;

(2) provide specific time lines for completion of the outsourced review;

(3) require disclosure of recommendations made by contract examiners;

(4) establish and use a dispute resolution or arbitration mechanism to resolve conflicts with insurers regarding examination fees; and

(5) require disclosure of the terms of contracts entered into with outside consultants, and specifically terms regarding the fees or hourly rates that may be charged by those consultants.

(c) The commissioner must review and affirmatively endorse detailed billings made by a qualified contract examiner before the detailed billings are sent to the insurer.

(d) An insurer may not be required to provide reimbursement for examiner fees under Subsection (a), whether those fees are incurred by market conduct surveillance personnel or qualified contract examiners, to the extent that those fees exceed the fees prescribed in the market conduct examiners handbook and any successor documents to that handbook, unless the commissioner demonstrates that the fees prescribed in the handbook are inadequate under the circumstances of the examination.

Added by Acts 2005, 79th Leg., Ch. 291 (S.B. 14), Sec. 3, eff. September 1, 2005.

Sec. 751.209. LIMIT ON CERTAIN EXAMINATIONS. The commissioner may not conduct a market conduct examination more frequently than once every three years. The commissioner may defer conducting a market conduct examination for longer than once every three years.

Added by Acts 2005, 79th Leg., Ch. 291 (S.B. 14), Sec. 3, eff. September 1, 2005.

SUBCHAPTER F. CONFIDENTIALITY REQUIREMENTS

Sec. 751.251. NO WAIVER. (a) The disclosure to the commissioner under this subchapter of a document, material, or information does not constitute the waiver of any applicable privilege or claim of confidentiality regarding the document, material, or information.

(b) Notwithstanding Subsection (a), an insurer may not be compelled to disclose a self-audit document or waive any statutory or common law privilege. An insurer may, however, voluntarily disclose a document described by this subsection to the commissioner in response to any market conduct action or examination.

(c) For the purposes of Subsection (b), "self-audit document" means a document that is prepared as a result of or in connection with an insurance compliance audit.

Added by Acts 2005, 79th Leg., Ch. 291 (S.B. 14), Sec. 3, eff. September 1, 2005.

Sec. 751.252. AUTHORITY OF COMMISSIONER. (a) The commissioner may share documents, materials, or other information obtained by or disclosed to the commissioner under this chapter with other state, federal, and international regulatory agencies and law enforcement authorities if the recipient agrees to and has the legal authority to maintain the confidentiality and privileged status of the document, material, or other information.

(b) The commissioner may receive documents, materials, or information, including otherwise confidential and privileged documents, materials, or information, from the National Association of Insurance Commissioners and that association's affiliates or subsidiaries, and from regulatory and law enforcement officials of other foreign or domestic jurisdictions. The commissioner shall maintain as confidential or privileged any document, material, or information received with notice or the understanding that the document, material, or information is confidential or privileged under the laws of the jurisdiction that is the source of the

document, material, or information.

(c) Consistent with this section, the commissioner may enter into agreements governing the sharing and use of information.

Added by Acts 2005, 79th Leg., Ch. 291 (S.B. 14), Sec. 3, eff. September 1, 2005.

SUBCHAPTER G. MARKET CONDUCT SURVEILLANCE PERSONNEL

Sec. 751.301. PERSONNEL; QUALIFICATIONS. (a) To conduct market conduct surveillance under this chapter, the commissioner may designate department staff to perform duties under this chapter, and may supplement that staff with qualified outside professional assistance if the commissioner determines that that assistance is necessary.

(b) Market conduct surveillance personnel must be qualified by education and experience and, if applicable, must hold appropriate professional designations.

Added by Acts 2005, 79th Leg., Ch. 291 (S.B. 14), Sec. 3, eff. September 1, 2005.

Sec. 751.302. CONFLICT OF INTEREST. (a) An individual who is a member of the market conduct surveillance personnel has a conflict of interest, either directly or indirectly, if the individual is affiliated with the management of, has been employed by, or owns a pecuniary interest in an insurer subject to an examination conducted under this chapter.

(b) This section may not be construed to automatically preclude the individual from being:

- (1) a policyholder or claimant under an insurance policy;
- (2) a grantee of a mortgage or similar instrument on the individual's residence from a regulated entity if done under customary terms and in the ordinary course of business;
- (3) an investment owner in shares of regulated diversified investment companies; or
- (4) a settlor or beneficiary of a blind trust into which any otherwise permissible holdings have been placed.

Added by Acts 2005, 79th Leg., Ch. 291 (S.B. 14), Sec. 3, eff.

September 1, 2005.

Sec. 751.303. ACCESS TO INFORMATION. (a) Except as otherwise provided by law, market conduct surveillance personnel shall, as practicable, have free and full access to all books and records, and all employees, officers, and directors, of the insurer during regular business hours.

(b) On the request of market conduct surveillance personnel, an insurer that uses a third-party model or product for any of the activities under examination shall make the details of those models or products available to that personnel.

Added by Acts 2005, 79th Leg., Ch. 291 (S.B. 14), Sec. 3, eff. September 1, 2005.

Sec. 751.304. AUTHORITY OF MARKET CONDUCT SURVEILLANCE PERSONNEL. Market conduct surveillance personnel may examine insurance company personnel under oath if that action is ordered by the commissioner under Subchapter C, Chapter 36.

Added by Acts 2005, 79th Leg., Ch. 291 (S.B. 14), Sec. 3, eff. September 1, 2005.

SUBCHAPTER H. SANCTIONS

Sec. 751.351. SANCTIONS. (a) The commissioner may impose sanctions under Chapter 82 against an insurer determined, as a result of a market conduct action or other action under this chapter, to have violated this code, a rule adopted under this code, or another insurance law of this state.

(b) In determining an appropriate sanction under Subsection (a) the commissioner shall consider:

(1) any actions taken by the insurer to maintain membership in, and comply with the standards of, best-practice organizations that promote high ethical standards of conduct in the insurance marketplace; and

(2) the extent to which the insurer maintains regulatory compliance programs to self-assess, self-report, and remediate problems detected by the insurer.

Added by Acts 2005, 79th Leg., Ch. 291 (S.B. 14), Sec. 3, eff. September 1, 2005.

CHAPTER 752. ENFORCEMENT OF BALANCE BILLING PROHIBITIONS

Sec. 752.0001. DEFINITION. In this chapter, "administrator" has the meaning assigned by Section 1467.001.

Added by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 1.01, eff. September 1, 2019.

Sec. 752.0002. INJUNCTION FOR BALANCE BILLING. (a) If the attorney general receives a referral from the appropriate regulatory agency indicating that an individual or entity, including a health benefit plan issuer or administrator, has exhibited a pattern of intentionally violating a law that prohibits the individual or entity from billing an insured, participant, or enrollee in an amount greater than an applicable copayment, coinsurance, and deductible under the insured's, participant's, or enrollee's managed care plan or that imposes a requirement related to that prohibition, the attorney general may bring a civil action in the name of the state to enjoin the individual or entity from the violation.

(b) If the attorney general prevails in an action brought under Subsection (a), the attorney general may recover reasonable attorney's fees, costs, and expenses, including court costs and witness fees, incurred in bringing the action.

Added by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 1.01, eff. September 1, 2019.

Sec. 752.0003. ENFORCEMENT BY REGULATORY AGENCY. (a) An appropriate regulatory agency that licenses, certifies, or otherwise authorizes a physician, health care practitioner, health care facility, or other health care provider to practice or operate in this state may take disciplinary action against the physician, practitioner, facility, or provider if the physician, practitioner, facility, or provider violates a law that prohibits the physician, practitioner, facility, or provider from billing an insured, participant, or enrollee in an amount greater than an applicable

copayment, coinsurance, and deductible under the insured's, participant's, or enrollee's managed care plan or that imposes a requirement related to that prohibition.

(b) The department may take disciplinary action against a health benefit plan issuer or administrator if the issuer or administrator violates a law requiring the issuer or administrator to provide notice of a balance billing prohibition or make a related disclosure.

(c) A regulatory agency described by Subsection (a) or the commissioner may adopt rules as necessary to implement this section. Section 2001.0045, Government Code, does not apply to rules adopted under this subsection.

Added by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. [1264](#)), Sec. 1.01, eff. September 1, 2019.

TITLE 6. ORGANIZATION OF INSURERS AND RELATED ENTITIES
SUBTITLE A. GENERAL PROVISIONS APPLICABLE TO INSURERS AND RELATED ENTITIES
CHAPTER 801. CERTIFICATE OF AUTHORITY
SUBCHAPTER A. GENERAL PROVISIONS

Sec. 801.001. DEFINITIONS. In this chapter:

- (1) "Control" has the meaning described by Section 823.005.
- (2) "Insurer" means the issuer of an insurance policy that is issued to another in consideration of a premium and that insures against a loss that may be insured against under the law. The term includes a:
- (A) fraternal benefit society;
 - (B) Lloyd's plan;
 - (C) mutual company of any kind, including a:
 - (i) statewide mutual assessment association;
 - (ii) local mutual aid association or burial association; and
 - (iii) county or farm mutual insurance company;
 - (D) reciprocal or interinsurance exchange;
 - (E) group hospital service corporation;
 - (F) health maintenance organization;
 - (G) nonprofit legal services corporation; and

(H) stock company.

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

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1022 (H.B. 4291), Sec. 1, eff. June 19, 2009.

Sec. 801.002. EXEMPTION FOR CERTAIN FRATERNAL BENEFIT SOCIETIES. This chapter does not apply to a fraternal benefit society that:

(1) sells insurance policies only as an incidental benefit to its members; and

(2) on September 6, 1955, was:

(A) organized and licensed by the department as a fraternal benefit society; or

(B) exempt under former Article 10.12 or 10.38, revised as Section 885.004.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER B. CERTIFICATE OF AUTHORITY

Sec. 801.051. APPROVAL, DENIAL, OR DISAPPROVAL OF APPLICATION FOR CERTIFICATE; ELIGIBILITY; HEARING. (a) The department shall approve, deny, or disapprove an application for a certificate of authority to act as an insurer.

(b) If the department determines that the applicant has complied with the law, the department shall approve the application and issue under the department's seal a certificate of authority to act as an insurer.

(c) On the applicant's request, the commissioner shall hold a hearing on a denial. Not later than the 30th day after the date of the applicant's request for a hearing, the commissioner shall request a hearing date.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1022 (H.B. 4291), Sec. 2, eff. June 19, 2009.

Sec. 801.052. EFFECT AND CONTENTS OF CERTIFICATE. A certificate of authority issued to an insurer under this chapter authorizes the insurer to engage in the business of insurance. The certificate of authority must state the specific kinds of insurance authorized under the certificate.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 801.053. DURATION OF CERTIFICATE. A certificate of authority issued to an insurer under this chapter is effective until it is suspended or revoked.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 801.054. PREFERENCE FOR DOMESTIC COMPANY. In issuing a certificate of authority to an applicant under this chapter, the department shall give preference to an application submitted by a domestic company.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 801.055. DEPOSIT OF FEES. A fee collected by the department under this chapter for a certificate of authority shall be deposited to the credit of the Texas Department of Insurance operating account.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 801.056. FAILURE TO PROVIDE COMPLETE SET OF FINGERPRINTS: GROUND FOR DENIAL OF APPLICATION. (a) In this section, "authorization" means any authorization issued by the department to engage in an activity regulated under this code, including:

- (1) a certificate of authority;
- (2) a certificate of registration;
- (3) a license; and

(4) a permit.

(b) The department may deny an application for an authorization if the applicant or a corporate officer of the applicant fails to provide a complete set of fingerprints on request by the department.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 801.057. FAILURE TO FILE ANNUAL STATEMENT: GROUND FOR REVOCATION OR SUSPENSION. A certificate of authority of an insurer that fails to file an annual statement required by law is subject to being suspended or revoked by the department.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER C. COMPETENCE, FITNESS, OR REPUTATION

Sec. 801.101. DEPARTMENT INQUIRY. The department may inquire into the competence, fitness, or reputation of:

- (1) an officer or director of an insurer; or
- (2) a person having control of an insurer.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 801.102. DENIAL OF APPLICATION OR REVOCATION OF CERTIFICATE. (a) If after conducting an inquiry under Section 801.101 the department determines that the person who is the subject of the inquiry is not worthy of the public confidence, the department shall:

- (1) deny the application for a certificate of authority; or
- (2) revoke the insurer's certificate of authority.

(b) On the applicant's request, the commissioner shall hold a hearing on a denial or revocation. Not later than the 30th day after the date of the applicant's request for a hearing, the commissioner shall request a hearing date.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1022 (H.B. [4291](#)), Sec. 3, eff. June 19, 2009.

SUBCHAPTER D. FELONY CONVICTION

Sec. 801.151. ISSUANCE OF CERTIFICATE PROHIBITED. Except as provided by Sections 801.153 and 801.154, the department may not issue a certificate of authority to an applicant if a corporate officer or member of the board of directors of the applicant has been convicted of a felony involving:

- (1) moral turpitude; or
- (2) breach of a fiduciary duty.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 801.152. REVOCATION OF CERTIFICATE. After notice and hearing, the department may revoke the certificate of authority of an insurer if a corporate officer or member of the board of directors of the insurer is convicted of a felony involving:

- (1) moral turpitude; or
- (2) breach of a fiduciary duty.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 801.153. PETITION FOR ISSUANCE OR REINSTATEMENT OF CERTIFICATE. A company may petition the commissioner for issuance or reinstatement of a certificate of authority of the company that is denied or revoked under this subchapter:

- (1) not earlier than the later of:
 - (A) the fifth anniversary of the date of the final conviction; or
 - (B) if the officer or director is sentenced to confinement or imprisonment or placed on community supervision, the fifth anniversary of the date the officer or director completes the sentence or period of community supervision; or
- (2) after the officer or director ceases to be an officer or director of the insurer.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 801.154. GRANT OF PETITION. The commissioner shall grant a petition for issuance or reinstatement of a certificate of authority under this subchapter if the petitioner demonstrates that granting the petition would be in the public interest and that justice would best be served by granting the petition.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 801.155. RULES RELATING TO CONTENTS OF PETITION. The department may adopt rules under this subchapter prescribing the contents of a petition for issuance or reinstatement of a certificate of authority.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

CHAPTER 802. ANNUAL STATEMENT

SUBCHAPTER A. ANNUAL STATEMENT OF INSURANCE COMPANIES

Sec. 802.001. FORM OF ANNUAL STATEMENT. (a) The commissioner, as necessary to obtain an accurate indication of the company's condition and method of transacting business, may change the form of any annual statement required to be filed by any kind of insurance company.

(b) The form may require only information that relates to the business of the insurance company.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 802.002. ACTUARIAL OPINION REQUIRED. (a) In this section, "qualified actuary" means:

(1) a member in good standing of the American Academy of Actuaries; or

(2) a person who has otherwise demonstrated actuarial competence to the satisfaction of the commissioner or an insurance regulatory official of another state in which the insurance company is domiciled.

(b) An insurance company's annual statement must include a statement of a qualified actuary entitled "Statement of Actuarial Opinion" that:

(1) is located on or is attached to the first page of the annual statement; and

(2) provides the opinion of the actuary relating to policy reserves and other actuarial items for life insurance, accident and health insurance, and annuities, or loss and loss adjustment expense reserves for property and casualty risks, as described in the annual statement instructions of the National Association of Insurance Commissioners as appropriate for the type of risks insured.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 802.003. FILING DATE OF ANNUAL STATEMENT DELIVERED BY POSTAL SERVICE. Except as otherwise specifically provided, for an annual statement that is required to be filed in the offices of the commissioner and that is delivered by the United States Postal Service to the offices of the commissioner after the date on which the annual statement is required to be filed, the date of filing is the date of:

(1) the postal service postmark stamped on the cover in which the document is mailed; or

(2) any other evidence of mailing authorized by the postal service reflected on the cover in which the document is mailed.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.201, eff. Sept. 1, 2003.

SUBCHAPTER B. FILING WITH NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Sec. 802.051. APPLICABILITY OF SUBCHAPTER. This subchapter applies to each company regulated by the commissioner, including:

- (1) a stock life, health, or accident insurance company;
- (2) a mutual life, health, or accident insurance company;
- (3) a stock fire or casualty insurance company;
- (4) a mutual fire or casualty insurance company;
- (5) a Mexican casualty company;
- (6) a Lloyd's plan;
- (7) a reciprocal or interinsurance exchange;
- (8) a fraternal benefit society;

- (9) a title insurance company;
- (10) a stipulated premium insurance company;
- (11) a nonprofit legal service corporation;
- (12) a health maintenance organization;
- (13) a statewide mutual assessment company;
- (14) a local mutual aid association;
- (15) a local mutual burial association;
- (16) an association exempt under Section 887.102;
- (17) a nonprofit hospital, medical, or dental service corporation, including a company subject to Chapter 842;
- (18) a county mutual insurance company; and
- (19) a farm mutual insurance company.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 967 (S.B. 2065), Sec. 5.006, eff. September 1, 2017.

Sec. 802.052. CONCURRENT FILING WITH NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS. (a) Each domestic, foreign, or alien insurance company authorized to engage in the business of insurance in this state shall file a copy of the company's annual statement with the National Association of Insurance Commissioners at the time the company files the statement with the commissioner.

(b) The statement required by Subsection (a) must:

- (1) meet requirements adopted by the commissioner, including:
 - (A) a change in substance or form;
 - (B) an additional filing; and
 - (C) any requirement that the statement be in a computer compatible format; and

(2) include the signed jurat page and the actuarial opinion, as required by the jurisdiction in which the insurance company is domiciled.

(c) The insurance company shall also file with the National Association of Insurance Commissioners a copy of any amendment or addition to the annual statement that is subsequently filed with the commissioner.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 802.053. EXEMPTION AUTHORITY. The commissioner may exempt any class of insurance companies from the requirements of this subchapter if the commissioner believes the information required under this subchapter will not be useful for regulatory purposes.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 802.054. COMPLIANCE. The commissioner may consider a foreign insurance company to be in compliance with the requirements of Section 802.052 if the company is domiciled in a state with a law substantially similar to that section.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 802.055. COSTS PAID BY INSURANCE COMPANY. An insurance company shall pay all costs of preparing and furnishing to the National Association of Insurance Commissioners the information required under Section 802.052, including any related filing fees.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 206, Sec. 17.01, eff. June 11, 2003; Acts 2003, 78th Leg., ch. 211, Sec. 2.04, eff. June 16, 2003; Acts 2003, 78th Leg., ch. 863, Sec. 1, eff. June 20, 2003.

Sec. 802.056. STATUS OF REPORTS AND OTHER INFORMATION. A report or any other information resulting from the collection, review, analysis, and distribution of information developed from the filing of annual statement convention blanks and provided to the department by the National Association of Insurance Commissioners is considered part of the process of examination of insurance companies under this code, including Chapters 86 and 401.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 2E.001, eff. April 1, 2009.

**CHAPTER 803. LOCATION OF BOOKS, RECORDS, ACCOUNTS, AND OFFICES
OUTSIDE OF THIS STATE**

Sec. 803.001. DEFINITIONS. In this chapter:

- (1) "Domestic company" means any entity licensed, chartered, or organized under this code, including:
- (A) a county mutual insurance company;
 - (B) a farm mutual insurance company;
 - (C) a fire and marine insurance company;
 - (D) a fraternal benefit society;
 - (E) a general casualty company;
 - (F) a group hospital service corporation;
 - (G) a health maintenance organization;
 - (H) a life, health, and accident insurance company;
 - (I) a Lloyd's plan;
 - (J) a local mutual aid association;
 - (K) a mutual life insurance company;
 - (L) a mutual insurance company other than a mutual life insurance company;
 - (M) a nonprofit legal services corporation;
 - (N) a reciprocal exchange;
 - (O) a statewide mutual assessment company;
 - (P) a stipulated premium insurance company;
 - (Q) a surety and trust company; and
 - (R) a title insurance company.

(2) "Insurance holding company system" has the meaning described by Section 823.006.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 803.002. APPLICABILITY OF CHAPTER. This chapter applies only to a domestic company that is:

- (1) an affiliate of an insurance holding company system and in compliance with Chapter 823;
- (2) a nonprofit legal services corporation the claims and daily affairs of which are handled under contract by a foreign insurer that holds a certificate of authority to engage in a similar business in this state; or

(3) a health maintenance organization that is affiliated with another health maintenance organization or a health care provider.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 803.003. AUTHORITY TO LOCATE OUT OF STATE. (a) A domestic company may locate and maintain its principal offices and all or any part of its books, records, and accounts outside this state at any other location in the United States if:

(1) the company has given written notice of this intention to the commissioner, except as provided by Subsection (b);

(2) the commissioner has not disapproved the notice before the 31st day after the date on which the company gives the notice; and

(3) the company meets the requirements of this chapter.

(b) A separate notice under this section is not required if:

(1) the domestic company has an agreement to maintain its books and records outside of the state with an affiliate; and

(2) the agreement:

(A) has been approved under Chapter 823; and

(B) contains substantially all the information required for notice under this section.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 803.004. LOCATION AT BRANCH OR AGENCY OFFICE. This chapter does not apply to the location and maintenance of the normal books, records, and accounts of a domestic company, including policyholder and claim files, relating to the business produced by or through an agency of the company at a branch or agency office located in the United States, regardless of whether the agency is an affiliate of the company as provided in Chapter 823.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 803.005. CONTROL OF BOOKS, RECORDS, ACCOUNTS, AND OFFICES.

(a) The books, records, accounts, or offices of a domestic company

must be under the company's direct supervision, management, and control.

(b) The ultimate controlling person of an insurance holding company system affiliated with a domestic company, or the immediate or intermediate controlling person of the domestic company, must be domiciled, licensed, or admitted to transact business in a jurisdiction in the United States.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 803.006. AGENT FOR SERVICE OF PROCESS. A domestic company that under this chapter has moved its principal offices and any part of its books, records, and accounts outside this state and the controlling person of an affiliated insurance holding company system must comply with Section 804.102.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 803.007. EXAMINATION EXPENSES. A credit on or an offset against the amount of premium taxes to be paid by a domestic company to the state in a taxable year may not be allowed on:

- (1) a fee or examination expense paid to another state; or
- (2) an examination expense:

(A) incurred by a representative of the department that is directly attributable to an examination of the books, records, accounts, or principal offices of a domestic company located outside this state; or

(B) paid in a different taxable year.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 803.008. RULES. The commissioner shall adopt rules to authorize a domestic company to maintain its books and records with a nonaffiliated entity other than an agency.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 803.009. CONFLICTING PROVISIONS. This chapter prevails over a conflicting provision of any other law of this state, including:

- (1) Chapters 221, 222, and 223;
- (2) Sections 401.151, 401.152, 401.155, and 401.156; and
- (3) Section 171.0525, Tax Code.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.002, eff. April 1, 2009.

CHAPTER 804. SERVICE OF PROCESS
SUBCHAPTER A. GENERAL PROVISIONS

Sec. 804.001. DEFINITION. In this chapter, "process" means legal process, including a demand or notice required or permitted by law.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 804.002. RULES. The commissioner may adopt rules essential for the effective implementation of this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 804.003. FEES. A fee collected under this chapter shall be deposited to the credit of the Texas Department of Insurance operating account for use by the department. The department shall use the money for payment of salaries and other expenses arising from the:

- (1) examination of insurance companies;
- (2) licensure of insurance companies; and
- (3) investigation of violations of the insurance laws of this state.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER B. PERSONS AUTHORIZED TO RECEIVE SERVICE OF PROCESS

Sec. 804.101. DOMESTIC COMPANY. (a) In this section:

(1) "Domestic company" means a company that is domiciled in and authorized to engage in the business of insurance in this state.

(2) "Company" means:

(A) an insurance company, including:

(i) a casualty insurance company;

(ii) a county mutual insurance company;

(iii) an exempt association under Section 887.102;

(iv) a farm mutual insurance company;

(v) a fire insurance company;

(vi) a fraternal benefit society;

(vii) a life insurance company;

(viii) a Lloyd's plan;

(ix) a mutual assessment company;

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

(xi) a reciprocal exchange;

(xii) a risk retention group;

(xiii) a stipulated premium insurance company;

(xiv) a title insurance company; and

(xv) a carrier providing job protection insurance;

(B) a group hospital service corporation;

(C) a health maintenance organization;

(D) a prepaid legal services corporation; or

(E) any other company engaged in the business of insurance as a principal.

(b) A domestic company may be served with process by:

(1) serving the president, an active vice president, secretary, or attorney in fact at the home office or principal place of business of the company; or

(2) leaving a copy of the process at the home office or principal business office of the company during regular business hours.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 804.102. DOMESTIC COMPANY THAT MAINTAINS PRINCIPAL OFFICES OR BOOKS, RECORDS, AND ACCOUNTS OUT OF STATE. (a) In this section,

"domestic company" has the meaning assigned by Section 803.001.

(b) As a condition of being authorized to engage in the business of insurance in this state, a domestic company that under Chapter 803 has moved its principal offices and any part of its books, records, and accounts outside this state and the controlling person of an affiliated insurance holding company system must appoint and maintain as agent for service of process a person in this state on whom a judicial or administrative process may be served.

(c) If a domestic company does not appoint or maintain a person in this state as agent for service of process or the agent cannot with reasonable diligence be found, the commissioner may accept service of process and notify the company in the manner provided by Subchapter C.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 804.103. AUTHORIZED ALIEN OR FOREIGN COMPANY. (a) In this section, "company" means:

- (1) an insurance company, including a:
 - (A) fire, casualty, or fire and casualty insurance company;
 - (B) fraternal benefit society;
 - (C) life insurance company, including a mutual or nonprofit life insurance company;
 - (D) Lloyd's plan;
 - (E) Mexican casualty insurance company;
 - (F) mutual fire, mutual casualty, or mutual fire and casualty insurance company;
 - (G) reciprocal exchange;
 - (H) risk retention group; and
 - (I) title insurance company;
- (2) a health maintenance organization; and
- (3) any other insurance company, regardless of its type or category, authorized to engage in the business of insurance in this state.

(b) As a condition to being issued a certificate of authority to engage in the business of insurance in this state, an alien or foreign company must appoint a person in this state as agent for service of process on whom any process to be served on the company

may be served.

(c) The commissioner is an alien or foreign company's agent on whom process may be served as provided by Subchapter C if the:

- (1) company fails to appoint or maintain an agent under Subsection (b);
- (2) agent appointed under Subsection (b) cannot with reasonable diligence be found; or
- (3) company's certificate of authority is revoked.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 804.104. RISK RETENTION GROUP NOT CHARTERED IN THIS STATE. A risk retention group that is not chartered but that is registered in this state under Section 2201.152, must designate the commissioner as its agent for service of process and receipt of legal documents.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.003, eff. April 1, 2009.

Sec. 804.105. PERSON IN RECEIVERSHIP. (a) Service of process with respect to an individual, insurer, or other entity for which a court has appointed the liquidator as receiver must be made only on the receiver.

(b) If Subsection (a) applies, service on the commissioner or the secretary of state has no effect.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 804.106. ELIGIBLE SURPLUS LINES INSURER; POLICY REQUIREMENT FOR INSURER AND AGENT. (a) Each surplus lines insurer that assumes a surplus lines risk under Chapter 981 is subject to this section.

(b) Any act of engaging in the business of insurance by an eligible surplus lines insurer:

- (1) constitutes the irrevocable appointment of the secretary of state by that insurer as agent for service of process

arising from the insurer's engaging in the business of insurance in this state, other than service of process for an action or proceeding by the department or state; and

(2) signifies the insurer's agreement that service under this subsection has the same effect as personal service on the insurer or the insurer's successor in interest.

(c) An appointment under Subsection (b)(1) is binding on the eligible surplus lines insurer and the insurer's successor in interest.

(d) A policy issued by an eligible surplus lines insurer or a certificate of insurance issued by the surplus lines agent must contain a provision stating the substance of this section and designating the person to whom the commissioner is to mail process. The plaintiff shall supply this address in any citation served under this section.

(e) This section is in addition to any other method provided by law for service of process on a surplus lines insurer, including the method provided by Subchapter C.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 804.107. UNAUTHORIZED PERSON OR INSURER. (a) In this section, "personal representative" includes an executor or administrator.

(b) Any act of engaging in the business of insurance as provided by Subchapter B, Chapter 101, by an unauthorized person or insurer:

(1) constitutes the irrevocable appointment of the commissioner by that person or insurer as agent for service of process arising from the person's or insurer's engaging in the business of insurance in this state, other than service of process for an action or proceeding by the department or state;

(2) constitutes the irrevocable appointment of the secretary of state by that person or insurer as agent for service of process for an action or proceeding described by Subsection (c) and arising from the person's or insurer's engaging in the business of insurance in this state; and

(3) signifies the agreement of the person or insurer that process served under this subsection and Subsection (d) has the same

effect as personal service in this state on that person or insurer or the personal representative of that person or insurer or if a corporation, the corporation's successor in interest.

(c) The process may be served on the secretary of state only in an action or proceeding brought:

(1) in court by the department or the state against an unauthorized person or insurer; or

(2) before the department by a process against the unauthorized person or insurer.

(d) Service of process on an unauthorized person or insurer may be served on a person in this state that engages, on the behalf of the unauthorized person or insurer, in an act of engaging in the business of insurance in this state as provided by Subchapter B, Chapter 101.

(e) In an action or proceeding in which process is served under Subsection (b) or (d), a plaintiff or complainant is not entitled to a default judgment or determination before the 30th day after the date on which the copy of the process is mailed to the defendant.

(f) This section does not apply to an entity that was an eligible surplus lines insurer under Chapter 981 on the date on which the applicable coverage was issued.

(g) This section does not limit or diminish the right to serve process on a person or insurer in any other manner provided by law.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 804.108. INSURANCE HOLDING COMPANY SYSTEM LAW. A person, as that term is defined by Section 823.002, that violates Chapter 823 is considered to have appointed the commissioner as agent for service of process on the person for an action or proceeding arising from a violation of that chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER C. PROCEDURES RELATING TO SERVICE OF PROCESS ON COMMISSIONER

Sec. 804.201. PROCEDURE FOR SERVING COMMISSIONER. (a) Process served by serving the commissioner under this chapter must be directed to the defendant and include:

(1) for an unauthorized person or insurer, the name and address of the person or insurer to be served;

(2) for a risk retention group, the name and address of the group to be served;

(3) for a surplus lines insurer, the name and address of the insurer to be served;

(4) for an unincorporated association, trust, or other organization formed under Chapter 1505, the name and address of the association, trust, or organization; or

(5) for an authorized company, the name and address of the company as it appears in the department records.

(b) Process may be served on the commissioner:

(1) personally by a disinterested person who is at least 18 years of age leaving two copies of the process at the office of the department during regular business hours with:

(A) the commissioner; or

(B) an appointee of the commissioner authorized to receive process; or

(2) by certified or registered mail.

(c) A fee not to exceed \$50, payable by check or money order to the department, must accompany each process served on the commissioner.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 2E.004, eff. April 1, 2009.

Sec. 804.202. EFFECT OF SERVICE ON COMMISSIONER. Service on the commissioner acting as agent for service of process is service on the principal.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 804.203. MAILING PROCESS; CERTIFICATE. (a) The commissioner shall immediately send by registered or certified mail, return receipt requested, one copy of process served on the commissioner under Section 804.201 to:

(1) the defendant at the address supplied in the process as

provided by Sections 804.201(a)(1) through (4); or

(2) if Section 804.201(a)(5) applies, the home office or principal business office of the authorized company, as indicated in the department records.

(b) The commissioner shall send by registered or certified mail, return receipt requested, copies of process served under Section 804.108 to the last known address of the person.

(c) On receiving the return receipt for certified or registered mail, the commissioner shall issue a certificate showing the service and proof of delivery by a return receipt to the plaintiff and clerk of the court or agency where the proceeding is pending.

(d) The commissioner shall provide on request the certificate described by Subsection (c). The commissioner may charge a fee not to exceed \$10 for the certificate.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 804.204. RECORD. The commissioner shall keep a record of:

- (1) each process served on the commissioner under this chapter; and
- (2) the action taken by the commissioner regarding the process.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER D. PROCEDURES RELATING TO SERVICE OF PROCESS ON SECRETARY OF STATE

Sec. 804.301. PROCEDURE FOR SERVING SECRETARY OF STATE.

Process served by serving the secretary of state under Section 804.107 must be served by leaving two copies of the process at the office of the secretary of state during regular business hours with:

- (1) the secretary of state; or
- (2) an appointee of the secretary of state authorized to receive service.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 804.302. MAILING PROCESS. The secretary of state shall

mail one copy of process in the proceeding served on the secretary of state under Section 804.301 to the defendant in a court proceeding or to whom the process in an administrative proceeding is addressed or directed, at the person's or entity's last known home office or principal place of business.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 804.303. RECORD. The secretary of state shall keep a record of each process served on the secretary of state.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

CHAPTER 805. DIRECTORS, OFFICERS, AND OTHER INTERESTED PERSONS
SUBCHAPTER A. ACTIVITIES OF DIRECTORS, OFFICERS, AND SHAREHOLDERS

Sec. 805.001. DEFINITIONS. In this subchapter:

(1) "Major shareholder" means an individual, corporation, partnership, association, joint-stock company, business trust, or unincorporated organization that is directly or indirectly the beneficial owner of more than 10 percent of any class of an equity security of an insurer.

(2) "Subsidiary" means a corporation:

(A) of which at least 50 percent of any class of an equity security is owned by an insurer; or

(B) that is managed, directly or indirectly controlled, or subject to control by an insurer.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 805.002. APPLICABILITY OF SUBCHAPTER. (a) This subchapter applies to any insurer, including a:

- (1) capital stock company;
- (2) reciprocal or interinsurance exchange;
- (3) Lloyd's plan;
- (4) fraternal benefit society;
- (5) mutual company, including a mutual assessment company;
- (6) local mutual aid association;
- (7) burial association;

- (8) county mutual insurance company;
- (9) farm mutual insurance company;
- (10) fidelity, guaranty, or surety company;
- (11) mutual life insurance company;
- (12) mutual insurance company other than a mutual life insurance company;
- (13) stipulated premium company;
- (14) title insurance company; and
- (15) any other insurance company engaged in the business of insurance in or organized under the laws of this state or otherwise regulated under this code.

(b) A provision of this code limiting regulation under this code does not limit the application of this subchapter.

(c) This subchapter controls if there is ambiguity or a conflict between this subchapter and another provision of this code.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 805.003. PROHIBITED ACTIVITIES. (a) A director, officer, or major shareholder of an insurer may not:

(1) except as provided by this subchapter, directly, indirectly, or through a substantial interest in another corporation, firm, or business unit receive money or another thing of value for negotiating, procuring, recommending, or aiding in a purchase, sale, or exchange of property or a loan from the insurer or its subsidiary;

(2) directly, indirectly, or through a substantial interest in another corporation, firm, or business unit have a pecuniary interest in a purchase, sale, exchange, or loan described by Subdivision (1) as a principal, co-principal, agent, or beneficiary; or

(3) directly or indirectly accept a loan or guarantee described by Subsection (b).

(b) An insurer may not directly, indirectly, or through its subsidiary make a loan to or guarantee the financial obligation of a director, officer, or major shareholder of an insurer.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 805.004. ACTIVITIES NOT PROHIBITED. This subchapter does

not prohibit:

(1) a director, officer, or major shareholder of an insurer from:

(A) becoming a policyholder of the insurer and exercising the usual rights of a policyholder;

(B) participating as beneficiary in a pension plan, deferred compensation plan, profit-sharing or bonus plan, stock option plan, or similar plan adopted by the insurer and for which the director, officer, or major shareholder may be eligible under the terms of the plan;

(C) receiving a salary, bonus, or other remuneration for a service rendered to the insurer as an employee of the insurer and not in violation of another provision of this code; or

(D) entering into an arms-length transaction with the insurer if:

(i) the transaction is not prohibited by another statute; and

(ii) the commissioner approves the transaction before the transaction is made;

(2) a director of an insurer from:

(A) performing professional services not required of a director by law; or

(B) receiving director's fees or reimbursement for an expense incurred in the performance of a duty as a director;

(3) a transaction within an insurance holding company system by an insurer with its holding company, subsidiary, or affiliate that:

(A) is not prohibited by law;

(B) meets the test of being fair and proper; and

(C) is regulated by another statute;

(4) a transaction or arrangement that:

(A) is not prohibited by law; and

(B) meets the test of being fair and proper as prescribed by rules adopted by the commissioner; or

(5) the approval and payment of lawful dividends to policyholders and shareholders.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER B. CERTAIN PAYMENTS BY DIRECTORS, OFFICERS, AND TRUSTEES

Sec. 805.021. LIABILITY FOR FEE AND TAX PAYMENTS. (a) In this section, "fee or tax" includes a license, excise, privilege, premium, or occupation fee or tax.

(b) A director, officer, or trustee of an insurer is not personally liable, in complying with the law, for the payment of or for the determination not to contest the payment of a fee or tax to a state or a political subdivision of a state that the board of directors or trustees considers to be in the corporate interest of the insurer.

(c) Subsection (b) does not apply if, before the payment of the fee or tax, the state court of final appellate jurisdiction or the United States Supreme Court expressly holds that the law imposing the fee or tax is invalid.

(d) This section does not directly or indirectly limit, minimize, or interpret the rights and powers of an insurer or the directors, officers, or trustees of an insurer.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBTITLE B. ORGANIZATION OF REGULATED ENTITIES**CHAPTER 821. GENERAL PROVISIONS****SUBCHAPTER A. MINIMUM INSURANCE TO BE MAINTAINED BY INSURER**

Sec. 821.001. APPLICABILITY OF SUBCHAPTER. (a) This subchapter applies to any insurer that is required by law to hold a certificate of authority issued by the department, including:

- (1) a domestic insurance company;
- (2) a mutual life insurance company;
- (3) a statewide mutual assessment company;
- (4) a mutual insurance company other than a life insurance company operating under Chapter 883;
- (5) a Lloyd's plan;
- (6) a reciprocal or interinsurance exchange; and
- (7) a title insurance company.

(b) This subchapter does not apply to:

- (1) an insurer before the second anniversary of the date the insurer's original certificate of authority is issued; or
- (2) an insurer that was paid more than \$50,000 in gross premium income by policyholders during the preceding accounting year

of the insurer.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 821.002. EXEMPTIONS. This subchapter does not apply to:

- (1) a fraternal benefit society operating under Chapter 885;
- (2) a local mutual aid association or local mutual burial association operating under Chapters 886, 887, and 888;
- (3) a statewide mutual assessment company or association operating under Chapters 881, 887, or 888;
- (4) another association operating under Subchapter C, Chapter 887;
- (5) a farm mutual insurance company operating under Chapter 911; or
- (6) a county mutual fire insurance company operating under Chapter 912.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 821.003. MINIMUM REQUIREMENTS. An insurer must maintain at all times not less than 100 policyholders or certificate holders nor less than \$200,000 of insurance that the insurer has written or acquired through reinsurance contracts.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 821.004. REPORT TO ATTORNEY GENERAL; SUIT AGAINST INSURER. (a) The department shall report to the attorney general an insurer's failure to comply with this subchapter.

(b) On receiving a report under Subsection (a), the attorney general shall bring suit in a district court in Travis County against the insurer to cancel, forfeit, and revoke the insurer's:

- (1) charter, articles of association, or articles of agreement; and
- (2) certificate of authority.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER B. ASSOCIATION OF INSURANCE COMPANIES

Sec. 821.051. PAYMENT OF TAXES AND FEES; COMPLIANCE WITH LAW.

(a) Life, health, fire, marine, or inland marine insurance companies that associate to issue or sell insurance policies may not engage in the business of insurance in this state until each company has:

- (1) paid the company's taxes and fees that are due; and
- (2) complied with all requirements of law.

(b) The commissioner may not authorize to engage in the business of insurance in this state an insurance company that does not comply with Subsection (a).

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

CHAPTER 822. GENERAL INCORPORATION AND REGULATORY REQUIREMENTS FOR INSURANCE COMPANIES OTHER THAN LIFE, HEALTH, OR ACCIDENT INSURANCE COMPANIES

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 822.001. APPLICABILITY OF CHAPTER. Except as otherwise provided by this code, this chapter applies to the formation of each company or organization that proposes to engage in any kind of insurance business other than a life, health, or accident insurance company organized or operating under Chapter 841, 881, 882, 884, 885, 886, 887, or 888.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 822.002. APPLICABILITY OF LAW GOVERNING CORPORATIONS. An insurance company incorporated in this state is subject to the Texas Business Corporation Act, the Texas Miscellaneous Corporation Laws Act (Article 1302-1.01 et seq., Vernon's Texas Civil Statutes), and any other law of this state that governs corporations in general to the extent those laws are not inconsistent with this code.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 822.003. EFFECT ON TRANSACTIONS BETWEEN INSURANCE

COMPANIES AND OTHERS. The following sections do not restrict or modify any provision of this code relating to a transaction between an insurance company and the insurance company's affiliates, or between an insurance company and certain shareholders, directors, or officers of the insurance company, as provided by Subchapter A, Chapter 805, and Chapter 823:

- (1) Sections 822.055 and 822.056;
- (2) Section 822.057(a)(4);
- (3) Section 822.061;
- (4) Section 822.156;
- (5) Sections 822.158(d) and (e); and
- (6) Sections 822.206 and 822.207.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER B. FORMATION AND STRUCTURE OF COMPANY

Sec. 822.051. FORMATION OF COMPANY. (a) Any number of persons may form a company for the purpose of engaging in the business of insurance.

(b) To form a company, each incorporator must adopt and sign the articles of incorporation of the company as provided by this code.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 822.052. ARTICLES OF INCORPORATION. Articles of incorporation of a proposed insurance company must state:

- (1) the name of the company;
- (2) the location of the company's principal business office;
- (3) the kind of insurance business in which the company proposes to engage;
- (4) the amount of the company's capital stock; and
- (5) the amount of the company's surplus.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 822.053. COMPANY'S NAME. An insurance company's name may

not be so similar to the name of another insurance company as to likely mislead the public.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 822.054. CAPITAL STOCK AND SURPLUS REQUIREMENTS. (a) An insurance company must have capital stock in an amount of at least \$2.5 million and surplus in an amount of at least \$2.5 million.

(b) At the time of incorporation, the required capital and surplus must be in cash.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1275 (H.B. 1476), Sec. 1, eff. September 1, 2009.

Sec. 822.055. SHARES OF STOCK WITH PAR VALUE. (a) An insurance company organized under the laws of this state may authorize the issuance of shares of stock with a par value of not less than \$1 or more than \$100. The company may increase from time to time the number of shares with a par value by an amendment to the company's charter.

(b) Each par value share of stock must be fully paid before issuance in an amount that is not less than the share's par value. Par value shares issued under this section are not subject to additional call or assessment, and the subscriber or holder of those shares is not required to make an additional payment with respect to those shares.

(c) When an application for charter or an amendment to the charter authorizing the issuance of shares of stock with a par value is filed, the insurance company shall file with the department a statement under oath stating:

(1) the total number of par value shares subscribed; and

(2) the actual total consideration the company received for those shares.

(d) Repealed by Acts 2023, 88th Leg., R.S., Ch. 825 (H.B. 1903), Sec. 3(1), eff. September 1, 2023.

(e) If all of the authorized par value shares of stock are not subscribed and paid for when the charter is granted or the amendment

is filed, respectively, the insurance company shall file with the department a certificate authenticated by a majority of the directors stating the total number of shares issued and the total consideration received for those shares. The company shall file the certificate not later than the 90th day after the date of issuance of those remaining shares. The company is not required to file an amendment to its charter or take further action to effect the increase in the capital and surplus of the company.

(f) The consideration received by an insurance company for a par value share constitutes capital to the extent of its par value and the remainder, if any, constitutes surplus.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 825 (H.B. 1903), Sec. 3(1), eff. September 1, 2023.

Sec. 822.056. SHARES OF STOCK WITHOUT PAR VALUE. (a) An insurance company organized under the laws of this state, on incorporation or by an amendment to its charter, may authorize the issuance of shares of stock without par value.

(b) Each share of stock without par value must be equal in all respects.

(c) An insurance company may issue and dispose of authorized shares without par value for money or for notes, bonds, mortgages, and stock in the form authorized by law for capital stock of insurance companies. Each share of stock without par value must be fully paid before issuance. After the company receives payment for a share of stock issued under this section, the share is not subject to additional call or assessment and the subscriber or holder of the share is not required to make an additional payment with respect to the share.

(d) The shareholders of an insurance company authorizing shares of stock without par value must pay a total amount of at least \$250,000 for the shares before the company is granted a charter or has its charter amended to authorize the issuance of shares without par value.

(e) If all of the authorized shares of stock without par value are not subscribed and paid for when the charter is granted or the

amendment is filed, respectively, the insurance company shall file with the department a certificate authenticated by a majority of the directors stating the number of shares without par value issued and the consideration received for those shares. An insurance company may issue and dispose of those remaining authorized shares for money or an instrument authorized for minimum capital under:

(1) a provision of Subchapter B, Chapter 424, other than Section 424.052, 424.072, or 424.073; and

(2) Section 822.204.

(f) The insurance company shall file the certificate required by Subsection (e) not later than the 90th day after the date of issuance of those remaining shares. The portion of the consideration received for shares without par value that is designated as capital by the company's directors, or by the company's shareholders if the charter or articles of incorporation reserve the right to make that determination to the shareholders, constitutes capital and the remainder, if any, constitutes surplus. The company is not required to file an amendment to its charter or take further action to effect the increase in the capital and surplus of the company.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 2E.005, eff. April 1, 2009.

Acts 2023, 88th Leg., R.S., Ch. 825 (H.B. [1903](#)), Sec. 1, eff. September 1, 2023.

Sec. 822.057. APPLICATION FOR CHARTER. (a) To obtain a charter for an insurance company, the incorporators must pay to the department the fees prescribed by law and file with the department:

(1) an application for charter on the form and containing the information prescribed by the commissioner;

(2) the company's proposed articles of incorporation;

(3) an affidavit made by the incorporators or officers of the company that states that:

(A) the capital and surplus is the bona fide property of the company; and

(B) the information in the articles of incorporation is true and correct; and

(4) if the application provides for the issuance of shares of stock without par value, a certificate authenticated by the incorporators stating:

(A) the number of shares without par value that are subscribed; and

(B) the actual consideration received by the company for those shares.

(b) If the commissioner is not satisfied with the affidavit filed under Subsection (a)(3), the commissioner may require that the incorporators provide at their expense additional evidence of a matter required in the affidavit before the commissioner:

(1) receives the proposed articles of incorporation or the application for charter; or

(2) issues a certificate of authority to the company.

(c) Repealed by Acts 2009, 81st Leg., R.S., Ch. 1022, Sec. 19(1), eff. June 19, 2009.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1022 (H.B. 4291), Sec. 4, eff. June 19, 2009.

Acts 2009, 81st Leg., R.S., Ch. 1022 (H.B. 4291), Sec. 19(1), eff. June 19, 2009.

Sec. 822.058. ACTION BY COMMISSIONER AFTER FILING OF APPLICATION FOR CHARTER. (a) Repealed by Acts 2009, 81st Leg., R.S., Ch. 1022, Sec. 19(2), eff. June 19, 2009.

(b) After the items required for a charter under Sections 822.057(a)(1) and (2) are filed with the department and the proposed insurance company has complied with all legal requirements, the commissioner shall conduct an examination of the company to determine whether:

(1) the minimum capital stock and surplus requirements of Section 822.054 are satisfied;

(2) the capital stock and surplus is the bona fide property of the company; and

(3) the insurance company has fully complied with insurance laws.

(c) The commissioner may appoint a competent and disinterested

person to conduct the examination required by this section. The examiner shall file an affidavit of the examiner's findings with the commissioner. The commissioner shall record the affidavit.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1022 (H.B. 4291), Sec. 5, eff. June 19, 2009.

Acts 2009, 81st Leg., R.S., Ch. 1022 (H.B. 4291), Sec. 19(2), eff. June 19, 2009.

Sec. 822.060. ACTION ON APPLICATION. (a) In considering the application, the commissioner shall determine if:

(1) the proposed capital structure of the company meets the requirements of this code;

(2) the proposed officers, directors, attorney in fact, or managing head of the company have sufficient insurance experience, ability, standing, and good record to make success of the proposed company probable; and

(3) the applicants are acting in good faith.

(b) If the commissioner determines that the applicant has not met the standards set out by Subsection (a), the commissioner shall deny the application in writing, giving the reason for the denial.

(c) If the commissioner does not deny the application under Subsection (b), the commissioner shall approve the application. On approval of an application, the articles of incorporation of the company shall be filed with the department.

(d) On the applicant's request, the commissioner shall hold a hearing on a denial. Not later than the 30th day after the date of the applicant's request for a hearing, the commissioner shall request a hearing date.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1022 (H.B. 4291), Sec. 6, eff. June 19, 2009.

Sec. 822.061. ISSUANCE OF CHARTER. (a) On receipt of a charter fee in the amount determined under Chapter 202, the

commissioner shall examine the articles of incorporation filed with the department under Section 822.060 and any certificate filed under Section 822.057(a)(4).

(b) If the commissioner approves the articles of incorporation and, if applicable, the certificate filed under Section 822.057(a)(4), the commissioner shall certify and file the approved documents with the department records and, on receipt of a fee in the amount determined under Chapter 202, the commissioner shall issue a certified copy of the charter to the incorporators.

(c) When the insurance company's charter is issued, the charter is effective and the incorporators may proceed with the organization of the company as provided by this code.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.006, eff. April 1, 2009.

SUBCHAPTER C. AUTHORITY TO ENGAGE IN BUSINESS IN THIS STATE

Sec. 822.101. CERTIFICATE OF AUTHORITY. When the articles of incorporation of an insurance company have been filed with the department under Section 822.060 or the company has been authorized to engage in business as provided by law, the commissioner shall issue to the company a certificate of authority to commence business as proposed in the company's articles of incorporation or application for charter if the commissioner determines that the company has fully complied with the law.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER D. MANAGEMENT OF COMPANY

Sec. 822.151. CONDUCTING SHAREHOLDERS MEETING. (a) Except as otherwise provided by this code, at a meeting of an insurance company's shareholders to elect the company's board of directors or to transact other company business, a quorum is any number of shareholders whose cumulative ownership in the company represents at least 51 percent of the company's stock.

(b) A shareholder may vote in person or by proxy.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 822.152. BOARD OF DIRECTORS. (a) An insurance company organized under the laws of this state is managed by its board of directors.

(b) The board consists of not fewer than five directors. A director:

(1) is not required to be a shareholder unless such a qualification is required by the articles of incorporation or bylaws of the company; and

(2) serves until the director's successor is elected and accepts the position.

(c) The board of directors may adopt bylaws and regulations as necessary to conduct the company's business. A majority of the board is a quorum.

(d) The board of directors shall keep a full and correct record of the board's transactions. The shareholders or other interested persons may inspect those records during business hours.

(e) The directors shall fill a vacancy that occurs on the board or in any office of the company.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2021, 87th Leg., R.S., Ch. 380 (S.B. 918), Sec. 1, eff. September 1, 2021.

Sec. 822.153. ELECTION OF DIRECTORS. (a) Not later than the 30th day after the date on which the company's subscription books are filed, the shareholders of an insurance company shall meet to elect the company's initial board of directors. At the meeting, each shareholder is entitled to one vote for each share of stock.

(b) The shareholders of an insurance company shall meet annually as provided by the company's bylaws to elect successor directors.

(c) If the shareholders do not elect directors at an annual meeting, the shareholders may elect the directors at a special shareholders meeting called for that purpose. Not later than the 30th day before the date of the special meeting, the shareholders

must publish notice of the meeting in a newspaper of general circulation in the county in which the principal office of the company is located.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by:

Acts 2021, 87th Leg., R.S., Ch. 380 (S.B. 918), Sec. 2, eff. September 1, 2021.

Sec. 822.154. OFFICERS. (a) An insurance company's directors shall choose one of the directors to serve as the company's president.

(b) Other officers of the insurance company shall be chosen in accordance with the company's bylaws. An officer other than the president is not required to be a director or a shareholder unless such a qualification is required by the company's bylaws or articles of incorporation.

(c) An insurance company's officers shall perform duties, receive compensation, and provide security as stated in the company's bylaws.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 822.155. APPLICATION FOR AMENDMENT OF CHARTER. A domestic insurance company may amend its charter by paying to the commissioner a fee in the amount determined under Chapter 202 and by filing with the department:

- (1) an application for a charter amendment on the form and containing the information prescribed by the commissioner; and
- (2) the company's proposed amendment.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.007, eff. April 1, 2009.

Sec. 822.156. CERTIFICATE REQUIRED FOR AMENDMENT OF CHARTER TO AUTHORIZE SHARES WITHOUT PAR VALUE. (a) If a proposed amendment to

the charter of an insurance company authorizes the issuance of shares of stock without par value, the insurance company must file with the department, at the time the proposed amendment is filed, a certificate authenticated by a majority of the directors stating:

- (1) the number of shares without par value that are subscribed; and
- (2) the consideration the company received for those shares.

(b) On receipt of the certificate, the commissioner shall examine the certificate. The commissioner shall certify and file the certificate if the commissioner approves the certificate.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 822.157. ACTION BY COMMISSIONER AFTER FILING OF APPLICATION FOR CHARTER AMENDMENT. (a) The commissioner may hold a hearing on an application for a charter amendment. If the commissioner determines to hold a hearing on the application, the commissioner, after the items required for the charter amendment are filed with the commissioner, shall set a date for the hearing and publish notice of the hearing in one or more daily newspapers of this state.

(b) The commissioner may not require a hearing for an amendment relating to one or more of the following issues:

- (1) a stock dividend resulting from a legal transfer of surplus to capital;
- (2) a change in the name of the insurance company; or
- (3) a change in the location of the insurance company's principal business office.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 822.158. DETERMINATION ON APPLICATION FOR CHARTER AMENDMENT. (a) Not later than the 60th day after the date the application under Section 822.155 is filed, the commissioner shall determine whether:

- (1) the proposed capital structure of the insurance company meets the requirements of this code;
- (2) the officers, directors, and managing head of the

insurance company have sufficient insurance experience, ability, standing, and good record to make success of the company probable;

(3) the applicants are acting in good faith;

(4) if the proposed amendment relates to a diminution of the insurance company's charter powers with respect to the kinds of insurance business in which the company may be engaged, all liabilities incidental to the exercise of the powers to be eliminated have been terminated or wholly reinsured; and

(5) the property involved in an increase of capital or surplus, or both, is:

(A) properly valued; and

(B) in the form authorized by the following provisions, to the extent those provisions apply:

(i) Subchapter B, Chapter 424, other than Sections 424.052, 424.072, and 424.073; and

(ii) Section 822.204.

(b) If the commissioner determines that the applicant has not met the requirements set out by Subsection (a), the commissioner shall deny the application. On the applicant's request, the commissioner shall hold a hearing on a denial. Not later than the 30th day after the date of the applicant's request for a hearing, the commissioner shall request a hearing date.

(c) If the commissioner does not deny the application under Subsection (b), the commissioner shall approve the application and the amendment shall be filed with the department.

(d) Except as provided by Subsection (e), when an amendment to an insurance company's charter is filed with the department, the amendment is effective.

(e) On approval of a certificate required under Section 822.156 and receipt of a fee in the amount determined under Chapter 202, the commissioner shall issue to the directors a certified copy of an amendment authorizing the issuance of shares of stock without par value that is filed under this section. The amendment is effective on issuance of the certified copy of the amendment.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 2E.008, eff. April 1, 2009.

Acts 2009, 81st Leg., R.S., Ch. 1022 (H.B. [4291](#)), Sec. 7, eff.

June 19, 2009.

SUBCHAPTER E. CAPITAL, SURPLUS, AND GUARANTY FUND REQUIREMENTS

Sec. 822.201. APPLICABILITY OF CAPITAL AND SURPLUS

REQUIREMENTS. The capital and surplus requirements of this chapter apply to each insurance company or other entity, other than a farm mutual insurance company, authorized to write property and casualty insurance in this state including:

- (1) a county mutual insurance company;
- (2) a mutual insurance company, other than a mutual life insurance company;
- (3) a Lloyd's plan; and
- (4) a reciprocal or interinsurance exchange.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 822.202. FULL COVERAGE AUTOMOBILE INSURANCE;

DETERMINATION OF AMOUNTS. Full coverage automobile insurance is one line of casualty insurance for purposes of determining:

- (1) the amount of capital and surplus of a capital stock company under this code;
- (2) the amount of surplus of a mutual insurance company or reciprocal exchange under this code; or
- (3) the amount of the guaranty fund and surplus of a Lloyd's plan under this code.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 822.203. CAPITAL REQUIRED GENERALLY. To engage in the kinds of insurance business for which an insurance company organized under this chapter holds a certificate of authority, the company must have at least the minimum amount of capital required for a newly incorporated company under Section 822.054.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 822.204. FORM OF CAPITAL AND SURPLUS. (a) After

incorporation and the issuance of a certificate of authority to an insurance company, the minimum capital stock and surplus of the company may consist only of:

- (1) United States currency;
- (2) bonds of this state;
- (3) bonds or other evidences of indebtedness of the United States the principal and interest of which are guaranteed by the United States;
- (4) bonds or other interest-bearing evidences of indebtedness of a county or municipality of this state; and
- (5) notes secured by first mortgages:
 - (A) on otherwise unencumbered real property in this state the title to which is valid; and
 - (B) the payment of which is insured wholly or partly by the United States.

(b) Not more than 50 percent of the minimum capital stock and minimum surplus of an insurance company may be invested in an investment described by Subsection (a)(5).

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 822.205. UNENCUMBERED SURPLUS OR GUARANTY FUND REQUIREMENTS FOR CERTAIN INSURANCE COMPANIES. (a) Except as provided by Section 912.308, this section applies only to an insurance company that:

- (1) writes insurance only in this state; and
 - (2) is not required by law to have capital stock.
- (b) Notwithstanding any other provision of this subchapter other than Sections 822.212(b) and (c), an insurance company must have a minimum amount of unencumbered surplus or a minimum amount of guaranty fund and unencumbered surplus equal to the greater of:
- (1) the amount of unencumbered surplus or the amount of guaranty fund and surplus, as appropriate, the company was required to have on August 31, 1991; or
 - (2) one-third of the company's net written premium for the preceding 12 months after deducting:
 - (A) lawfully ceded reinsurance; and
 - (B) any policy fees not ceded to reinsurers.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 677 (H.B. 2449), Sec. 1, eff. September 1, 2009.

Sec. 822.206. REPURCHASE OF CAPITAL STOCK BY TENDER OFFER OR PRIVATE TRANSACTION. (a) An insurance company may, on prior approval of the department, purchase outstanding shares of the company's capital stock in accordance with the Texas Business Corporation Act either by making a tender offer or by entering into a negotiated private transaction.

(b) The application for approval under Subsection (a) must:

- (1) state the number of shares offered;
- (2) describe the shares;
- (3) contain any pertinent information regarding the value of the shares, including:
 - (A) the price offered by the company for the shares;
 - (B) the book value of the shares; and
 - (C) the market value of the shares if a market exists for those shares; and

(4) demonstrate that the shares will be purchased using uncommitted earned surplus.

(c) Before filing the application the insurance company must present a copy of the application to the seller of the shares.

(d) The commissioner shall approve the application promptly if:

- (1) the price offered by the insurance company for the shares appears to be a reasonably fair price; and
- (2) the application complies with the requirements of this section and the Texas Business Corporation Act.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 822.207. REPURCHASE OF CAPITAL STOCK ON OPEN MARKET. (a) On prior approval of the commissioner, an insurance company, the capital stock of which is listed on a national securities exchange, may purchase from time to time outstanding shares of the company's capital stock on the open market. The shares must be purchased:

- (1) in the name of the company for its own account; and
- (2) in accordance with the Texas Business Corporation Act.

- (b) The application for approval under Subsection (a) must:
- (1) state the maximum number of shares to be purchased;
 - (2) state the maximum period, not to exceed 180 days, during which the purchase will be made;
 - (3) describe the shares;
 - (4) contain a commitment that the company will not pay a price for the shares to be purchased that is greater than an amount equal to the average of the bid price and the asked price at the time of the purchase plus a standard broker's commission;
 - (5) contain any pertinent information relating to the value of the shares, including the book value of the shares; and
 - (6) demonstrate that the shares will be purchased using uncommitted earned surplus.
- (c) The commissioner shall approve the application promptly if the application complies with the requirements of this section and the Texas Business Corporation Act.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 822.208. APPLICATION FOR REPURCHASE OF COMPANY'S SHARES SUBJECT TO OTHER LAW. An application filed by an insurance company under Section 822.206 or 822.207 is subject to the substantive requirements for the approval of payment of an extraordinary dividend under Chapter 823.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 822.209. REINVESTMENT OF CAPITAL STOCK. An insurance company may, as circumstances require, exchange and reinvest its capital stock in like securities.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 822.210. COMMISSIONER MAY REQUIRE LARGER CAPITAL AND SURPLUS AMOUNTS. (a) The commissioner by rule or guideline may require an insurance company organized under this chapter to maintain capital and surplus in amounts that exceed the minimum amounts required by this chapter because of:

(1) the nature and kind of risks the company underwrites or reinsures;

(2) the premium volume of risks the company underwrites or reinsures;

(3) the composition, quality, duration, or liquidity of the company's investments;

(4) fluctuations in the market value of securities the company holds; or

(5) the adequacy of the company's reserves.

(b) A rule adopted under Subsection (a) must be designed to ensure the financial solvency of an insurance company for the protection of policyholders.

(c) An insurance company that, after notifying the commissioner, ceases to write or assume business continues to be subject to this section.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 822.211. ACTION OF COMMISSIONER WHEN CAPITAL OR SURPLUS REQUIREMENTS NOT SATISFIED. If an insurance company does not comply with the capital and surplus requirements of this chapter, the commissioner may enter an order prohibiting the company from writing new business and may:

(1) place the company under state supervision or conservatorship;

(2) declare the company to be in a hazardous condition as provided by Subchapter A, Chapter 404;

(3) declare the company to be impaired as provided by Subchapter B, Chapter 404; or

(4) apply to the company any other applicable sanction provided by this code.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 2E.009, eff. April 1, 2009.

Sec. 822.212. INCREASE OF CAPITAL AND SURPLUS. (a) Notwithstanding Section 822.203, to engage in the kinds of insurance

business for which an insurance company organized under this chapter holds a certificate of authority in this state, an insurance company organized under this chapter that on September 1, 2009, had less than the minimum amount of capital and surplus required for a newly incorporated company under Section 822.054 must:

(1) not later than December 31, 2010, have increased the amount of its capital by at least 10 percent of the difference between the amount of minimum capital required for a newly incorporated company under Section 822.054 and the amount of the company's capital on December 31, 2009;

(2) not later than December 31, 2011, have increased the amount of its capital by at least 20 percent of the difference between the amount of minimum capital required for a newly incorporated company under Section 822.054 and the amount of the company's capital on December 31, 2009;

(3) not later than December 31, 2012, have increased the amount of its capital by at least 30 percent of the difference between the amount of minimum capital required for a newly incorporated company under Section 822.054 and the amount of the company's capital on December 31, 2009;

(4) not later than December 31, 2013, have increased the amount of its capital by at least 40 percent of the difference between the amount of minimum capital required for a newly incorporated company under Section 822.054 and the amount of the company's capital on December 31, 2009;

(5) not later than December 31, 2014, have increased the amount of its capital by at least 50 percent of the difference between the amount of minimum capital required for a newly incorporated company under Section 822.054 and the amount of the company's capital on December 31, 2009;

(6) not later than December 31, 2015, have increased the amount of its capital by at least 60 percent of the difference between the amount of minimum capital required for a newly incorporated company under Section 822.054 and the amount of the company's capital on December 31, 2009;

(7) not later than December 31, 2016, have increased the amount of its capital by at least 70 percent of the difference between the amount of minimum capital required for a newly incorporated company under Section 822.054 and the amount of the company's capital on December 31, 2009;

(8) not later than December 31, 2017, have increased the amount of its capital by at least 80 percent of the difference between the amount of minimum capital required for a newly incorporated company under Section 822.054 and the amount of the company's capital on December 31, 2009;

(9) not later than December 31, 2018, have increased the amount of its capital by at least 90 percent of the difference between the amount of minimum capital required for a newly incorporated company under Section 822.054 and the amount of the company's capital on December 31, 2009; and

(10) not later than December 31, 2019, have at least the minimum amount of capital required under Section 822.054 for a newly incorporated company.

(b) An insurance company that on September 1, 2009, had less than the minimum amount of capital and surplus required for a newly incorporated company under Section 822.054 shall immediately increase the amount of its capital and surplus to an amount equal to the required amount of capital and surplus under Section 822.054 if there is:

(1) a change in the control of at least 50 percent of the voting securities of the insurance company;

(2) a change in the control of at least 50 percent of the voting securities of a holding company controlling the insurance company; or

(3) a change in control of at least 50 percent by any other method of control if the insurance company or holding company is not controlled by voting securities.

(c) For purposes of Subsection (b), a transfer of ownership that occurs because of death, regardless of whether the decedent dies testate or intestate, may not be considered a change in the control of an insurance company or holding company if ownership is transferred solely to one or more individuals each of whom would be an heir of the decedent if the decedent had died intestate.

(d) An insurance company that, after notifying the commissioner, ceases to write or assume business is not required to comply with this section. If the company resumes writing business at a later date, the company shall comply with this section on the date the company resumes business.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1275 (H.B. 1476), Sec. 2, eff. September 1, 2009.

CHAPTER 823. INSURANCE HOLDING COMPANY SYSTEMS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 823.001. FINDINGS AND PURPOSE. (a) It is consistent with the public interest and the interest of policyholders to permit insurers to:

(1) engage in activities that would enable the insurers to make better use of management skills and facilities;

(2) have free access to capital markets that could provide funds for insurers to use in diversification programs;

(3) implement sound tax planning conclusions; and

(4) serve the changing needs of the public and adapt to changing conditions of the social, economic, and political environment, so that insurers are able to compete effectively and to meet the growing public demand for institutions capable of providing a comprehensive range of financial services.

(b) The public interest and the interests of policyholders are adversely affected if:

(1) control of an insurer is sought by persons who would use the control adversely to the interest of policyholders;

(2) acquisition of control of an insurer substantially lessens competition or creates a monopoly in the insurance business in this state;

(3) an insurer that is part of a holding company system is caused to enter into transactions or relationships with affiliated companies on terms that are not fair and reasonable; or

(4) an insurer pays dividends to shareholders that jeopardize the financial condition of the insurer.

(c) The purpose of this chapter is to promote the public interest by:

(1) facilitating the achievement of the objectives described by Subsection (a);

(2) requiring disclosure of pertinent information relating to and approval of changes in control of an insurer;

(3) requiring disclosure and approval of material transactions and relationships between the insurer and the insurer's

affiliates, including certain dividends to shareholders paid by the insurer; and

(4) providing standards governing material transactions between the insurer and the insurer's affiliates.

(d) It is desirable to prevent unnecessary multiple and conflicting regulation of insurers. In accordance with this purpose and except as provided by this chapter, this state shall exercise regulatory authority under this chapter only with respect to domestic insurers.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.010, eff. April 1, 2009.

Sec. 823.002. DEFINITIONS. In this chapter:

(1) "Acquiring person" means the person who is acquiring control of a domestic insurer or on whose behalf control of a domestic insurer is being acquired.

(2) "Controlled insurer" means an insurer that is controlled directly or indirectly by a holding company.

(3) "Controlled person" means a person, other than a controlled insurer, who is controlled directly or indirectly by a holding company.

(3-a) "Divesting person" means a person who has control of a domestic insurer and who intends to divest control of the domestic insurer.

(3-b) "Divestiture" means an abandonment of control of a domestic insurer by a divesting person that does not result in the transfer of control to another person.

(4) "Domestic insurer" includes a commercially domiciled insurer described by Section 823.004.

(4-a) "Enterprise risk" means any activity, circumstance, event, or series of events involving one or more affiliates of an insurer that, if not remedied promptly, is likely to have a material adverse effect on the financial condition or liquidity of the insurer or its insurance holding company system as a whole, including anything:

(A) that would cause the insurer's risk-based capital

to fall into company action level; or

(B) that would cause the insurer to be in hazardous financial condition.

(4-b) "Group-wide supervisor" means the regulatory official authorized to engage in conducting and coordinating group-wide supervision activities who is determined or acknowledged by the commissioner under Section 823.0147 to have sufficient significant contacts with the internationally active insurance group.

(5) "Holding company" means a person who directly or indirectly controls an insurer. The term does not include the United States, a state or a political subdivision, agency, or other instrumentality of a state, or a corporation that is wholly owned directly or indirectly by the United States, a state, or an instrumentality of a state.

(6) "Insurer" means any insurance company organized under the laws of this state, a commercially domiciled insurer, or an insurer authorized to engage in the business of insurance in this state. The term includes a capital stock company, mutual company, farm mutual insurance company, title insurance company, fraternal benefit society, local mutual aid association, statewide mutual assessment company, county mutual insurance company, Lloyd's plan, reciprocal or interinsurance exchange, stipulated premium insurance company, and group hospital service corporation. The term does not include an agency, authority, or instrumentality of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state.

(6-a) "Internationally active insurance group" means an insurance holding company system that:

(A) includes an insurer registered under Subchapter B; and

(B) meets the following criteria:

(i) has premiums written in at least three countries;

(ii) has a percentage of gross premiums written outside the United States of at least 10 percent of the insurance holding company system's total gross written premiums; and

(iii) based on a three-year rolling average, has total assets of at least \$50 billion or total gross written premiums of at least \$10 billion.

(7) "Person" means an individual, corporation, partnership, association, joint stock company, trust, or unincorporated organization, or a similar entity or a combination of the listed entities acting in concert. The term does not include a securities broker while performing no more than a function that is usual and customary for a securities broker.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 922 (S.B. 1431), Sec. 1, eff. September 1, 2011.

Acts 2017, 85th Leg., R.S., Ch. 38 (H.B. 3220), Sec. 1, eff. May 19, 2017.

Sec. 823.003. CLASSIFICATION AS AFFILIATE OR SUBSIDIARY. (a) A person is an affiliate of another if the person directly or indirectly through one or more intermediaries controls, is controlled by, or is under common control with the other person.

(b) A person is a subsidiary of another if the person is an affiliate of and is controlled by the other person directly or indirectly through one or more intermediaries.

(c) A subsidiary or holding company of a person is an affiliate of that person.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 823.004. CLASSIFICATION AS COMMERCIALY DOMICILED INSURER.

(a) For purposes of this chapter, a foreign or alien insurer authorized to engage in the business of insurance in this state is a commercially domiciled insurer if during the period described by Subsection (b) the average of the gross premiums written by the insurer in this state is:

(1) more than the average of the gross premiums written by the insurer in its state of domicile; and

(2) 30 percent or more of the total gross premiums written by the insurer in the United States, as reported in its three most recent annual statements.

(b) The period applicable to Subsection (a) is:

(1) the three most recent fiscal years of the insurer that

precede the fiscal year in which the determination under this section is made; or

(2) if the insurer has been authorized to engage in the business of insurance in this state for less than the period described by Subdivision (1), the period for which the insurer has been authorized to engage in the business of insurance in this state.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 823.005. DESCRIPTION OF CONTROL; DETERMINATION OF CONTROL. (a) For purposes of this chapter, control is the power to direct, or cause the direction of, the management and policies of a person, other than power that results from an official position with or corporate office held by the person. The power may be possessed directly or indirectly by any means, including through the ownership of voting securities or by contract, other than a commercial contract for goods or nonmanagement services.

(b) For purposes of this chapter, a person controls another if the person possesses the power described by Subsection (a) with regard to the other person.

(c) After providing notice and opportunity for hearing to each person in interest, the commissioner may determine that, notwithstanding the absence of a presumption under Section 823.151, a person controls an authorized insurer if the person, directly or indirectly and alone or under an agreement with one or more other persons, exercises such a controlling influence over the management or policies of the insurer that it is necessary or appropriate in the public interest or for the protection of the insurer's policyholders that the person be considered to control the insurer. The commissioner shall make specific findings of fact to support a determination under this subsection.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 823.006. DESCRIPTION OF INSURANCE HOLDING COMPANY SYSTEM. An insurance holding company system consists of two or more affiliates, at least one of which is an insurer.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 823.007. DESCRIPTION OF VOTING SECURITY. For purposes of this chapter, a voting security is a security or an instrument that:

(1) has the power at a meeting of shareholders of a person to vote for or against the election of directors of the person or any other matter involving the direction of the management and policies of the person; or

(2) under rules adopted by the commissioner in the public interest, the commissioner considers to be of similar nature to that described by Subdivision (1) and considers necessary or appropriate to treat as a voting security.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 823.008. STANDARD FOR DETERMINING SURPLUS REASONABLENESS AND ADEQUACY. (a) In determining whether an insurer's policyholders' surplus is reasonable in relation to the insurer's outstanding liabilities and adequate to the insurer's financial needs, the following factors, among others, shall be considered:

(1) the size of the insurer as measured by its assets, capital and surplus, reserves, premium writings, insurance in force, and other appropriate criteria;

(2) the extent to which the insurer's business is diversified among the different lines of insurance;

(3) the number and size of risks insured in each line of insurance;

(4) the extent of the geographical dispersion of the insurer's insured risks;

(5) the nature and extent of the insurer's reinsurance program;

(6) the quality, diversification, and liquidity of the insurer's investment portfolio;

(7) the recent past and projected future trend in the size of the insurer's:

(A) policyholders' surplus; and

(B) investment portfolio;

(8) the policyholders' surplus maintained by comparable insurers;

(9) the adequacy of the insurer's reserves;

(10) the quality and liquidity of investments in subsidiaries made under Subchapter F; and

(11) the quality of the insurer's earnings and the extent to which the insurer's reported earnings include extraordinary items.

(b) The commissioner may treat an investment described by Subsection (a)(10) as a nonadmitted or disallowed asset for purposes of Subsection (a) if in the commissioner's judgment the investment justifies that treatment.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 823.009. SITUS OF SECURITIES OF DOMESTIC INSURER. For purposes of this chapter, the situs of the ownership of securities of a domestic insurer is considered to be in this state.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 823.010. DISCLAIMER OF AFFILIATION. (a) A disclaimer of affiliation with an authorized insurer may be filed with the commissioner by any person, including the authorized insurer or a member of an insurance holding company system.

(b) The disclaimer must fully disclose:

(1) all material relationships and bases for affiliation between the person and the insurer; and

(2) the basis for disclaiming the affiliation.

(c) Except as provided by Subsection (d), the disclaimer shall be deemed to have been allowed unless, not later than 60 days after the receipt of a complete disclaimer, the commissioner notifies the filing party that the disclaimer is disallowed.

(d) Notwithstanding Subsection (c), if the commissioner at any time determines that the information disclosed in the disclaimer is incomplete or inaccurate or is no longer accurate, the commissioner may disallow the disclaimer.

(e) If the commissioner disallows a disclaimer, the party who filed the disclaimer may request an administrative hearing. The commissioner shall grant the request for the hearing.

(f) Except as provided by Subsection (h), if the commissioner allows a disclaimer:

(1) the insurer is not required to register or report under Subchapter B due to a duty arising from the insurer's relationship with the party who filed the disclaimer; and

(2) the party who filed the disclaimer is not required to comply with Section 823.154, 823.155, 823.159, or 823.160.

(g) If the commissioner allows a disclaimer, the commissioner at the same time may also waive another provision of this chapter with relation to the party who filed the disclaimer. The commissioner may require reasonable controls and safeguards that are consistent with the purposes of this chapter in granting a waiver under this subsection.

(h) If the commissioner disallows a disclaimer under Subsection (d):

(1) effective on the date of the disallowance, the insurer shall register and report as required by Subchapter B; and

(2) the party who filed the disclaimer shall comply with Sections 823.154, 823.155, 823.159, and 823.160.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 922 (S.B. [1431](#)), Sec. 2, eff. September 1, 2011.

Sec. 823.011. CONFIDENTIALITY OF INFORMATION. (a) This section applies only to information, including documents and copies of documents, that is:

(1) reported or otherwise provided under Subchapter B or C or Section 823.201(d) or (e) or Section 823.0147;

(2) disclosed to the commissioner under Section 823.010; or

(3) obtained by or disclosed to the commissioner or another person in the course of an examination or investigation under Subchapter H or Chapter 401.

(b) The information shall be confidential and privileged for all purposes. Except as provided by Subsections (c) and (d), the information may not be disclosed without the prior written consent of the insurer to which it pertains.

(c) The commissioner may publish all or any part of the information in the manner that the commissioner considers appropriate if the commissioner, after giving the insurer and its affected

affiliates notice and an opportunity to be heard, determines that the interests of policyholders or the public will be served by the publication of the information.

(d) Except as provided by Subsection (e), if the recipient of documents or other information described by Subsection (a) agrees in writing to maintain the confidential and privileged status of the documents or other information, and verifies in writing the legal authority to maintain the confidential and privileged status of the documents or information, the commissioner or another person may disclose the information to any of the following entities functioning in an official capacity:

- (1) a commissioner of insurance or an insurance department of another state;
- (2) an authorized law enforcement official;
- (3) a district attorney of this state;
- (4) the attorney general;
- (5) a grand jury;
- (6) members of a supervisory college described by Section 823.0145;
- (7) the National Association of Insurance Commissioners and its affiliates and subsidiaries; or
- (8) another state, federal, or international regulatory agency.

(d-1) The commissioner may receive documents or information, including otherwise confidential and privileged documents or information, from the entities listed in Subsection (d) and shall maintain as confidential or privileged any document or information received by the commissioner with notice or an understanding that the document or information is confidential or privileged under the laws of the jurisdiction of the entity that provides the document or information.

(e) Notwithstanding Subsection (d), the commissioner may share confidential and privileged information reported under Section 823.0595 only with the commissioner of insurance of a state that has a statute or rule substantially similar to Subsection (d) who agrees in writing not to disclose the information.

(f) Information described by Subsection (a), including information in the possession of the National Association of Insurance Commissioners under this section, is confidential and privileged for all purposes, including for purposes of:

- (1) Chapter 552, Government Code;
- (2) a response to a subpoena; or
- (3) discovery or admissibility in evidence in a civil action.

(g) The commissioner shall enter into written agreements with the National Association of Insurance Commissioners that comply with the requirements of Subsection (d) regarding the sharing and use of information provided under this chapter. An agreement entered into under this subsection must:

- (1) specify procedures and protocols regarding the confidentiality and security of information shared with the National Association of Insurance Commissioners and its affiliates and subsidiaries under this chapter, including procedures and protocols for sharing by the National Association of Insurance Commissioners with other state, federal, or international regulators;

- (2) specify that ownership of information shared with the National Association of Insurance Commissioners and its affiliates and subsidiaries under this chapter remains with the commissioner, and that use of the information by the National Association of Insurance Commissioners is subject to the direction of the commissioner;

- (3) require prompt notice to an insurer whose confidential information is in the possession of the National Association of Insurance Commissioners under this chapter that the information is subject to a request or subpoena to the National Association of Insurance Commissioners for disclosure or production; and

- (4) require the National Association of Insurance Commissioners and its affiliates and subsidiaries to give consent to intervention by an insurer in any judicial or administrative action in which the National Association of Insurance Commissioners and its affiliates and subsidiaries may be required to disclose confidential information about the insurer shared with the National Association of Insurance Commissioners and its affiliates and subsidiaries under this chapter.

(h) This section may not be construed to prevent the commissioner from using information described by Subsection (a) in the furtherance of a legal or regulatory action relating to the administration of this code.

(i) The commissioner remains solely responsible for the administration, execution, and enforcement of this chapter, and the

commissioner's sharing of information does not constitute a delegation of regulatory or rulemaking authority.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 922 (S.B. 1431), Sec. 3, eff. September 1, 2011.

Acts 2013, 83rd Leg., R.S., Ch. 1087 (H.B. 3460), Sec. 1, eff. June 14, 2013.

Acts 2017, 85th Leg., R.S., Ch. 38 (H.B. 3220), Sec. 2, eff. May 19, 2017.

Sec. 823.012. RULES; PROCEDURES FOR CONSIDERING CERTAIN DISTRIBUTIONS. (a) The commissioner may, after notice and opportunity for all interested persons to be heard, adopt rules and issue orders to implement this chapter, including the conducting of business and proceedings under this chapter.

(b) The commissioner by rule shall establish procedures to:

(1) promptly consider the prepayment notices reported under Section 823.053(b);

(2) annually review each reported ordinary dividend paid within the 12 months preceding the date of the report; and

(3) take appropriate actions authorized by this code.

(c) A procedure established under Subsection (b)(1) must include consideration of the factors provided by Section 823.008.

(d) A rule or order under this section must be consistent with this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 823.013. MANDAMUS. A person aggrieved by the failure of the commissioner to act, including making a determination, as required by this chapter may petition a district court of Travis County for a writ in the nature of a mandamus or a peremptory mandamus directing the commissioner to immediately act or make the determination.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 823.014. APPLICABILITY OF CHAPTER TO FOREIGN OR ALIEN INSURER. (a) A foreign insurer that is authorized to engage in the business of insurance in this state and that is domiciled in a jurisdiction that has not adopted, by statute or regulation, controls considered by the commissioner to be substantially similar to those provided by this chapter:

(1) is subject to this chapter to the same extent as a domestic insurer; and

(2) on failure to comply with this chapter, is subject to all remedies, penalties, and sanctions authorized by this code in the same manner as a domestic insurer, including, after notice and hearing, the suspension or revocation of the insurer's certificate of authority to engage in the business of insurance in this state.

(b) If a jurisdiction adopts controls considered by the commissioner to be substantially similar to those provided by this chapter, the commissioner after that adoption may exempt an insurer domiciled in that jurisdiction from the application of this section.

(c) Notwithstanding Subsection (a), a foreign or alien insurer is not subject to this chapter if the commissioner has approved a withdrawal plan for the insurer under Chapter 827.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 823.0145. SUPERVISORY COLLEGES. (a) With respect to any insurer registered under Subchapter B, and in accordance with Subsection (c), the commissioner may participate in a supervisory college for a domestic insurer that is part of an insurance holding company system with international operations in order to determine the insurer's compliance with this chapter. The commissioner may:

(1) initiate the establishment of a supervisory college;

(2) clarify the membership and participation of other entities in the supervisory college;

(3) clarify the functions of the supervisory college and the role of other entities in the supervisory college;

(4) establish a group-wide supervisor;

(5) coordinate the ongoing activities of the supervisory college, including meetings, regulatory activities, and processes for information sharing; and

(6) establish a crisis management plan.

(b) In order to assess the business strategy, financial position, legal and regulatory position, risk exposure, risk management and governance processes, and as part of the examination of individual insurers under Subchapter H, the commissioner may participate in a supervisory college with other entities that regulate the insurer or its affiliates, including other state, federal, and international regulatory entities. The commissioner may enter into agreements under Section 823.011 to cooperate with other regulatory entities. Nothing in this section shall be construed as delegating to the supervisory college the commissioner's authority to regulate the insurer or its affiliates.

(c) A registered insurer subject to this section shall pay the reasonable expenses, including reasonable travel expenses, of the commissioner's participation in a supervisory college under Subsection (b). For purposes of this section, a supervisory college may be convened as either a temporary or permanent forum for communication and cooperation between the entities that regulate the insurer or its affiliates, and the commissioner may establish a regular assessment to the insurer for the payment of expenses related to the regulation of the insurer.

Added by Acts 2011, 82nd Leg., R.S., Ch. 922 (S.B. [1431](#)), Sec. 4, eff. September 1, 2011.

Sec. 823.0147. GROUP-WIDE SUPERVISION OF INTERNATIONALLY ACTIVE INSURANCE GROUPS. (a) The commissioner is authorized to act as the group-wide supervisor for any internationally active insurance group under the provisions of this section.

(b) The commissioner may otherwise acknowledge another regulatory official as the group-wide supervisor where the internationally active insurance group:

(1) does not have substantial insurance operations in the United States;

(2) has substantial insurance operations in the United States, but not in this state; or

(3) has substantial insurance operations in the United States and this state, but the commissioner has determined under the factors in Subsections (e) and (k) that the other regulatory official is the appropriate group-wide supervisor.

(c) An insurance holding company system that does not otherwise qualify as an internationally active insurance group may request that the commissioner make a determination or acknowledgment as to a group-wide supervisor under this section.

(d) In cooperation with other state, federal, and international regulatory agencies, the commissioner will identify a single group-wide supervisor for an internationally active insurance group. The commissioner may determine that the commissioner is the appropriate group-wide supervisor for an internationally active insurance group that conducts substantial insurance operations concentrated in this state. The commissioner may acknowledge that a regulatory official from another jurisdiction is the appropriate group-wide supervisor for the internationally active insurance group.

(e) The commissioner shall consider the following factors when making a determination or acknowledgment under Subsection (d):

(1) the place of domicile of the insurers within the internationally active insurance group that hold the largest share of the group's written premiums, assets, or liabilities;

(2) the place of domicile of the top-tiered insurers in the insurance holding company system of the internationally active insurance group;

(3) the location of the executive offices or largest operational offices of the internationally active insurance group;

(4) whether another regulatory official is acting or is seeking to act as the group-wide supervisor under a regulatory system that the commissioner determines to be:

(A) substantially similar to the system of regulation provided under the laws of this state; or

(B) otherwise sufficient in terms of providing for group-wide supervision, enterprise risk analysis, and cooperation with other regulatory officials; and

(5) whether another regulatory official acting or seeking to act as the group-wide supervisor provides the commissioner with reasonably reciprocal recognition and cooperation.

(f) A commissioner identified under this section as the group-wide supervisor may determine that it is appropriate to acknowledge another supervisor to serve as the group-wide supervisor. The acknowledgment of the group-wide supervisor shall be made after consideration of the factors listed in Subsection (e), and shall be made in cooperation with and subject to the acknowledgment of other

regulatory officials involved with supervision of members of the internationally active insurance group, and in consultation with the internationally active insurance group.

(g) Notwithstanding any other provision of law, when another regulatory official is acting as the group-wide supervisor of an internationally active insurance group, the commissioner shall acknowledge that regulatory official as the group-wide supervisor.

(h) The commissioner shall make a determination or acknowledgment as to the appropriate group-wide supervisor for an internationally active insurance group under Subsection (d) or (f) in the event of a material change in the internationally active insurance group that results in:

(1) the internationally active insurance group's insurers domiciled in this state holding the largest share of the group's premiums, assets, or liabilities; or

(2) this state being the place of domicile of the top-tiered insurers in the insurance holding company system of the internationally active insurance group.

(i) Under Subchapter H, the commissioner is authorized to collect from any insurer registered under Subchapter B all information necessary to determine whether the commissioner may act as the group-wide supervisor of an internationally active insurance group or if the commissioner may acknowledge another regulatory official to act as the group-wide supervisor. Prior to issuing a determination that an internationally active insurance group is subject to group-wide supervision by the commissioner, the commissioner shall notify the insurer registered under Subchapter B and the ultimate controlling person within the internationally active insurance group. The internationally active insurance group shall have not less than 30 days to provide the commissioner with additional information pertinent to the pending determination. The commissioner may publish on the department's website the identity of internationally active insurance groups that the commissioner has determined are subject to group-wide supervision by the commissioner.

(j) If the commissioner is the group-wide supervisor for an internationally active insurance group, the commissioner is authorized to engage in any of the following group-wide supervision activities:

(1) assess the enterprise risks within the internationally active insurance group to ensure that:

(A) the material financial condition and liquidity risks to the members of the internationally active insurance group that are engaged in the business of insurance are identified by management; and

(B) reasonable and effective mitigation measures are in place;

(2) request, from any member of an internationally active insurance group subject to the commissioner's supervision, information necessary and appropriate to assess enterprise risk, including information about the members of the internationally active insurance group regarding:

(A) governance, risk assessment, and management;

(B) capital adequacy; and

(C) material intercompany transactions;

(3) coordinate and, through the authority of the regulatory officials of the jurisdictions where members of the internationally active insurance group are domiciled, compel development and implementation of reasonable measures designed to ensure that the internationally active insurance group is able to timely recognize and mitigate enterprise risks to members of the internationally active insurance group that are engaged in the business of insurance;

(4) communicate with other state, federal, and international regulatory agencies for members within the internationally active insurance group and share relevant information, subject to the confidentiality provisions of Section 823.011, through supervisory colleges in Section 823.0145 or otherwise;

(5) enter into agreements with or obtain documentation from any insurer registered under Subchapter B, any member of the internationally active insurance group, and any other state, federal, and international regulatory agencies for members of the internationally active insurance group, providing the basis for or otherwise clarifying the commissioner's role as group-wide supervisor, including provisions for resolving disputes with other regulatory officials, provided that such agreements or documentation may not serve as evidence in any proceeding to show that any insurer or person within an insurance holding company system not domiciled or incorporated in this state is doing business in this state or is otherwise subject to jurisdiction in this state; and

(6) other group-wide supervision activities, consistent

with the authorities and purposes enumerated above, as considered necessary by the commissioner.

(k) If the commissioner acknowledges that another regulatory official from a jurisdiction that is not accredited by the National Association of Insurance Commissioners is the group-wide supervisor, the commissioner is authorized to reasonably cooperate, through supervisory colleges or otherwise, with group-wide supervision undertaken by the group-wide supervisor, provided that:

(1) the commissioner's cooperation is in compliance with the laws of this state; and

(2) the regulatory official acknowledged as the group-wide supervisor also recognizes and cooperates with the commissioner's activities as a group-wide supervisor for other internationally active insurance groups where applicable.

(l) Where recognition and cooperation are not reasonably reciprocal under Subsection (k)(2), the commissioner is authorized to refuse recognition and cooperation.

(m) The commissioner is authorized to enter into agreements with or obtain documentation from any insurer registered under Subchapter B, any affiliate of the insurer, and other state, federal, and international regulatory agencies for members of the internationally active insurance group that provides the basis for or otherwise clarifies a regulatory official's role as group-wide supervisor.

(n) The commissioner may adopt rules necessary for the administration of this section.

(o) A registered insurer subject to this section shall be liable for and shall pay the reasonable expenses of the commissioner's participation in the administration of this section, including the engagement of attorneys, actuaries, and any other professionals and all reasonable travel expenses.

Added by Acts 2017, 85th Leg., R.S., Ch. 38 (H.B. [3220](#)), Sec. 3, eff. May 19, 2017.

Sec. 823.015. EXEMPTION FROM CHAPTER. The commissioner may exempt from the application of this chapter a commercially domiciled insurer that the commissioner determines has assets physically located in this state or an asset-to-liability ratio sufficient to

justify the conclusion that there is no reasonable danger that the operations or conduct of the business of the insurer could present a danger of loss to the policyholders of this state.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2005, 79th Leg., Ch. 884 (S.B. 1283), Sec. 1, eff. September 1, 2005.

SUBCHAPTER B. REGISTRATION

Sec. 823.051. REGISTRATION BY INSURER REQUIRED. (a) Each insurer authorized to engage in the business of insurance in this state that is a member of an insurance holding company system shall register with the commissioner. The insurer shall register not later than the 15th day after the date the insurer becomes subject to registration under this subchapter.

(b) The commissioner for good cause shown may extend the period for registration under this section.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 823.052. REQUIRED INFORMATION; REGISTRATION STATEMENT.

(a) To register as required by Section 823.051, an insurer must file a registration statement with the department.

(b) The registration statement must be in a format prescribed by the National Association of Insurance Commissioners or adopted by rule of the commissioner and contain current information about:

(1) the identity and relationship of each affiliate in the insurance holding company system of which the insurer is a part;

(2) the capital structure, general financial condition, and ownership and management of the insurer, the insurer's holding company, the insurer's subsidiaries, and, if the commissioner considers the information necessary, any of the insurer's other affiliates; and

(3) any pledge of stock of the insurer or a subsidiary or controlling affiliate of the insurer for a loan made to a member of the insurer's insurance holding company system.

(c) The registration statement must also contain information about:

(1) each outstanding loan the insurer makes to an affiliate of the insurer or an affiliate makes to the insurer;

(2) each purchase, sale, or exchange of securities or other investment between the insurer and an affiliate of the insurer;

(3) each purchase, sale, or exchange of assets between the insurer and an affiliate of the insurer;

(4) each management and service contract or cost-sharing arrangement between the insurer and an affiliate of the insurer;

(5) each reinsurance agreement between the insurer and an affiliate of the insurer that covers one or more lines of insurance of the ceding company;

(6) each agreement between the insurer and an affiliate of the insurer to consolidate federal income tax returns;

(7) each transaction between the insurer and an affiliated financial institution;

(8) each transaction between the insurer and an affiliate of the insurer that is not in the ordinary course of business;

(9) each guarantee or undertaking, other than an insurance contract entered into in the ordinary course of the insurer's business, for the benefit of an affiliate of the insurer that results in a contingent exposure of the insurer's assets to liability;

(10) each dividend or distribution to the insurer's shareholders;

(11) each transaction between the insurer and an affiliate of the insurer not specified by this subsection that is subject to Section 823.103 or 823.104;

(12) the corporate governance and internal control responsibilities of the insurer's board of directors, including a statement that:

(A) the insurer's senior management or officers have approved and implemented, and continue to maintain and monitor, corporate governance and internal control procedures; and

(B) the insurer's board of directors oversees corporate governance and internal controls; and

(13) any other information that the commissioner requires by rule.

(c-1) On request of the commissioner, an insurer shall include with the statement a copy of all financial statements for the insurance holding company system and all affiliates of the holding company system, including annual audited financial statements filed

with the United States Securities and Exchange Commission pursuant to the Securities Act of 1933 (15 U.S.C. Section 77a et seq.) or the Securities Exchange Act of 1934 (15 U.S.C. Section 78a et seq.). An insurer may not be required to submit financial statements for an affiliate that is privately owned by not more than five security holders, each of whom is an individual, unless the commissioner determines that the operations of the affiliate may materially affect the operations, management, or financial condition of an insurer in a holding company system. An affiliate may seek judicial review of a request for financial statements under this subsection.

(c-2) An insurer required by the commissioner to submit financial statements under this section, Section 823.201, or Section 823.351 may satisfy the requirement by submitting to the commissioner:

(1) the financial statements that the insurer's parent corporation most recently filed with the United States Securities and Exchange Commission; and

(2) if the insurer is required to submit financial statements for an affiliate, the financial statements that the affiliate most recently filed with an agency that regulates the affiliate.

(d) The information required by Subsection (c) applies only to agreements in force, relationships subsisting, and transactions outstanding.

(e) The commissioner shall adopt the format of the registration statement. In adopting or revising the format, the commissioner may require information on other matters concerning transactions between a registered insurer and an affiliate of the insurer.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 157 (S.B. 1542), Sec. 1, eff. September 1, 2007.

Acts 2011, 82nd Leg., R.S., Ch. 922 (S.B. 1431), Sec. 5, eff. September 1, 2011.

Acts 2013, 83rd Leg., R.S., Ch. 1087 (H.B. 3460), Sec. 2, eff. June 14, 2013.

Sec. 823.053. REPORTING MATERIAL CHANGES. (a) To keep the

information required to be disclosed in a registration statement filed under Section 823.052 current, a registered insurer shall report each material change to the information, including the addition of information, not later than the 15th day after the last day of the month in which the insurer learns of the change.

(b) Subject to Section 823.107, each registered insurer shall report each dividend or distribution made to the shareholders not later than the earlier of:

(1) the second business day after the date the dividend or distribution is declared; or

(2) the 11th day before the date of payment.

(c) For purposes of this section, reports are considered to be made when received by the department.

(d) Reports made under this section are for informational purposes only.

(e) An insurer is not required to report under this section a transaction that is approved under Section 823.103. That approval is considered to be an amendment of the registration statement filed under Section 823.052 without being reported under this section.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 1087 (H.B. [3460](#)), Sec. 3, eff. June 14, 2013.

Sec. 823.054. MATERIAL INFORMATION. (a) Information about a transaction is not required to be disclosed on a registration statement filed under Section 823.052 or in a report under Section 823.053 unless the transaction is considered to be material under this section.

(b) If the amount of a single transaction or the total amount of all transactions involving sales, purchases, exchanges, loans or other extensions of credit, or investments is more than one-half of one percent of an insurer's admitted assets as of December 31 of the year preceding the date of the transaction or transactions, the transaction or transactions, respectively, are considered to be material for purposes of this section.

(c) Each dividend or distribution to shareholders is material for the purposes of this section.

(d) The commissioner, by rule or order, may provide a standard that is different from the standard provided by Subsection (b).

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 38 (H.B. 3220), Sec. 4, eff. May 19, 2017.

Acts 2017, 85th Leg., R.S., Ch. 67 (S.B. 1073), Sec. 1, eff. May 22, 2017.

Sec. 823.055. ANNUAL REGISTRATION STATEMENT; SUMMARY OF MATERIAL CHANGES. (a) In this section, "ultimate controlling person" means the person in an insurance holding company system who is not controlled by another person.

(b) Not later than the 120th day after the last day of each fiscal year of the ultimate controlling person, each registered insurer in the ultimate controlling person's insurance holding company system shall file an annual registration statement.

(c) An insurer required to file an annual registration statement shall also furnish a summary of material changes from the prior year's annual registration statement as specified by the commissioner by rule.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 157 (S.B. 1542), Sec. 2, eff. September 1, 2007.

Sec. 823.056. TERMINATION OF REGISTRATION. The commissioner shall terminate the registration of an insurer that demonstrates that the insurer has ceased to be a member of an insurance holding company system.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 823.057. CONSOLIDATED FILING. The commissioner may require or permit two or more insurers that are affiliates of each other and that are required to register under this chapter to file:

- (1) a consolidated registration statement; or
- (2) a consolidated report amending:
 - (A) the consolidated registration statement; or
 - (B) the individual registration statement of each insurer.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 823.058. ALTERNATIVE REGISTRATION. The commissioner may permit an insurer authorized to engage in the business of insurance in this state that is a part of an insurance holding company system to:

- (1) register on behalf of another insurer that is an affiliate of the insurer and that is required to register under Section 823.051; and
- (2) file on behalf of the affiliate all information and material required to be filed under this subchapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 823.059. EXEMPTIONS. (a) The registration requirement under Section 823.051 does not apply to a foreign or nondomestic insurer, other than a commercially domiciled insurer, that is subject to disclosure requirements adopted by statute or regulation in the jurisdiction of its domicile that are substantially similar to the disclosure requirements provided by this chapter.

(b) The commissioner may require an insurer that is exempt from registration under Subsection (a) to provide a copy of the registration statement or other information filed by the insurer with the insurance regulatory authority of its domiciliary jurisdiction.

(c) The commissioner, by rule or order, may exempt an insurer, information, or a transaction from the application of this subchapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 823.0595. ENTERPRISE RISK REPORT. (a) Except as provided by Subsections (d) and (f), the ultimate controlling person, as

defined by Section 823.055, of each insurer required to file an annual registration shall file with the registration an annual enterprise risk report. The report must, to the best of the ultimate controlling person's knowledge, identify the material risks within the insurance holding company system that may pose enterprise risk to the insurer. The report must be filed with the lead state commissioner of the insurance holding company system, as determined by the commissioner. In determining the lead state commissioner, the commissioner shall consider the procedures adopted by the National Association of Insurance Commissioners.

(d) Except as provided by Subsection (e), the ultimate controlling person of a domestic insurer that is authorized, admitted, or eligible to engage in the business of insurance only in this state and has total direct or assumed annual premiums of less than \$300 million is not required to submit an enterprise risk report under Subsection (a) unless the ultimate controlling person of the domestic insurer also controls other insurers that do not meet the requirements of this subsection. For the purposes of this subsection, an insurer is not considered to be authorized, admitted, or eligible to engage in the business of insurance only in this state if the insurer directly or indirectly writes or assumes insurance in any manner in another state.

(e) Regardless of total direct or assumed annual premium, the ultimate controlling person of an insurer that is not in compliance with applicable risk-based capital standards or that is otherwise in hazardous condition, as determined by the commissioner, shall file an enterprise risk report required by Subsection (a) as directed by the commissioner.

(f) An insurer that in the preceding calendar year had direct written and assumed premiums of more than \$300 million but less than \$500 million and otherwise meets the requirements of Subsection (d) may request an exemption from the reporting requirements of Subsection (a) by filing with the commissioner a written statement describing the undue financial or organizational hardship the insurer would suffer as a result of complying with Subsection (a). The commissioner may grant the exemption if the commissioner finds that compliance with Subsection (a) would impose an undue financial or organizational hardship on the insurer.

(g) The ultimate controlling person of an insurance holding company system is not required to submit an enterprise risk report

under Subsection (a) if:

(1) the ultimate controlling person:

(A) has owned a controlling interest in the voting securities of an insurer described by Subdivision (2) since September 1, 1991, or before;

(B) is a charitable foundation, trust, or both; and

(C) has not filed or received a disclaimer under Section 823.010; and

(2) the insurer in which the ultimate controlling person owns a controlling interest:

(A) was organized under the laws of this state before January 1, 1910;

(B) is registered under this subchapter;

(C) has issued equity shares of stock registered under Section 12, Securities Exchange Act of 1934 (15 U.S.C. Section 781);

(D) on September 1, 2011, owns or controls an insurance company subsidiary that is part of the same insurance holding company system as the insurer; and

(E) files with the commissioner all registration statements and information relating to material changes of the insurance holding company system required under this subchapter, including the financial statements of the ultimate controlling person described by Subdivision (1).

(h) An exemption under Subsection (g) applies only for the period during which the ultimate controlling person described by Subsection (g)(1) satisfies the requirements of Subsection (g) and expires on the date of a change in control of the insurer described by Subsection (g)(2) involving at least 50 percent of the voting securities of the insurer. An insurance holding company system may reapply for an exemption under Subsection (g) after the change in control if the system continues to meet the requirements of Subsection (g).

(i) An ultimate controlling person described by Subsection (g)(1) and an insurer described by Subsection (g)(2) shall respond to reasonable inquiries from the department related to the administration of Chapter 404.

Added by Acts 2011, 82nd Leg., R.S., Ch. 922 (S.B. [1431](#)), Sec. 6, eff. September 1, 2011.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 67 (S.B. 1073), Sec. 2, eff. May 22, 2017.

Sec. 823.0596. LIQUIDITY STRESS TEST. (a) In this section:

(1) "Liquidity stress test framework" means an evidence-based analysis that aims to capture the impact on financial markets of aggregate asset sales of certain insurers under various liquidity stress scenarios.

(2) "Scope criteria" means the designated exposure bases, including minimum magnitudes of the bases for a specified data year, adopted by the commissioner by rule under Subsection (e) to establish a preliminary list of insurers included in the liquidity stress test framework for that data year.

(3) "Ultimate controlling person" has the meaning assigned by Section 823.055.

(b) The ultimate controlling person of an insurer shall file the insurer's results of a specific year's liquidity stress test performed using the liquidity stress test framework adopted by the commissioner by rule under Subsection (e) if:

(1) this state is the lead state of the insurer's group; and

(2) the insurer or the insurer's group meets the scope criteria.

(c) The filing must be made on the reporting template for the relevant year adopted by the commissioner by rule under Subsection (e).

(d) The commissioner may exempt from the filing requirement for a data year an insurer described by Subsection (b) after the commissioner consults with other state insurance commissioners regarding the impact that exempting the insurer may have on the aggregation of liquidity stress test results filed by other insurers with those states.

(e) The commissioner by rule shall adopt a liquidity stress test framework, including scope criteria and reporting templates, consistent with the framework published by the National Association of Insurance Commissioners to facilitate the aggregation of results from the liquidity stress test filed with this and other states.

(f) The commissioner shall collect the results filed under Subsection (b) and report them to the National Association of

Insurance Commissioners in a manner that facilitates the aggregation of other insurers' results filed with this and other states.

(g) In addition to the confidentiality protections under Section 823.011:

(1) a filing required by Subsection (b) in the possession or control of the department that is obtained by, created by, or disclosed to the commissioner or any other person, including the National Association of Insurance Commissioners, is recognized by this state as being proprietary and to contain trade secrets; and

(2) the commissioner and any other person, including the National Association of Insurance Commissioners, who receives a filing required by Subsection (b) may not testify or be required to testify in any private civil action concerning that filing.

Added by Acts 2023, 88th Leg., R.S., Ch. 843 (H.B. 2839), Sec. 1, eff. September 1, 2023.

Sec. 823.060. VIOLATION OF SUBCHAPTER. The failure to file a registration statement or an amendment to a registration statement, or an enterprise risk report, within the time specified for filing the statement, amendment, or report, as required by this subchapter, is a violation of this subchapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 922 (S.B. 1431), Sec. 7, eff. September 1, 2011.

SUBCHAPTER C. TRANSACTIONS OF REGISTERED INSURER

Sec. 823.101. STANDARDS FOR TRANSACTION WITHIN AN INSURANCE HOLDING COMPANY SYSTEM. (a) This section applies only to a material transaction within an insurance holding company system to which an insurer subject to a registration under Section 823.052 is a party.

(b) The terms of the transaction shall be fair and equitable.

(b-1) An agreement, including an agreement for cost-sharing, services, or management, must include all provisions required by rule of the commissioner.

(c) The charges or fees for services performed shall be reasonable.

(d) The books, accounts, and records of each party to the transaction shall be maintained so that the precise nature and details of the transaction are clearly and accurately disclosed.

(e) The expenses incurred and payments received relating to the transaction shall be allocated to the registered insurer on an equitable basis in conformity with customary insurance accounting principles consistently applied.

(f) After a registered insurer pays a dividend or makes a distribution to a holding company or shareholder affiliate of the insurer, the insurer's policyholders' surplus shall be reasonable in relation to the insurer's outstanding liabilities and adequate to the insurer's financial needs.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 922 (S.B. 1431), Sec. 8, eff. September 1, 2011.

Acts 2011, 82nd Leg., R.S., Ch. 922 (S.B. 1431), Sec. 9, eff. September 1, 2011.

Sec. 823.103. NOTICE OF AND COMMISSIONER'S DECISION ON SPECIFIED TRANSACTIONS. (a) This section applies only to:

(1) a sale, purchase, exchange, loan or other extension of credit, or investment between a domestic insurer and any person in the insurer's insurance holding company system, including an amendment or modification of an affiliate agreement previously filed under this section, provided the transaction is not less than:

(A) with respect to nonlife insurers, the lesser of three percent of the insurer's admitted assets or 25 percent of the insurer's surplus as regards policyholders as of December 31 of the year preceding the year in which the transaction occurs; or

(B) with respect to life insurers, three percent of the insurer's admitted assets as of December 31 of the year preceding the year in which the transaction occurs;

(2) a loan or other extension of credit to a person who is not an affiliate if the insurer makes a loan or extension of credit with the agreement or understanding that the proceeds of the transaction, wholly or in substantial part, are to be used to make loans or extensions of credit to, to purchase assets of, or to make

investment in, an affiliate of the insurer making the loan or extension of credit, provided the transaction is not less than:

(A) with respect to nonlife insurers, the lesser of three percent of the insurer's admitted assets or 25 percent of the insurer's surplus as regards policyholders as of December 31 of the year preceding the year in which the transaction occurs; or

(B) with respect to life insurers, three percent of the insurer's admitted assets as of December 31 of the year preceding the year in which the transaction occurs;

(3) a reinsurance agreement, including a reinsurance treaty or pooling agreement, or an amendment or modification of an agreement previously filed under this section, between a domestic insurer and any person in the insurer's holding company system;

(4) a rendering of services between a domestic insurer and any person in the insurer's holding company system on a regular or systematic basis, including a tax-allocation agreement, or an amendment or modification of an agreement previously filed under this section; or

(5) any material transaction between a domestic insurer and any person in the insurer's holding company system that is specified by rule and that the commissioner determines may adversely affect the interests of the insurer's policyholders or of the public, including an amendment or modification of an agreement previously filed under this section.

(b) Subsection (a)(3) includes a reinsurance agreement that requires as consideration a transfer of assets from an insurer to a nonaffiliate and in relation to which the insurer and nonaffiliate agree that any part of the transferred assets are to be transferred to one or more affiliates of the insurer.

(c) A domestic insurer shall give to the commissioner written notice of the insurer's intent to enter into a transaction to which this section applies before the 30th day preceding the date of the proposed transaction. The commissioner may authorize a shorter period of notice under this subsection.

(d) A domestic insurer may not enter into a transaction for which the insurer gives notice under Subsection (c) if the commissioner disapproves the proposed transaction during the period for notice.

(e) The notice described by Subsection (c) must include:

(1) the reasons for entering into or changing the

transaction; and

(2) the financial impact of the transaction on the domestic insurer.

(f) Not later than the 30th day after the termination of a previously filed agreement, the domestic insurer shall give notice of the termination to the commissioner.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 922 (S.B. 1431), Sec. 11, eff. September 1, 2011.

Acts 2013, 83rd Leg., R.S., Ch. 1087 (H.B. 3460), Sec. 4, eff. June 14, 2013.

Sec. 823.104. PROHIBITION OF ACTION TO AVOID APPLICATION OF SUBCHAPTER. (a) A domestic insurer may not enter into transactions with persons in the insurer's insurance holding company system if:

(1) the transactions are part of a plan or series of similar transactions; and

(2) the purpose of entering into the transactions is to avoid a threshold amount provided by Section 823.103.

(b) If the commissioner determines that over any 12-month period a domestic insurer enters into transactions that violate Subsection (a), the commissioner may:

(1) consider the cumulative effect of the transactions; and

(2) apply:

(A) Section 823.103; or

(B) sanctions under this code.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 1087 (H.B. 3460), Sec. 5, eff. June 14, 2013.

Sec. 823.105. TYPE OF AUTHORITY PROVIDED. Nothing in Section 823.103 or 823.104 authorizes a transaction that would violate law that is applicable to an insurer that is not subject to this subchapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 1087 (H.B. 3460), Sec. 6, eff.
June 14, 2013.

Sec. 823.106. STANDARDS OF REVIEW; REASONS FOR DISAPPROVAL.

(a) In reviewing a transaction under this subchapter, the commissioner shall consider whether the transaction:

(1) complies with the standards provided by Section 823.101; and

(2) may adversely affect the interest of the insurer's policyholders.

(b) The commissioner shall set forth the specific reasons for the disapproval of a transaction reviewed under Subsection (a).

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 823.107. EXTRAORDINARY DIVIDENDS OR DISTRIBUTIONS. (a) Except as provided by Subsection (b), for purposes of this section, an extraordinary dividend or distribution includes the payment of a dividend or distribution of cash or other property, the fair market value of which combined with the fair market value of each other dividend or distribution made in the preceding 12 months exceeds the greater of:

(1) 10 percent, or 20 percent if the insurer is a title insurer, of the insurer's policyholders' surplus, as of December 31 of the year preceding the year in which the fair market value is being determined; or

(2) the net gain from operations of the insurer, if the insurer is a life or title insurer, or the net income, if the insurer is another type of insurer, for the calendar year preceding the year in which the fair market value is being determined.

(b) For purposes of this section, an extraordinary dividend or distribution does not include pro rata distributions of any class of securities of the insurer.

(c) An insurer that is required to register under Subchapter B shall give the commissioner notice of the insurer's intent to make an extraordinary dividend or distribution to shareholders, before the

30th day preceding the date of the proposed dividend or distribution. The commissioner may authorize a shorter period of notice under this subsection.

(d) An insurer may not make an extraordinary dividend or distribution for which the insurer gives notice if the commissioner disapproves the dividend or distribution during the period for the notice.

(e) A registered insurer may declare an extraordinary dividend or distribution that is conditional on its approval by the commissioner. The declaration does not confer any rights on shareholders before the dividend or distribution may be made under Subsection (d).

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER D. CONTROL OF DOMESTIC INSURER; ACQUISITION OR MERGER

Sec. 823.151. PRESUMPTION OF CONTROL. (a) Control of an entity is presumed if:

(1) a person or a person and members of the person's immediate family, directly or indirectly, own, control, or hold with the power to vote 10 percent or more of the voting securities or authority of the entity; or

(2) a person who is not a corporate officer or director of the entity holds proxies representing 10 percent or more of the voting securities or authority of the entity.

(b) Control of a Lloyd's plan is presumed if a person is designated as an attorney-in-fact for the insurer under Chapter 941.

(c) Control of a reciprocal or interinsurance exchange is presumed if a person is designated as an attorney-in-fact for the exchange under Chapter 942.

(d) A presumption under this section may be rebutted by a showing made in the manner provided by Section 823.010 that control does not exist in fact and that the person rebutting the presumption is complying with Sections 823.154, 823.155, 823.159, and 823.160.

(e) For purposes of this section, the members of a person's immediate family are:

(1) the person's spouse, father, mother, children, brothers, sisters, and grandchildren;

(2) the father, mother, brothers, and sisters of the

person's spouse; and

(3) the spouse of the person's child, brother, sister, mother, father, or grandparent.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 823.152. EMPLOYMENT OF EXPERTS. (a) The commissioner may employ an attorney, actuary, accountant, or other expert who is not a member of the commissioner's staff and who is reasonably necessary to assist in analyzing a merger or acquisition of control proposed under Section 823.154.

(b) The acquiring person shall pay all reasonable expenses incurred in connection with the employment of a person under this section.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 823.153. CONTROLLER OF DOMESTIC INSURER CONSIDERED DOMESTIC INSURER. For purposes of this subchapter, any person who controls a domestic insurer is considered to be a domestic insurer unless:

(1) the assets of all insurance subsidiaries of the person are equal to less than 20 percent of the person's consolidated assets;

(2) the gross revenues, including investment income, of all insurance subsidiaries of the person are equal to less than 20 percent of the person's consolidated gross revenues; and

(3) the shareholders' equity of all insurance subsidiaries of the person is equal to less than 20 percent of the person's consolidated shareholders' equity.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 823.154. REQUIREMENTS FOR ACQUISITION OR EXERCISE OF CONTROL OR DIVESTITURE OF DOMESTIC INSURER. (a) Before a person who directly or indirectly controls, or after the acquisition would directly or indirectly control, a domestic insurer may in any manner acquire a voting security of a domestic insurer or before a person

may otherwise acquire control of a domestic insurer or exercise any control over a domestic insurer, or before a person may initiate a divestiture of control of a domestic insurer:

(1) the acquiring person shall file with the commissioner a statement that satisfies the requirements of Subchapter E;

(2) the acquisition or divestiture of control must be approved by the commissioner in accordance with this subchapter; and

(3) if the person is initiating a divestiture of control, the divesting person shall file with the commissioner a notice of divestiture on a form adopted by the National Association of Insurance Commissioners or adopted by the commissioner by rule.

(b) The acquiring person or divesting person shall send a copy of the statement filed under this section to the domestic insurer.

(c) A statement or notice filed under this section must be filed not later than the 60th day before the proposed effective date of the acquisition or change of control or divestiture and is subject to public inspection at the office of the commissioner.

(d) Notwithstanding Subsection (a), a divesting person is not required to provide the commissioner with notice of divestiture required by Subsection (a)(3) if an acquiring person submits the statement required by Subsection (a)(1) and that acquisition is approved by the commissioner.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.202(a), eff. Sept. 1, 2003.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 922 (S.B. [1431](#)), Sec. 12, eff. September 1, 2011.

Sec. 823.155. AMENDMENT OF STATEMENT. If a material change occurs in the facts contained in a statement filed under Section 823.154, the person required to file the statement shall, not later than the second business day after the date the person learns of the change, file with the commissioner and send to the domestic insurer an amendment stating the change and a copy of each document and other material relevant to the change.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 823.156. NOTICE EXPENSES. (a) A person who files a statement under Section 823.154 shall pay the expenses of mailing each related notice required by the commissioner.

(b) As security for the payment of the expenses, the person, at the request of the commissioner or the domestic insurer, shall file with the commissioner an acceptable bond or other deposit in an amount determined by the commissioner.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 823.157. APPROVAL OF ACQUISITION, CHANGE, OR DIVESTITURE OF CONTROL. (a) The commissioner shall approve or deny an acquisition, change, or divestiture of control for which a statement or notice is filed under Section 823.154 not later than the 60th day after the date the statement required by that section is filed. The 60-day period may be waived by the person filing the statement or notice required by Section 823.154 and the domestic insurer. On the request of either the person filing the statement or notice required by Section 823.154, or the domestic insurer, the commissioner shall hold a hearing on a denial.

(b) In considering whether to approve or deny, the commissioner shall consider whether:

(1) immediately on the acquisition, change, or divestiture of control the domestic insurer would not be able to satisfy the requirements for the issuance of a new certificate of authority to write the line or lines of insurance for which the insurer holds a certificate of authority;

(2) the effect of the acquisition, change, or divestiture of control would be substantially to lessen competition in a line or subclassification lines of insurance in this state or tend to create a monopoly in a line or subclassification lines of insurance in this state;

(3) the financial condition of the acquiring person may jeopardize the financial stability of the domestic insurer or prejudice the interest of the domestic insurer's policyholders;

(4) the acquiring person has a plan or proposal to liquidate the domestic insurer or cause the insurer to declare dividends or make distributions, sell any of its assets, consolidate or merge with any person, make a material change in its business or

corporate structure or management, or enter into a material agreement, arrangement, or transaction of any kind with any person, and that the plan or proposal is unfair, prejudicial, hazardous, or unreasonable to the insurer's policyholders and not in the public interest;

(5) due to a lack of competence, trustworthiness, experience, and integrity of the persons who would control the operation of the domestic insurer, the acquisition or change of control would not be in the interest of the insurer's policyholders and the public;

(5-a) the divestiture of control may jeopardize the financial stability of the domestic insurer or prejudice the interest of the domestic insurer's policyholders and other claimants; or

(6) the acquisition, change, or divestiture of control would violate the law of this or another state or the United States.

(c) If a proposed acquisition, change, or divestiture of control will require the approval of more than one commissioner, the commissioner may participate in a public hearing referred to in this chapter held on a consolidated basis on request of the person filing the statement required by Section 823.154. The person filing the statement under Section 823.154 shall file the statement with the National Association of Insurance Commissioners within five days of making the request for a public hearing. A hearing conducted on a consolidated basis shall be public and shall be held within the United States before the commissioners of the states in which the insurers are domiciled. The commissioners shall hear and receive evidence at the hearing. The commissioner may attend the hearing in person or by telecommunication.

(d) This section does not require the commissioner to hold a hearing before approving or denying an acquisition, change, or divestiture of control.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.203(a), eff. Sept. 1, 2003.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 922 (S.B. [1431](#)), Sec. 13, eff. September 1, 2011.

Sec. 823.159. HEARING; TIME OF DETERMINATION. (a) A hearing under Section 823.152, 823.157, or 823.160 shall be held not later than the 60th day after the date of the denial.

(b) Not later than the 21st day before the date of the hearing, the commissioner shall give notice of the hearing to the person who filed the statement and to the domestic insurer unless the person and the domestic insurer waive notice.

(c) The person who filed the statement and the domestic insurer shall provide notice of the hearing in the time and manner specified by the commissioner to each person designated by the commissioner.

(d) The acquiring person has the burden of providing sufficient competent evidence for the commissioner to make the findings required under Section 823.157.

(e) The commissioner shall make a determination on the acquisition of control not later than the 60th day after the date the record of the hearing is closed.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.203(c), (d), eff. Sept. 1, 2003.

Sec. 823.160. DEADLINE FOR COMPLETION OF ACQUISITION. (a) An acquisition of control of a domestic insurer must be completed not later than the 90th day after the date of the commissioner's order approving the acquisition unless the commissioner on a showing of good cause for the delay grants an extension in writing.

(b) An increase in a company's capital and surplus required under this code because of the change of control of a domestic insurer must be completed not later than the 90th day after the date of the commissioner's order approving the change of control and before the insurance company writes any new insurance business.

(c) If a deadline under Subsection (a) or (b) is not met, the person seeking to acquire control of the domestic insurer shall resubmit the statement required by Section 823.154 and the commissioner may reconsider approval of acquisition of control under this subchapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 823.161. INSURER'S DUTY TO NOTIFY. (a) Not later than the 30th day after the date an event requiring notice under this subchapter occurs, an insurer authorized to engage in the business of insurance in this state shall notify the commissioner in writing of the identity of any person who the insurer knows, or has reason to believe, controls or has taken any action, other than preliminary negotiations or discussions, to acquire control of the insurer.

(b) This section does not apply to a foreign insurer that is subject to disclosure requirements and standards adopted by statute or regulation in the jurisdiction of the insurer's domicile that are substantially similar to the requirements and standards provided by this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 823.162. PROHIBITION ON CERTAIN ACTIONS RELATED TO ACQUISITION OF CONTROL OR MERGER. A person may not effect or attempt to effect an acquisition of control of or merger with a domestic insurer unless the commissioner has approved the acquisition or merger.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 823.163. RETENTION OF CONTROL. (a) This section applies only to a domestic insurer that is a controlled insurer, regardless of when that control was acquired.

(b) A person violates this section if:

(1) the person is a domestic insurer, a person who controls the domestic insurer, including the insurer's holding company, or an officer or director of the insurer or controlling person who violates this chapter or otherwise demonstrates untrustworthiness affecting the domestic insurer;

(2) the person is a domestic insurer that violates Chapter 15, Business & Commerce Code, or another antitrust law of this state; or

(3) the person is a domestic insurer's affiliate that violates Chapter 15, Business & Commerce Code, or another antitrust law of this state and whose violation affects the domestic insurer.

(c) If, after notice and an opportunity for a hearing, the

commissioner determines that a person violates this section, the commissioner shall issue written findings and an order based on those findings that directs the person to take appropriate action to cure the violation. The commissioner shall serve the order and findings on the person and the affected domestic insurer.

(d) In addition to this chapter, Subchapter C, Chapter 801, applies to a person who fails to comply with an order under this section.

(e) The commissioner may require the submission of any information the commissioner considers necessary to determine whether retention of control complies with this chapter and may require, as a condition of approval of the retention of control, that all or any part of that information be disclosed to the domestic insurer's shareholders.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 823.164. EXEMPTIONS FROM SUBCHAPTER. (a) This subchapter does not apply to a transaction that is subject to:

- (1) Subchapter K or L, Chapter 882; or
- (2) Section 887.065 or Subchapter J or K, Chapter 887.

(b) This subchapter does not apply to a transaction that is subject to and complies with:

- (1) Chapter 828; or
- (2) Subchapter L, Chapter 884.

(c) This subchapter does not apply to a transaction that is subject to and complies with Sections 824.101 and 824.102 and Subchapters A and B, Chapter 824, relating to the merger or consolidation of two or more insurers, until the plan of merger or consolidation is filed by the domestic insurer with the commissioner under that chapter. After the plan is filed, the transaction is subject to this subchapter. The commissioner may exempt the transaction from this subchapter, other than the approval provisions of Sections 823.157-823.160, if the commissioner finds that the materials provided to shareholders and security holders in connection with the merger or consolidation, including the notice and proxy statement, contained reasonable and adequate information, including factual and financial disclosures and material, relating to that transaction.

(d) This subchapter does not apply to a transaction that is subject to Subchapter K, Chapter 884, if the agreement to which the transaction relates is a total direct reinsurance agreement.

(e) This subchapter does not apply to an acquisition of any voting security that, immediately before consummation of the acquisition, is not issued and outstanding by a person who is a broker-dealer under state or federal securities law if:

(1) the acquisition is solely for resale under a plan approved by the commissioner;

(2) the resale will not reasonably result in an acquisition of control; and

(3) before the resale a positive act of control relating to those shares is not committed.

(f) This subchapter does not apply to an acquisition of a voting security of a domestic insurer by a person who:

(1) controls the insurer if, after the acquisition, the person directly or indirectly owns or controls less than 50 percent of the issued and outstanding voting securities of the insurer; or

(2) before the acquisition, directly or indirectly owns or controls more than 50 percent of the issued and outstanding voting securities of the insurer.

(g) This subchapter does not apply to an acquisition of a voting security of a domestic insurer by a person who, before the acquisition, directly or indirectly owns or controls at least 10 percent but less than 50 percent of the issued and outstanding voting securities of the insurer and who, after the acquisition, directly or indirectly owns or controls 50 percent or more of the issued and outstanding voting securities of the insurer if:

(1) the person has applied in writing for the exemption; and

(2) the commissioner by order has determined that the acquisition:

(A) will not jeopardize the financial stability of the insurer;

(B) will not prejudice the interests of the insurer's policyholders; and

(C) will not adversely affect the public interest.

(h) The commissioner by order may exempt from the application of this subchapter an offer, request, invitation, agreement, or acquisition that:

(1) is not made or entered into to change or influence the control of a domestic insurer and does not have the effect of changing or influencing that control; or

(2) is not comprehended as within the purposes of this subchapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 823.165. VIOLATION OF SUBCHAPTER. The failure to file a statement, amendment, or other material required to be filed under this subchapter is a violation of this subchapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER E. ACQUISITION STATEMENT

Sec. 823.201. ACQUIRING PERSON. (a) A statement required under Section 823.154 must contain the name and address of the acquiring person.

(b) If the acquiring person is an individual, the statement must contain:

- (1) the acquiring person's principal occupation or employment;
- (2) each material occupation, employment, office, or position held by the acquiring person during the preceding five-year period; and
- (3) any criminal conviction of the acquiring person, other than a conviction of a minor traffic violation, during the preceding 10-year period.

(c) If the acquiring person is not an individual, the statement must contain:

(1) a report of the nature of the acquiring person's business operations during the preceding five-year period or, if the acquiring person and any predecessors of the acquiring person have been in existence for less than five years, during that shorter period;

(2) a description, complete in all material respects, of any business the acquiring person intends to begin; and

(3) a list that contains:

(A) the name of each director or executive officer of

the acquiring person, or individual who performs or who is to perform, functions appropriate to that position; and

(B) for each individual listed under Paragraph (A), the information required for an individual under Subsection (b).

(d) The acquiring person shall agree to provide the annual enterprise risk report required by Section 823.0595 for as long as the acquiring person maintains control of the insurer.

(e) The acquiring person and all subsidiaries within the acquiring person's control in the insurance holding company system shall provide information to the commissioner on request of the commissioner as the commissioner deems necessary to evaluate enterprise risk to the insurer.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 922 (S.B. 1431), Sec. 14, eff. September 1, 2011.

Sec. 823.202. CONSIDERATION FOR ACQUISITION. (a) A statement required under Section 823.154 must contain:

(1) the source, nature, and amount of consideration for the acquisition of control;

(2) a description of any transaction from which the consideration for the acquisition of control is obtained; and

(3) the identity of each person providing the consideration.

(b) On request of the person filing the statement, the identity of a commercial lender who in the ordinary course of business provides consideration for the acquisition is confidential.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 823.203. FINANCIAL INFORMATION ABOUT ACQUIRING PERSON.

(a) A statement required under Section 823.154 must contain:

(1) fully audited financial information about the earnings and financial condition of the acquiring person for the preceding three fiscal years or, if the acquiring person and any predecessors of the acquiring person have been in existence for less than three fiscal years, for that shorter period; and

(2) similar unaudited financial information about the earnings and financial condition of the acquiring person as of a date not earlier than the 120th day preceding the date the statement is filed.

(b) The statement must be accompanied by an affidavit or certification of the chief financial officer of the acquiring person stating that:

(1) the unaudited financial information provided under Subsection (a) is true and correct, as of its date; and

(2) a material change in financial condition, as determined under Section 823.054, did not occur during the period beginning on the date of that information and ending on the date of the affidavit or certification.

(c) If an acquiring person is an individual, the acquiring person shall provide the personal unaudited financial information required by the commissioner.

(d) If an acquiring person is an insurer authorized to engage in the business of insurance in this state and actively engaging in the business of insurance, the acquiring person may provide financial statements that conform to the requirements of:

(1) the annual statements of the insurer filed with the insurance department of the insurer's state of domicile; and

(2) insurance or other accounting principles prescribed by or authorized under the law and regulations of the state of domicile.

(e) A statement required under Section 823.154 must contain additional financial information in the form or substance required by the commissioner that is material to a finding under Section 823.157(3).

(f) The commissioner may waive any financial information required under this section that the commissioner does not consider to be material.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 823.204. PLAN FOR FUTURE OF INSURER. A statement required under Section 823.154 must contain:

(1) any plan or proposal of the acquiring person to:

(A) cause the insurer to pay dividends or make distributions;

(B) liquidate the insurer;

(C) sell any of the insurer's assets;

(D) merge or consolidate the insurer with any person;

(E) make any other material change in the insurer's business or corporate structure or management; or

(F) cause the insurer to enter into material agreements, arrangements, or transactions of any kind with any person; and

(2) any oral or written arrangement or agreement between the acquiring person or an affiliate of the acquiring person and the domestic insurer entered into during the 12 months preceding the date of the statement.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 823.205. VOTING SECURITIES. (a) In this section, "voting security" means a voting security of a domestic insurer the acquisition of which requires the filing of a statement under Section 823.154 as a condition precedent.

(b) A statement required under Section 823.154 must contain:

(1) the number of shares of a voting security that the acquiring person or an affiliate of the acquiring person proposes to acquire and the terms of the acquisition;

(2) the amount of each class of a voting security that is beneficially owned by the acquiring person and by each affiliate of the acquiring person;

(3) the amount of each class of a voting security the beneficial ownership of which the acquiring person or an affiliate of the acquiring person has a right to acquire;

(4) a copy of any written or confirmed description of any oral agreement, arrangement, or understanding relating to a voting security and in which the acquiring person or an affiliate of the acquiring person is involved, including an agreement, arrangement, or understanding relating to the transfer of any of the voting securities, joint ventures, loan or option agreements, puts or calls, guarantees of loans, guarantees against loss, guarantees of profits, division of losses or profits, or the giving or withholding of proxies;

(5) a description of each purchase of a voting security,

including the date of purchase, name of the purchaser, and consideration for the purchase, made during the 12 calendar months preceding the date of the filing of the statement by:

- (A) the acquiring person; or
- (B) an affiliate, director, or executive officer of the

acquiring person;

(6) a copy of any written, or a confirmed description of any oral, recommendation to purchase a voting security made during the 12 calendar months preceding the date of the filing of the statement by:

- (A) the acquiring person;
- (B) an affiliate of the acquiring person; or
- (C) a person based on an interview with, or at the suggestion of, the acquiring person or an affiliate of the acquiring person;

person;

(7) a copy of each tender offer for, request or invitation for tender of, exchange offer for, or agreement to acquire or exchange a voting security and any additional distributed soliciting material relating to that offer, request, invitation, or agreement;

(8) a copy of any written, or a confirmed description of any oral, agreement, arrangement, or understanding made with a broker-dealer relating to the solicitation of a voting security for tender, and the amount of any compensation, including fees and commissions, to be paid to a broker-dealer with regard to the solicitation; and

(9) any additional information the commissioner by rule prescribes as necessary or appropriate to protect:

- (A) policyholders of the insurer whose voting securities are to be acquired; or
- (B) the public.

(c) An insurer required to file information under Section 823.154 may satisfy the requirement of Section 823.052(c-1) by providing the commissioner with the most recently filed parent corporation reports that have been filed with the United States Securities and Exchange Commission, if required by the commissioner.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 922 (S.B. [1431](#)), Sec. 15, eff. September 1, 2011.

Sec. 823.206. ADDITIONAL INFORMATION ABOUT ACQUIRING ORGANIZATION. (a) If the person required to file the statement under Section 823.154 is a partnership, limited partnership, syndicate, or other group, the commissioner may require that the information required for an individual under this subchapter be given with respect to:

(1) each person who is a partner of the partnership or limited partnership or a member of the syndicate or group; and

(2) each person who controls a person described by Subdivision (1).

(b) If the person required to file the statement under Section 823.154 or the person with respect to whom information is required under Subsection (a) is a corporation, the commissioner may require that:

(1) the information required under this subchapter be given with respect to that corporation; and

(2) the information required for an individual under this subchapter be given with respect to:

(A) each executive officer and director of that corporation; and

(B) each person who is directly or indirectly the beneficial owner of more than 10 percent of the outstanding voting securities of that corporation.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 823.207. OATH OR AFFIRMATION REQUIRED. A statement required under Section 823.154 must be made under oath or affirmation.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER F. INSURER'S LOANS TO OR INVESTMENT IN AFFILIATE

Sec. 823.251. DEFINITION. In this subchapter, "securities" includes common stock, preferred stock, and debt obligations.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 823.252. GENERAL AUTHORITY RELATING TO AFFILIATES. A domestic insurer, by itself or in cooperation with one or more other persons, may organize, acquire, invest in, or make loans to one or more subsidiaries, and may loan to or invest in affiliates, as permitted by the provisions of this code governing investments.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 823.253. GENERAL STANDARD FOR INVESTMENT IN AFFILIATE.

(a) A domestic insurer may invest in the securities of one or more of the insurer's affiliates organized for any lawful purpose if:

(1) the amounts invested under this subsection in the aggregate do not exceed the lesser of:

(A) 10 percent of the insurer's assets; or

(B) 50 percent of the insurer's policyholders' surplus;

and

(2) after investment under this subsection, the insurer's policyholders' surplus is reasonable in relation to the insurer's outstanding liabilities and adequate to the insurer's financial needs.

(b) For purposes of computing the amount of the investments under this section:

(1) investments in domestic or foreign insurance subsidiaries are excluded; and

(2) the following amounts are included:

(A) the total net amount spent and the amount of obligations assumed to acquire or form a subsidiary, including all organizational expenses and contributions to capital and surplus of the subsidiary regardless of whether represented by the purchase of capital stock or issuance of other securities; and

(B) all amounts spent to acquire additional securities and all contributions to the capital or surplus of a subsidiary made after the acquisition or formation of the subsidiary.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 823.254. STANDARD FOR INVESTMENT IN AFFILIATE BY INSURER

WITH LOW TOTAL LIABILITIES. If a domestic insurer's total liabilities, as computed for National Association of Insurance Commissioners annual statement purposes, are less than 10 percent of the insurer's assets, the insurer may invest any amount in the securities of one or more affiliates organized for any lawful purpose if after the investment, treating the investment as if it were a nonadmitted asset, the insurer's policyholders' surplus is reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 823.255. AGREEMENT OF AFFILIATE TO LIMIT CERTAIN INVESTMENTS. (a) A domestic insurer may invest any amount in the securities of one or more affiliates organized for any lawful purpose if each affiliate agrees to limit its investments in any particular asset so that the investments will not cause the amount of the total investment of the insurer to exceed the amount the insurer could have directly invested in that asset.

(b) To compute the amount of the total investment of an insurer in an asset for purposes of Subsection (a), the following amounts are included:

(1) any direct investment by the insurer in that asset;

and

(2) the insurer's proportionate share of investment in that asset by any affiliate of the insurer.

(c) To compute the insurer's proportionate share of investment under Subsection (b)(2), the amount of the affiliate's investment in the asset is multiplied by the percentage of the insurer's ownership of that affiliate.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 823.256. COMMISSIONER'S APPROVAL OF INVESTMENT. With the prior approval of the commissioner, a domestic insurer may invest any amount in the securities of one or more affiliates if after the investment the insurer's policyholders' surplus is reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 823.257. DETERMINATION REQUIRED BEFORE INVESTMENT. (a) Whether an investment meets an applicable requirement of this subchapter shall be determined before the investment is made by applying that requirement as if the investment had been made.

(b) In making the determination under Subsection (a):

(1) the amount to be used for the total of previous investments in debt obligations is the principal balance outstanding on all of those obligations at the time of the determination;

(2) the amount to be used for previous investments in equity securities is the sum of values of each previous investment as of the day the previous investment was made; and

(3) any return of capital invested, not including dividends, shall be subtracted.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 823.258. DISPOSITION OF INVESTMENT IN SUBSIDIARY AFTER CESSATION OF CONTROL. (a) An insurer that ceases to control a subsidiary shall dispose of any investment in the subsidiary made under this subchapter before the third anniversary of the date the insurer ceases to control the subsidiary, unless:

(1) at any time after the investment is made the investment qualifies for investment under another provision of this code; and

(2) the insurer notifies the commissioner of that qualification.

(b) The commissioner may extend the period under Subsection (a) during which disposition is required.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 823.259. EXEMPTION FROM CERTAIN LIMITATIONS; INVESTMENT AUTHORITY CUMULATIVE OF OTHER LAW. (a) An investment made under this subchapter is not subject to the restrictions and prohibitions relating to investments contained in this code other than those provided by Subchapter C.

(b) Investments authorized by this subchapter are in addition

to other investments permitted under this code for a domestic insurer.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER G. VALUATION OF INVESTMENT FOR FINANCIAL STATEMENT

Sec. 823.301. SCOPE OF SUBCHAPTER. (a) This subchapter applies only to the determination of the valuation for a financial statement of an investment by an insurer in an affiliate that is not an insurer.

(b) This subchapter does not apply for determining the amount invested under Section 823.253.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 823.302. BASES FOR DETERMINING VALUATION. Subject to this subchapter, the valuation of an investment to which this subchapter applies is the greater of:

(1) the net shareholder equity value that the insurer owns in the affiliate adjusted, if the affiliate is a subsidiary, to include the value of only those assets of the subsidiary that would constitute lawful investments for the insurer if the assets were acquired or held directly by the insurer; or

(2) the amount determined using one of the following methods that is applicable for the affiliate in which the investment is made:

(A) the net worth of the affiliate determined at the end of the affiliate's most recent fiscal year in accordance with generally accepted accounting principles and reported in the financial statements of the affiliate for that fiscal year that were audited by an independent certified public accountant in accordance with generally accepted auditing standards;

(B) the value equal to the cost of the stock of the affiliate, determined and adjusted to reflect subsequent operating results in accordance with generally accepted accounting principles;

(C) the market value of the stock of the affiliate, if the stock is listed on a national securities exchange;

(D) the value, if any, placed on the stock of the affiliate by the National Association of Insurance Commissioners; or

(E) an amount that the insurer can substantiate to the satisfaction of the commissioner as being a reasonable value of that investment.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 823.303. ADJUSTMENT TO DETERMINATION. If an affiliate is valued using a method other than the method provided by Section 823.302(2)(C), the valuation of the investment is computed by subtracting from the determined value an amount equal to the value claimed for any of the affiliate's assets that would not be admitted assets for the insurer if held directly by the insurer and that:

(1) are held by the affiliate but are used, including use under a lease agreement, significantly in the conduct of the insurer's business; or

(2) were acquired from or purchased for the benefit or use of the insurer by the affiliate under specific circumstances that, in the commissioner's opinion, support a reasonable finding that the primary purpose of the acquisition or purchase was to evade or avoid application of this code.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 823.304. USE OF DIFFERENT BASES. An insurer is not required to value the stock of all of its affiliates on the same basis.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 823.305. VALUATING ACQUIRED AFFILIATE. (a) Not later than the 30th day after the date an insurer acquires an affiliate that is not an insurer, the insurer shall file with the commissioner relevant information identifying, supporting, and justifying the value of the affiliate and the basis of valuation under Section 823.302 used for that affiliate.

(b) After filing the information under Subsection (a), the insurer shall use the specified basis of valuation for that affiliate unless a change is substantiated as reasonable to and is approved in

writing by the commissioner.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 823.306. USE OF UNAUDITED INFORMATION. If an affiliate is valued using the basis provided by Section 823.302(2)(A) and the books of the affiliate are not audited at the time the valuation is included in the insurer's annual statement, the insurer, as soon as possible after an audit of those books, shall report and explain any difference between the value of the affiliate reported in the insurer's annual statement and the value determined by the audit.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 823.307. MODIFICATION BY COMMISSIONER. After notice and opportunity for a hearing, the commissioner may:

(1) determine that the basis used for valuation of the stock of an affiliate does not, under the specific circumstances, reflect the value of the affiliate; and

(2) order an adjustment in the valuation or the use of another basis of valuation provided by this subchapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER H. EXAMINATIONS

Sec. 823.351. EXAMINATION OF INSURER. (a) Subject to Section 823.352, the commissioner may order an insurer registered under Subchapter B to produce records, books, or other information papers in the possession of the insurer or an affiliate of the insurer that are necessary to ascertain the financial condition or legality of conduct of the insurer, including the enterprise risk to the insurer by the ultimate controlling party, or by any entity or combination of entities within the insurance holding company system, or by the insurance holding company system on a consolidated basis.

(a-1) To determine compliance with this chapter, the commissioner may order any insurer registered under Subchapter B to produce information not in the possession of the insurer if the insurer can obtain access to the information pursuant to contractual

relationships, statutory obligations, or other methods. In the event that the insurer is unable to obtain the information requested by the commissioner, the insurer shall provide the commissioner with a detailed explanation of the reason why the insurer is unable to obtain the information, and the identity of the holder of information. If it appears to the commissioner that the insurer's explanation is without merit, the commissioner may after notice and hearing:

- (1) require the insurer to pay a penalty of not less than \$100 for each day the insurer delays producing the information; or
- (2) suspend or revoke the insurer's license.

(b) If an insurer fails to comply with an order under this section, the commissioner by order may require the examination of each holding company of the insurer and each controlled person or affiliate in the insurer's insurance holding company system if the commissioner has cause to believe that:

- (1) the operations of that person may materially affect the operations, management, or financial condition of any controlled insurer in that system; and
- (2) the commissioner is unable to obtain relevant information from the controlled insurer.

(b-1) The commissioner may issue subpoenas, administer oaths, and examine under oath any person for purposes of determining compliance with this section. On the failure or refusal of a person to obey a subpoena, the commissioner may petition a court of competent jurisdiction, and on proper showing, the court may enter an order compelling the witness to appear and testify or produce documentary evidence. Failure to obey the court order is punishable as contempt of court. A person shall attend as a witness at the place specified in the subpoena, when subpoenaed, at any location in this state. The person is entitled to the same fees and mileage, if claimed, as a witness in district court. Fees, mileage, and actual expenses necessarily incurred in securing the attendance of a witness shall be itemized and charged against, and be paid by, the insurer being examined.

(c) The commissioner shall specify in an order under Subsection (b) the grounds for the examination. An examination under Subsection (b) shall be confined to matters specified in the order.

(d) Only the person sought to be examined under Subsection (b) is entitled to seek judicial review of an order under that

subsection.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 922 (S.B. [1431](#)), Sec. 16, eff. September 1, 2011.

Sec. 823.352. LIMITATION ON POWER. The commissioner may exercise power under Section 823.351 only if:

(1) examination of the insurer under another provision of this code is inadequate; or

(2) the interests of the insurer's policyholders may be adversely affected.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 823.353. PAYMENT OF EXAMINATION COSTS. (a) Each registered insurer that complies with an order under Section 823.351(a) shall pay the expense of the examination in accordance with Sections 401.151, 401.152, 401.155, and 401.156.

(b) The commissioner shall assess the cost of an examination under Section 823.351(b) against the person examined. The controlled insurer may not directly or indirectly reimburse that person for any part of the cost.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 2E.011, eff. April 1, 2009.

Sec. 823.354. USE OF ADVISORS. (a) The commissioner may employ at the registered insurer's expense attorneys, actuaries, accountants, and other experts that are not a part of the commissioner's staff and that are reasonably necessary to assist in the conduct of an examination under Section 823.351.

(b) A person employed under this section is under the direction and control of the commissioner and may act only as an advisor.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 823.355. CUMULATIVE AUTHORITY. The authority provided by this subchapter is in addition to other powers relating to the examination of insurers given to the commissioner under this code.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER I. LIMITATIONS RELATING TO CONTROLLED INSURERS

Sec. 823.401. PROHIBITION OF INDIRECT ACTION FOR CONTROLLED INSURER. (a) A holding company or controlled person may not directly or indirectly do or cause to be done for or on behalf of a controlled insurer any act intended to affect, influence, change, or alter the insurance operations of the insurer that would violate this code if done by the insurer alone.

(b) This section does not limit or prohibit a holding company or a person in the insurance holding company system from conducting on behalf of the person any type of business that would be normal and natural to the person if the person were not in the holding company system.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 823.402. PROHIBITION ON VOTING CERTAIN SECURITIES. (a) A security that is the subject of an agreement or arrangement regarding an acquisition or that is acquired or to be acquired in violation of this chapter or a rule or order under this chapter may not be voted at a shareholders' meeting or counted for quorum purposes. An action of shareholders requiring the affirmative vote of a percentage of shares may be taken as though the security was not outstanding.

(b) An action taken at a shareholders' meeting is not invalidated by the voting of a security to which Subsection (a) applies unless:

- (1) the action would materially affect control of the insurer; or
- (2) a court of this state invalidates the action.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 823.403. MANAGEMENT OF CONTROLLED INSURER. (a) The control of an authorized insurer by another person does not relieve an officer or director of the insurer of any obligation or liability to which the officer or director is subject by law. The insurer shall be managed to assure the insurer's separate operating identity consistent with this code.

(b) This section does not preclude an authorized insurer from having a common management or joint use of personnel, property, or services with one or more other persons under an arrangement that meets the standards of Section 823.101(e).

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER J. CIVIL REMEDIES AND SANCTIONS

Sec. 823.451. RECEIVERSHIP. If it appears to the commissioner that a person's violation of this chapter so impairs the financial condition of a domestic insurer as to threaten the insurer's insolvency or make the further transaction of the insurer's business hazardous to the insurer's policyholders or creditors or the public, the commissioner may proceed under Chapters 441 and 443 to take possession of the insurer's property and conduct the business of the insurer.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 2E.012, eff. April 1, 2009.

Sec. 823.452. REVOCATION, SUSPENSION, OR NONRENEWAL OF INSURER'S AUTHORITY. (a) If it appears to the commissioner that a person's violation of this chapter makes the continued operation of an insurer contrary to the interest of policyholders or the public, the commissioner, after notice and opportunity for a hearing, may suspend, revoke, or refuse to renew the insurer's certificate of authority to engage in the business of insurance in this state for the period the commissioner finds is required for the protection of policyholders or the public.

(a-1) If the commissioner determines that a person has committed a violation of Subchapter D that prevents the full understanding of the enterprise risk to the insurer by affiliates or by the insurance holding company system, the violation may serve as an independent basis for disapproving dividends or distributions and for issuing an order under Chapter 404 or Chapter 441.

(b) The commissioner shall provide specific findings of fact and conclusions of law to accompany a determination under this section.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 922 (S.B. 1431), Sec. 17, eff. September 1, 2011.

Sec. 823.453. VOIDING UNAUTHORIZED ACTION. If it appears to the commissioner that a person has entered into a transaction or performed an act before complying with the applicable provisions of this chapter or has obtained the commissioner's approval of or acquiescence in a transaction or act that is subject to this chapter based on a material fraudulent misrepresentation, misstatement, or omission, the commissioner, after notice and opportunity for a hearing, by order may void the transaction or act and return the parties to the position they would have occupied if the transaction or act had not occurred.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 823.454. ADMINISTRATIVE PENALTY. (a) A director or officer of an insurer or insurance holding company system that is subject to this chapter is subject to an administrative penalty under Chapter 84 if the director or officer knowingly and wilfully:

(1) participates in or assents to a transaction or an investment that has not been properly reported or submitted under this chapter;

(2) permits an officer, agent, or employee of the insurer or holding company system, as appropriate, to engage in a transaction or make an investment that has not been properly reported or submitted under this chapter; or

(3) violates this chapter.

(b) The amount of an administrative penalty under this section may not exceed \$10,000 for each violation.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 823.455. EQUITABLE RELIEF. (a) If it appears to the commissioner that an insurer or a director, officer, employee, or agent of an insurer has committed or is about to commit a violation of this chapter or a rule or order under this chapter, the commissioner may apply to a district court of Travis County for an order enjoining the violation and for other equitable relief that the nature of the case and the interest of the insurer's policyholders or creditors or the public requires.

(b) If an insurer or the commissioner has reason to believe that a security of the insurer was or is about to be acquired in violation of this chapter or a rule or order under this chapter, the insurer or the commissioner may apply to a district court of Travis County or of the county in which the insurer has its principal place of business to:

(1) enjoin any offer, request, invitation, agreement, or acquisition made in violation of Subchapter D or a rule or order under that subchapter;

(2) enjoin the voting of a security acquired in violation of Subchapter D or a rule or order under that subchapter; or

(3) void a vote of the security that was cast at any shareholders' meeting.

(c) In a suit filed under Subsection (b), the insurer or the commissioner may also apply for other equitable relief that the nature of the case and the interests of the insurer's policyholders or creditors or the public requires.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 823.456. SEIZURE OR SEQUESTRATION OF VOTING SECURITIES. If a person acquires or is proposing to acquire a voting security in violation of this chapter or a rule or order under this chapter, a district court of Travis County or of the county in which the insurer has its principal place of business, on application of the insurer or

the commissioner and notice that the court considers appropriate, may seize or sequester any voting securities of the insurer that are owned directly or indirectly by that person and may issue an order relating to those securities that is appropriate to implement this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 823.457. LONG ARM JURISDICTION; SERVICE OF PROCESS. (a) The courts of this state have jurisdiction over a person who is not a resident of, domiciled in, or authorized to engage in business in this state and files a statement with the commissioner under Subchapter D, and over the actions involving that person that arise out of a violation of this chapter.

(b) A person described by Subsection (a) is considered to have appointed the commissioner as the person's agent for service of process in any action, suit, or proceeding arising out of a violation of this chapter.

(c) The commissioner shall forward by registered or certified mail to the person's last known address copies of all processes that are served on the commissioner under Subsection (b).

(d) Additional procedures and fees for service of process are provided by Subchapter C, Chapter 804.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 823.458. SANCTIONS. An entity that holds a certificate of authority issued by the department and that violates this code is subject to sanctions under Chapter 82.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER K. CRIMINAL PENALTIES

Sec. 823.501. OFFENSE OF VIOLATING CHAPTER. (a) A person commits an offense if the person is an insurer or individual and wilfully violates this chapter.

(b) If the person is an insurer, an offense under Subsection (a) is a misdemeanor punishable by a fine not to exceed \$50,000 for

each violation.

(c) If the person is an individual, an offense under Subsection (a) is a misdemeanor punishable by a fine not to exceed \$10,000 for each violation except as provided by Subsection (d) and Section 823.502.

(d) An offense under Subsection (a) is a felony if the person is an individual and the violation involves the deliberate perpetration of a fraud on the department, an insurer, an insurer's subsidiary, or policyholders. The felony is punishable by:

- (1) imprisonment for a term not to exceed five years;
- (2) a fine not to exceed \$10,000 for each violation; or
- (3) both fine and imprisonment under this subsection.

(e) A fine under this section is in addition to any civil or administrative penalty.

(f) An individual on whom a fine is imposed under this section shall pay the fine in that person's individual capacity.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 823.502. OFFENSE OF SUBSCRIBING TO OR MAKING FALSE STATEMENT. (a) A person commits an offense if the person is an officer, director, or employee of a domestic insurer or the insurer's insurance holding company system and wilfully and knowingly subscribes to or makes or causes to be made a false statement on a written instrument required to be filed with the commissioner.

(b) An offense under Subsection (a) is a felony punishable by:

- (1) imprisonment for a term of not less than two years;
- (2) a fine not to exceed \$10,000 for each violation; or
- (3) both fine and imprisonment under this subsection.

(c) A person on whom a fine is imposed under this section shall pay the fine in that person's individual capacity.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 823.503. BEGINNING CRIMINAL PROCEEDINGS. If it appears to the commissioner that an insurer or a director, officer, employee, or agent of an insurer has wilfully violated this chapter, the commissioner may cause criminal proceedings to be instituted against that person by the district attorney for the county in which the

principal office of the insurer is located or, if the insurer does not have a principal office in this state, the district attorney of Travis County.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

CHAPTER 824. MERGER AND CONSOLIDATION OF STOCK INSURANCE CORPORATIONS
SUBCHAPTER A. AUTHORITY AND PROCEDURES

Sec. 824.001. AUTHORITY TO MERGE OR CONSOLIDATE. Two or more insurance corporations that engage in a similar line of the business of insurance may merge or consolidate under this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 824.002. PROCEDURES; APPLICABILITY OF TEXAS BUSINESS CORPORATION ACT. (a) To the extent that the provisions of the Texas Business Corporation Act are not inconsistent with the provisions of this code, the Texas Business Corporation Act governs:

(1) the procedures for a merger or consolidation under this chapter;

(2) the effect of a merger or consolidation under this chapter; and

(3) the rights and duties of creditors, shareholders, and the corporations that are involved in a merger or consolidation under this chapter.

(b) To the extent that the Texas Business Corporation Act applies under this chapter to insurance corporations, the commissioner shall perform each duty, exercise each power, and perform each act vested in, required of, or to be performed by the secretary of state under the Texas Business Corporation Act.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 824.003. PROPOSED PLAN OF MERGER OR CONSOLIDATION; APPROVAL OF DIRECTORS AND SHAREHOLDERS. (a) A proposed plan of merger or consolidation must be approved by the boards of directors of the corporations that are parties to the merger or consolidation.

(b) After approval by the boards of directors, the proposed

plan shall be submitted for approval to the shareholders of each corporation that is a party to the plan at a separate regular or special meeting of the shareholders called in the manner provided by the bylaws of the respective corporations.

(c) A plan is approved on the affirmative vote of the holders of two-thirds of the shares of the capital stock of each corporation that is a party to the plan.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 824.004. FILING OF PROPOSED PLAN WITH COMMISSIONER. After a proposed plan of merger or consolidation has been approved as provided by Section 824.003, the plan shall be filed with the commissioner.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 824.005. COMMISSIONER ACTION ON PLAN. (a) The commissioner shall hold a hearing on a proposed plan of merger or consolidation not later than the 15th day after the date on which the plan is filed with the commissioner as required by Section 824.004.

(b) Not later than the 15th day after the hearing date, the commissioner shall:

(1) give written approval of the plan to each insurance corporation that is a party to the proposed merger or consolidation; or

(2) disapprove the plan if the commissioner determines that the plan:

(A) is contrary to law; or

(B) would not be in the best interests of the policyholders affected by the plan and would substantially reduce the security of and service to be rendered to policyholders of the insurance corporation in this state or elsewhere.

(c) The commissioner may extend the period during which the commissioner may affirmatively approve or disapprove the proposed plan if representatives of the applicants for the proposed merger or consolidation concur in that extension.

(d) If the commissioner disapproves a proposed plan, the commissioner shall specify in detail the reasons for that

disapproval.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER B. EFFECTIVE DATE OF MERGER OR CONSOLIDATION

Sec. 824.051. EFFECTIVE DATE OF MERGER. A merger takes effect on the date specified in the proposed plan of merger.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 824.052. EFFECTIVE DATE OF CONSOLIDATION. (a) A new insurance corporation resulting from a plan of consolidation shall be issued a charter and a certificate of authority on:

(1) submission of proper articles of incorporation to the commissioner;

(2) approval by the commissioner in accordance with the procedures required for the issuance of a new charter; and

(3) submission of proof that the new corporation has capital and surplus at least equal to that of the corporation that is a party to the consolidation and has the largest capital and surplus.

(b) A consolidation takes effect on the date of issuance of the charter and certificate of authority under Subsection (a).

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 824.053. APPROVAL OF MERGER OR CONSOLIDATION AFFECTING FOREIGN CORPORATION; EFFECTIVE DATE. Notwithstanding Section 824.051 or 824.052, a merger or consolidation involving a corporation organized under the laws of another state does not take effect until the merger or consolidation is approved by the proper official of the domiciliary state, if that approval is required.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER C. EFFECT OF MERGER OR CONSOLIDATION

Sec. 824.101. EFFECT OF MERGER OR CONSOLIDATION ON OUTSTANDING INSURANCE POLICIES. (a) A new or surviving corporation resulting

from a merger or consolidation shall assume each insurance policy outstanding against each insurance corporation that merges or consolidates on the same terms and under the same conditions as if the policy had continued in force through the original corporation.

(b) The new or surviving insurance corporation shall implement the terms of the policy.

(c) The new or surviving insurance corporation is entitled to:

(1) all rights and privileges under the policy; and

(2) all reserves that accumulated on the policy before the merger or consolidation.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 824.102. EFFECT OF MERGER OR CONSOLIDATION ON CERTAIN INVESTMENTS. (a) This section applies to each investment of an affected corporation, including an investment in real property, that:

(1) was authorized as a proper asset, as of the date on which the investment was made and under the laws of the state in which the insurance corporation was organized, for investment of funds of an insurance corporation; and

(2) is taken over by the new or surviving corporation under the terms of the merger or consolidation.

(b) On the merger or consolidation of two or more insurance corporations under this chapter, an investment of the affected corporations described by Subsection (a) is a proper asset under the laws of this state of the new or surviving corporation if the investment is:

(1) approved by the commissioner; and

(2) taken over on terms satisfactory to the commissioner.

(c) A new or surviving corporation that acquires, under the terms of the merger or consolidation, real property that exceeds the amount of real property permitted by the applicable sections of this code relating to owning or holding real property must sell and dispose of the excess real property:

(1) within the period specified by those sections; or

(2) within a longer period if the corporation obtains a certificate from the commissioner:

(A) stating that the interests of the corporation will materially suffer by the forced sale of the affected real property;

and

(B) specifying the longer period for the sale of the excess real property.

(d) This section does not preclude the designation and use of the acquired excess real property as branch offices in accordance with this code.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 824.103. RETIREMENT AND CANCELLATION OF TREASURY SHARES.

(a) After a merger or consolidation is completed, any shares of the new or surviving corporation acquired by that corporation as a result of distribution of shares to the shareholders of another corporation that is merged or consolidated or as a result of purchase of shares of dissenting shareholders, may be held as treasury shares until the first anniversary of the date on which the merger or consolidation takes effect.

(b) After the period during which shares described by Subsection (a) are held as treasury shares, the corporation shall retire and cancel those shares by proper amendments to its charter if the shares have not previously been reissued.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 824.104. EFFECT ON ANTITRUST LAWS. This chapter does not affect in any manner the antitrust laws of this state.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER D. MERGER OR CONSOLIDATION OF LIFE INSURANCE CORPORATIONS

Sec. 824.151. PURCHASE OF OUTSTANDING SHARES BY LIFE INSURANCE CORPORATION. (a) A life insurance corporation may purchase or contract to purchase all or part of the outstanding shares of another life insurance corporation for purposes of merger or consolidation.

(b) Except as provided by Section 824.152, the provisions of Subchapter D, Chapter 425, that limit investments in the corporate stock of another corporation do not apply to a purchase made under this section.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.013,
eff. April 1, 2009.

Sec. 824.152. LIMITATIONS ON PURCHASE OF OUTSTANDING SHARES BY LIFE INSURANCE CORPORATION. (a) A purchase or contract to purchase under Section 824.151 is subject to this section.

(b) The intention to merge or consolidate must be evidenced by a resolution adopted by the board of directors of the purchasing corporation on or before the purchase of the shares or the execution of a contract to purchase the shares.

(c) The purchasing corporation shall obtain or seek to obtain at least the number of shares of the other insurance corporation necessary to vote an approval of the merger or consolidation under the laws of the state in which the other insurance corporation is organized, by one or more of the following means:

(1) initially purchasing or contracting to purchase the shares; or

(2) offering to purchase, making a tender offer for, requesting or inviting tenders of, or otherwise seeking to acquire the shares in the open market or otherwise.

(d) A purchase, offer to purchase, tender offer, request to purchase, or invitation to purchase shares in excess of the limits imposed under Subchapter D, Chapter 425, may not be made until it is filed with and approved by the commissioner in accordance with Chapter 823.

(e) Following the earlier of the date of the contract to purchase the shares or the date of the commissioner's approval of the purchase, offer to purchase, tender offer, or request or an invitation to purchase the shares, the corporation the shares of which are being purchased may not purchase or contract to purchase any of its own shares as treasury shares, issue or contract to issue any of its authorized but unissued shares, or make any investments in or loans to the purchasing corporation or any of its affiliates unless the investment or loan is otherwise authorized and approved in advance by the commissioner under Chapter 823.

(f) The merger or consolidation must take effect on or before December 31 of the second year after the earlier of the year in which

the initial purchase of the shares is made or the year in which the initial contract to purchase is executed unless the commissioner for good cause shown extends that period.

(g) If the merger or consolidation does not take effect within the period finally determined and extended by the commissioner, the purchasing corporation must sell or otherwise dispose of the purchased shares that exceed the investment limitations imposed under Subchapter D, Chapter 425, within six months of the final effective date.

(h) Amounts actually paid by the purchasing corporation for the purchase of shares acquired or obtained under this subchapter may not include the minimum capital, minimum surplus, and policy reserves required by law for the purchasing corporation.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.014, eff. April 1, 2009.

**CHAPTER 825. CONVERSION OF STOCK INSURANCE COMPANY TO MUTUAL
INSURANCE COMPANY**

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 825.001. DEFINITIONS. In this chapter:

(1) "Converting company" means a stock insurance company that converts to a mutual insurance company under this chapter.

(2) "Resulting company" means a mutual insurance company to which a stock insurance company converts under this chapter.

(3) "Stock acquisition plan" means a converting company's plan for the acquisition of shares of its capital stock.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 825.002. AUTHORITY TO CONVERT TO MUTUAL INSURANCE COMPANY.

(a) A domestic stock insurance company, as defined by law, may convert to a mutual insurance company.

(b) To convert to a mutual insurance company, a stock insurance company must implement a plan for the acquisition of shares of its capital stock.

(c) In implementing a stock acquisition plan under this

chapter, a converting company may acquire shares of its stock by gift, bequest, or purchase.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER B. STOCK ACQUISITION PLAN

Sec. 825.051. CONTENTS OF STOCK ACQUISITION PLAN. (a) A stock acquisition plan must:

- (1) be adopted by a vote of a majority of the directors of the corporation at a directors' meeting called for that purpose;
- (2) be approved by a vote of shareholders representing a majority of the capital stock at a meeting of shareholders called for that purpose;
- (3) enable each shareholder to dispose of the same proportion of the shareholder's holdings at the same price per share and on the same terms as any other shareholder;
- (4) be approved by a vote of the majority of the policyholders eligible under Section 825.054 to participate at a meeting of the policyholders called for that purpose; and
- (5) be submitted to the commissioner and approved by the commissioner in writing.

(b) If the purchase price for the company's acquisition of shares of its capital stock is not set by the stock acquisition plan, each payment for those shares is subject to the commissioner's approval.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 825.052. SUFFICIENT ASSETS REQUIRED. The commissioner may not approve a stock acquisition plan or a payment for stock under Section 825.051(b) unless, at the time of the approval, the company has assets equal to at least \$500,000 more than the entire liability of the company, including the net values of its outstanding contracts computed as required by law, and all funds and contingent reserves, after deducting:

- (1) the aggregate amount allocated by the plan for the acquisition of any part or all of its capital stock, to be paid in cash or other assets of the company; and
- (2) the amount of any payment not set by the plan and

subject to separate approval by the commissioner after the approval of the plan.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 825.053. STOCK ACQUISITION PLAN APPROVAL. A policyholders' meeting for approval of a stock acquisition plan may not be called until Sections 825.051(a)(1) and (2) are satisfied.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 825.054. POLICYHOLDER ELIGIBILITY. To be eligible to participate in a policyholders' meeting held to approve a stock acquisition plan, a policyholder must have insurance coverage issued by the converting company that:

- (1) is in the amount of at least \$1,000;
- (2) is in force on the date of the policyholders' meeting;

and

(3) has been in force for at least one year before the date of the policyholders' meeting.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 825.055. POLICYHOLDERS' MEETING. (a) A converting company shall give notice of the policyholders' meeting to each eligible policyholder.

(b) The notice must be mailed from the home office of the converting company not later than the 31st day before the scheduled date of the meeting in a sealed envelope, postage prepaid, to the policyholder at the policyholder's last known mailing address.

(c) The policyholders' meeting shall be conducted in the manner provided by the stock acquisition plan.

(d) The commissioner shall supervise and direct the procedure of the policyholders' meeting. The converting company shall pay all necessary expenses incurred by the commissioner as certified by the commissioner.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 825.056. POLICYHOLDER VOTING. (a) A policyholder may vote in person, by proxy, or by mail. All votes must be cast by ballot.

(b) The commissioner shall appoint an adequate number of inspectors to conduct the voting at the policyholders' meeting.

(c) The inspectors determine all questions concerning the verification of the ballots, the validity of the ballots, the qualification of the voters, and the canvass of the vote and shall certify the results to the commissioner and the converting company.

(d) An inspector shall act under rules prescribed by the commissioner.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER C. ACQUISITION OF SHARES

Sec. 825.101. ISSUANCE OF ANNUITY BONDS IN PAYMENT OF STOCK.

(a) A stock acquisition plan may provide that all or part of the purchase price of any part or all of the shares of stock of a converting company that are acquired by the company under the plan may be paid by the company through the issuance of annuity bonds payable in annual amounts and for the term provided by the plan.

(b) Each annuity bond issued under Subsection (a) must expressly provide, on the face of the bond, that the bond is payable only out of the surplus of the converting company remaining after all liabilities, including reserves, are provided for and is not otherwise a liability or claim against the converting company or any of its assets, as provided by Section 882.253.

(c) Not more than three-fourths of the net earnings of the converting company during any calendar year may be used or applied to the payment of the annuity bonds.

(d) On the approval of the commissioner, the company issuing the annuity bonds or any life insurance company may invest its funds in the annuity bonds. The investment in the annuity bonds may not at any time exceed 10 percent of the company's total admitted assets.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 825.102. ACQUISITION IN TRUST. (a) Until all of the shares of a converting company are acquired, any shares acquired under the stock acquisition plan shall be held in trust for the policyholders of the converting company by three trustees appointed as provided by the stock acquisition plan.

(b) Each appointee must file with the converting company a verified acceptance of the appointment and a declaration that the appointee will faithfully discharge the appointee's duties.

(c) The shares shall be assigned and transferred on the books of the converting company to the trustees. The trustees shall vote the shares at each meeting at which shareholders are entitled to vote, until all the capital stock of the converting company is canceled under Section 825.104.

(d) After paying the necessary expenses of executing the trust, the trustees shall immediately pay all dividends and other amounts received on the shares of stock acquired under Section 825.101 to the converting company for the benefit of those who are or become policyholders of the resulting company entitled to participate in the profits of the resulting company.

(e) All amounts received by the converting company under Subsection (d) shall be added to the surplus earned by the resulting company and accordingly are apportionable as a part of the surplus among the resulting company's policyholders.

(f) A vacancy among the trustees shall be filled as provided by the stock acquisition plan.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 825.103. DISTRIBUTION OF DIVIDENDS. After conversion, the converting company shall annually distribute among its policyholders, under terms approved by the commissioner, dividends or earnings accruing to the converting company as the result of the acquisition of shares of the converting company's stock under this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 825.104. CONVERSION COMPLETE ON CANCELLATION OF STOCK; APPLICATION OF CERTAIN LAWS. (a) When the converting company acquires all of its capital stock and the purchase price for that

stock, including any annuity bond issued for the purchase of the stock, is paid in full, the stock shall be canceled.

(b) On cancellation of the stock, the converting company becomes a mutual insurance company without capital stock and is subject to the laws of this state governing mutual insurance companies.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

**CHAPTER 826. CONVERSION OF MUTUAL INSURANCE COMPANY TO STOCK
INSURANCE COMPANY**

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 826.001. DEFINITIONS. In this chapter:

(1) "Conversion plan" means a plan adopted under this chapter to convert a mutual insurance company into a stock insurance company.

(2) "Converting company" means a domestic mutual insurance company that is converting under this chapter into a domestic stock insurance company.

(3) "Eligible member" means a member of a converting company whose policy is in force on the date that the company's board of directors adopts a conversion plan. The term does not include a person insured under a group policy.

(4) "Mutual insurance company" means a domestic mutual insurance company.

(5) "Participating policy" means a policy issued by a mutual insurance company that grants a holder the right to receive declared dividends.

(6) "Resulting company" means a domestic stock insurance company that has converted under this chapter from a domestic mutual insurance company.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 826.002. AUTHORITY TO CONVERT TO STOCK INSURANCE COMPANY.

(a) A mutual insurance company may convert to a stock insurance company.

(b) A converting company may not engage in the business of insurance as a stock insurance company until it complies with the

requirements of this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 826.003. RIGHTS AND PRIVILEGES OF RESULTING COMPANY; LAWS APPLICABLE. Except as provided by this chapter, a resulting company:

(1) may exercise only the rights and privileges of a stock insurance company; and

(2) is subject to:

(A) all of the requirements and rules imposed on stock insurance companies organized under this code; and

(B) the laws of this state relating to the regulation or supervision of insurance companies.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 826.004. CERTAIN CONVERSIONS PROHIBITED. A mutual insurance company may not convert to a stock insurance company under this chapter if, as a direct result of the conversion, any affiliate or other person acquires control of the resulting company, unless that affiliate or person complies with Section 823.154.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 826.005. CORPORATE EXISTENCE. (a) On the effective date of a conversion under this chapter:

(1) the corporate existence of the converting company continues in the resulting company;

(2) all assets, rights, franchises, and interests of the converting company in and to property and any accompanying thing in action are vested in the resulting company without a deed or transfer; and

(3) the resulting company assumes all the obligations and liabilities of the converting company.

(b) Except as otherwise specified by the conversion plan, the directors and officers of the converting company serving on the effective date of the conversion serve as directors and officers of the resulting company until new directors and officers are elected

under the articles of incorporation and bylaws of the resulting company.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER B. CONVERSION PLAN ADOPTION AND REQUIREMENTS

Sec. 826.051. PLAN ADOPTION. (a) To convert to a stock insurance company a mutual insurance company must adopt, by the affirmative vote of at least two-thirds of the members of its board of directors, a conversion plan consistent with this chapter.

(b) For a conversion plan to take effect:

- (1) the commissioner must approve the conversion plan; and
- (2) the eligible members must approve the conversion plan and adopt the amended or restated articles of incorporation of the resulting company.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 826.052. GENERAL REQUIREMENTS; EFFECT OF CONVERSION ON POLICIES. (a) Each conversion plan must include the provisions required by this chapter.

(b) Each policy in effect on the effective date of the conversion remains in effect under the terms of that policy, except that the following rights, to the extent they existed in the converting company, are extinguished on the effective date of the conversion:

- (1) any voting rights of policyholders;
- (2) except as provided by Subsection (c), a right to share in the surplus or profits of the converting company; and
- (3) any assessment provisions.

(c) The holder of a participating policy in effect on the effective date of the conversion continues to have a right to receive dividends as provided by the participating policy.

(d) On the renewal date of a participating policy, the resulting company may issue to the insured a nonparticipating policy as a substitute for the participating policy, unless the participating policy is:

- (1) a guaranteed renewable accident and health policy; or
- (2) a guaranteed renewable, noncancellable accident and

health policy.

(e) All the costs and expenses connected with a conversion plan shall be paid or reimbursed by the converting company or the resulting company.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 826.053. SALE OF CAPITAL STOCK. A conversion plan must provide that shares of capital stock of the resulting company shall be sold in a private placement, public offering, or an alternative method approved by the commissioner unless the shares are:

- (1) sold or distributed to a holder of surplus notes of the converting company; or
- (2) subscribed to by:
 - (A) a tax-qualified employee benefit plan under Section 826.059;
 - (B) a director or officer under Section 826.056(b); or
 - (C) an eligible member exercising subscription rights under Section 826.058.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 826.054. PURCHASE PRICE OF CAPITAL STOCK. (a) A conversion plan must set the total price of the capital stock in an amount equal to the estimated pro forma market value of the resulting company based on an independent valuation by a qualified expert, giving consideration to the amount of capital that the board of directors considers necessary to be raised by the company. The pro forma market value may be the value estimated to be necessary to attract full subscription for the shares, as indicated by the independent valuation, and may be stated as a range of values.

(b) The conversion plan may set the purchase price for a share of capital stock at any reasonable amount. The price per share is not required to be the same for each class of purchaser. However, eligible members purchasing stock under subscription rights received under Section 826.058 may purchase shares at the lowest available price under the plan.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 826.055. LIMITATION ON ACQUISITION OF CAPITAL STOCK. (a) The conversion plan must provide that a person or group of persons acting in concert may not acquire, in the public or private offering or through the exercise of subscription rights, more than 10 percent of the capital stock of the resulting company except with the approval of the commissioner.

(b) This section does not apply to an entity that purchases 100 percent of the capital stock of the resulting company as part of the conversion plan approved by the commissioner.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 826.056. DIRECTORS AND OFFICERS. (a) Except as otherwise provided by this section, the conversion plan must provide that a director or officer of the converting company, or a person acting in concert with a director or officer, may not acquire, without the permission of the commissioner, any capital stock of the resulting company or the stock of another corporation that is participating in the conversion plan before the third anniversary of the effective date of the conversion. This subsection does not prohibit a director or officer from:

- (1) acquiring capital stock through a broker-dealer;
- (2) making purchases through the exercise of subscription rights received under the conversion plan; or
- (3) participating in a stock benefit plan permitted by Section 826.059 or approved by the eligible members under Section 826.107.

(b) A conversion plan may provide that the directors and officers of the converting company may receive, without payment, nontransferable subscription rights to purchase capital stock of the resulting company or the stock of another corporation that is participating in the conversion plan.

(c) The aggregate number of shares that may be purchased by directors and officers under Subsection (b) may not exceed:

- (1) 35 percent of the total number of shares to be issued for the resulting company if the total assets of the converting company are less than \$50 million; or

(2) 25 percent of the total number of shares to be issued for the resulting company if the total assets of the converting company are more than \$500 million.

(d) For converting companies with total assets between \$50 million and \$500 million, inclusive, the maximum percentage of the total number of shares that may be purchased shall be interpolated from amounts provided under Subsection (c).

(e) A conversion plan must provide that a director or officer of the converting company may not sell stock purchased under the conversion plan before the first anniversary of the effective date of the conversion.

(f) Notwithstanding Subsection (e), a conversion plan may provide for the purchase or redemption of stock in the event that a director or officer is no longer associated with the resulting company during the period described by Subsection (e).

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 826.057. RIGHTS OF HOLDER OF SURPLUS NOTES. A conversion plan must provide that any rights of a holder of a surplus note to participate in the conversion are governed by the terms of the surplus note.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 826.058. SUBSCRIPTION RIGHTS; GENERAL PROVISIONS. (a) Except for an alternate conversion plan adopted under Section 826.061, each conversion plan must specify the subscription rights of eligible members.

(b) The conversion plan must provide that:

(1) each eligible member is to receive, without payment by the member, nontransferable subscription rights to purchase a portion of the capital stock of the resulting company; and

(2) in the aggregate, all eligible members have the right, before the right of any other party, to purchase 100 percent of the capital stock of the resulting company after provision for:

(A) capital stock required to be sold or distributed to the holders of surplus notes, if any;

(B) capital stock purchased by a stock benefit plan as

permitted by Section 826.059; and

(C) capital stock acquired by the directors and officers, as permitted by Section 826.056(b).

(c) As an alternative to subscription rights in the resulting company, the conversion plan may provide that each eligible member is to receive, without payment by the member, nontransferable subscription rights to purchase a portion of the capital stock of:

(1) a corporation organized for the purpose of purchasing and holding all the stock of the resulting company;

(2) a stock insurance company owned by the converting company into which the converting company is to be merged; or

(3) an unaffiliated stock insurance company or other corporation that is to purchase all the stock of the resulting company.

(d) The conversion plan must provide that the subscription rights are allocated in whole shares among the eligible members using a fair and equitable formula. The formula may consider that the different classes of policies of the eligible members contributed to the surplus of the converting company or any other factors that may be fair or equitable as determined by the board of directors.

(e) The conversion plan must provide a fair and equitable method for allocating shares of capital stock in the event of an oversubscription to shares by eligible members exercising subscription rights under this section.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 826.059. SUBSCRIPTION RIGHTS; TAX-QUALIFIED EMPLOYEE BENEFIT PLAN. The conversion plan may allocate to a tax-qualified employee benefit plan nontransferable subscription rights to purchase not more than 10 percent of the capital stock of the resulting company.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 826.060. LIQUIDATION ACCOUNT. (a) The conversion plan may provide for the creation of a liquidation account for the benefit of members in the event of a voluntary liquidation after the conversion.

(b) The liquidation account must be in an amount equal to the surplus of the converting company, exclusive of the principal amount of any surplus note, on the last day of the quarter preceding the date the conversion plan is adopted.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 826.061. ALTERNATE CONVERSION PLAN. (a) The board of directors may adopt a conversion plan that does not rely in whole or in part on the issuance of nontransferable subscription rights to members to purchase stock of the resulting company if the commissioner determines that the plan:

- (1) complies with this chapter;
- (2) is fair and equitable; and
- (3) permits the resulting company to satisfy the requirements in effect on the date of the determination for a certificate of authority applicable to a domestic stock insurance company.

(b) The conversion plan may:

- (1) include the merger of a domestic mutual insurance company with a domestic or foreign stock insurance company;
- (2) provide for issuing stock, cash, or other consideration to members instead of subscription rights;
- (3) provide for the formation of a mutual holding company under Subchapter E; or
- (4) establish another plan containing other provisions approved by the commissioner.

(c) The commissioner may retain, at the converting company's expense, a qualified expert who is not a member of the commissioner's staff to assist in reviewing whether the conversion plan meets the requirements for approval by the commissioner.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER C. ADOPTION OF CONVERSION PLAN

Sec. 826.101. PLAN INFORMATION FILED WITH COMMISSIONER; COMMISSIONER POWERS AND DUTIES. Not later than the 90th day after the date on which a converting company's board of directors adopts a conversion plan, the company shall file with the commissioner:

- (1) a copy of the documents relating to the conversion plan, including the valuation required by Section 826.054(a);
- (2) the form of notice required by Section 826.104;
- (3) the form of proxy to be solicited from eligible members under Section 826.107(a);
- (4) the form of notice required by Section 826.151 to persons whose policies are issued after adoption of the conversion plan but before the effective date of the conversion plan;
- (5) the proposed amended or restated articles of incorporation of the resulting company;
- (6) a statement regarding acquisition of control, if applicable, as required by Chapter 823; and
- (7) any other information requested by the commissioner.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 826.102. APPROVAL OF PLAN BY COMMISSIONER. (a) The commissioner shall approve a conversion plan if the commissioner determines that:

- (1) the plan complies with this chapter;
- (2) the plan's method of allocating subscription rights or other value is fair and equitable; and
- (3) the resulting company would satisfy the requirements applicable to a domestic stock insurance company for a certificate of authority on the date of the determination.

(b) Except as otherwise provided by this section, the commissioner shall approve or disapprove a conversion plan not later than the 60th day after the first day on which all the documents required under Section 826.101 are filed with the commissioner.

(c) The commissioner may extend the time for decision by an additional 30 days on written notice to the converting company. Except as provided under Subsection (e), the commissioner may not extend the time for decision beyond that 30-day period.

(d) The commissioner shall immediately give written notice to the converting company of the commissioner's decision and, if the commissioner disapproves the plan, a detailed statement of the reasons for the disapproval.

(e) The commissioner may retain, at the mutual insurance company's expense, a qualified expert who is not a member of the

commissioner's staff to assist the commissioner in reviewing the conversion plan and the valuation required under Section 826.054(a). If the commissioner retains a qualified expert under this subsection, the commissioner may extend the period for decision by an additional 60 days beyond the initial 60-day period.

(f) After giving written notice to the converting company and other interested persons, the commissioner may hold a hearing on whether the conversion plan complies with this chapter. The company and any other interested person have the right to appear at the hearing. Notice to interested persons who have not filed an appearance in the matter may be made through publication in the Texas Register.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 826.103. AMENDMENTS; WITHDRAWAL OF PLAN. Before a conversion plan takes effect, a converting company may amend or withdraw the plan by the affirmative vote of at least two-thirds of the members of its board of directors.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 826.104. NOTICE TO ELIGIBLE MEMBERS; COMMENTS. (a) Not later than the 10th business day after the date of filing with the commissioner the documents required under Section 826.101, the converting company shall send to each eligible member a notice advising the member of:

(1) the adoption and filing of the conversion plan; and
(2) the member's right to comment on the plan to the commissioner and the converting company.

(b) The notice must include a description of the procedure to be used in making comments. An eligible member who elects to make comments must make the comments in writing not later than the 30th day after the date on which the notice is sent.

(c) Not later than the 60th day after the date of the commissioner's approval of the plan, the converting company shall send to each eligible member notice of the members' meeting to vote on the conversion plan. The notice must be sent to the member's last known address, as shown on the converting company's records, before

the 30th day preceding the date set for the meeting. The notice must:

- (1) briefly but fairly describe the proposed conversion plan; and
- (2) inform the member of the member's right to vote on the conversion plan.

(d) If the meeting to vote on the conversion plan is held during the converting company's annual meeting of policyholders, a combined meeting notice satisfies the requirements of this section.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 826.105. SUBSTANTIAL COMPLIANCE WITH NOTICE REQUIREMENTS. If the converting company in good faith substantially complies with the notice requirements of this chapter, the company's failure to send a member the required notice does not impair the validity of an action taken under this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 826.106. INSOLVENT CONVERTING COMPANY; NOTICE REQUIREMENTS. If a converting company is insolvent or, in the judgment of the commissioner, is in hazardous financial condition, its board of directors, by a majority vote, may request in its submission to the commissioner a waiver of the requirements for notice to and approval of the proposed conversion by eligible members. The request must specify:

- (1) the method and basis for the issuance of the resulting company's shares of its capital stock to an independent party in connection with an investment by the independent party in an amount sufficient to restore the resulting company to a sound financial condition; and
- (2) that the conversion is to be accomplished without payment of consideration to past, present, or future policyholders if the commissioner determines that the value of the converting company is insufficient to justify that payment.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 826.107. ELECTION; APPROVAL OF PLAN; ADOPTION OF AMENDED OR RESTATED ARTICLES OF INCORPORATION. (a) At a meeting convened to consider the conversion plan, an eligible member entitled to vote on the proposed conversion plan may vote in person or by proxy. The number of votes each eligible member may cast is determined by the converting company's bylaws. If the bylaws do not contain an applicable provision, each member may cast one vote. Before the eligible members may vote on approval of a conversion plan, the converting company must comply with Sections 826.101 and 826.102.

(b) At the meeting held to vote on the conversion plan, the eligible members shall also consider the adoption of amended or restated articles of incorporation.

(c) Adoption of the conversion plan or adoption of amended articles of incorporation requires the affirmative vote of at least two-thirds of the votes cast by eligible members.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 826.108. FILING OF MINUTES, ARTICLES OF INCORPORATION, AND BYLAWS; EFFECTIVE DATE OF CONVERSION. (a) Not later than the 30th day after the date on which the eligible members approve the conversion plan, the converting company shall file with the commissioner:

(1) the minutes of the meeting at which the plan was approved; and

(2) the amended or restated articles of incorporation and bylaws of the resulting company.

(b) A conversion plan takes effect on the date that the amended or restated articles of incorporation are filed with the commissioner.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 826.109. CONFLICT OF INTEREST. (a) Except as provided by a conversion plan approved by the commissioner or this section, a director, officer, agent, or employee of a converting company may not receive a fee, commission, or other consideration, other than that person's usual salary or compensation, for aiding, promoting, or assisting in a conversion under this chapter.

(b) This section does not prohibit the payment of reasonable fees and compensation to an attorney, accountant, or actuary for professional services performed by that person, even if the person is also a director or officer of the converting company.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 826.110. LIMITATION ON ACTIONS. An action challenging the validity of or arising out of acts taken or proposed to be taken regarding a conversion plan under this chapter must be commenced not later than the 30th day after the effective date of the conversion plan.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER D. RIGHTS OF MEMBERS ON CONVERSION

Sec. 826.151. RIGHTS OF MEMBERS WHOSE POLICIES ARE ISSUED AFTER ADOPTION OF CONVERSION PLAN BUT BEFORE EFFECTIVE DATE. (a) On issuance of a policy after a conversion plan has been adopted by the board of directors but before the effective date of the conversion plan, the converting company shall send to each member to whom a policy is issued a written notice regarding the conversion plan.

(b) Except as provided by Subsection (d), a member of an accident and health insurance company entitled to notice under Subsection (a) is entitled to rescind the member's policy and receive a full refund of any amount paid for the policy not later than the 10th day after the date on which the notice is received.

(c) Except as provided by Subsection (d), each member insured under a property or casualty insurance policy is entitled to notice under Subsection (a) and shall be advised of the member's right to:

- (1) cancel the policy; and
- (2) receive a pro rata refund of unearned premiums.

(d) A member who has made or filed a claim under the insurance policy is not entitled to a refund under Subsection (b) or (c). A member who has exercised a right provided by Subsection (b) or (c) may not make or file a claim under the insurance policy.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 826.152. AMENDMENT OF POLICIES. A converting company, by endorsement or rider approved by the commissioner and sent to the policyholder, may simultaneously with or at any time after the adoption of a conversion plan amend an insurance policy in effect to terminate a right of the holder of the policy to share in the surplus or profits of the converting company. The amendment is void if the conversion plan does not take effect.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER E. CONVERSION THROUGH MUTUAL HOLDING COMPANY

Sec. 826.201. CONVERSION THROUGH CREATION OF HOLDING COMPANY.

(a) A converting company, on approval by the commissioner, may reorganize by forming a holding company based on a mutual plan and continuing the corporate existence of the converting company as a stock insurance company.

(b) A mutual holding company is considered an insurer subject to this chapter and Chapter 883. A mutual holding company is automatically a party to an administrative proceeding under this code involving an insurance company that, as a result of a reorganization under this subchapter, is a subsidiary of the mutual holding company. In any proceeding involving the resulting company, the assets of the mutual holding company are considered assets of the resulting company for purposes of satisfying the claims of the resulting company's policyholders.

(c) A mutual holding company may not dissolve or liquidate without the approval of the commissioner.

(d) A mutual holding company may convert to a stock holding company under this chapter as if the mutual holding company were a mutual insurance company.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 826.202. COMMISSIONER POWERS AND DUTIES; APPROVAL. (a) The commissioner shall review the proposed plan of reorganization as an alternate conversion plan under Section 826.061. The commissioner may require as a condition of approval modifications of the proposed plan of reorganization that the commissioner determines necessary to protect the members' interests.

(b) The commissioner may retain a qualified expert as provided by Section 826.102(e).

(c) The commissioner has jurisdiction over a mutual holding company organized under this subchapter to ensure that member interests are protected.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 826.203. APPLICABILITY OF CERTAIN LAWS; INCORPORATION. A mutual holding company that results from the reorganization of a domestic mutual insurance company organized under Chapter 883 must be organized under Sections 883.051, 883.052, 883.054, and 883.056. The articles of incorporation, and any amendments to those articles, of the mutual holding company are subject to approval of the commissioner in the same manner as those of a mutual insurance company.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 826.204. MEMBERSHIP INTERESTS. (a) The membership interests of the policyholders of the resulting company become membership interests in the mutual holding company. Eligible members of the converting company become members of the mutual holding company in accordance with the articles of incorporation and bylaws of the mutual holding company.

(b) A membership interest in a mutual holding company does not constitute a security as defined by Section 4001.068, Government Code.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 491 (H.B. [4171](#)), Sec. 2.30, eff. January 1, 2022.

Sec. 826.205. CAPITAL STOCK HELD BY MUTUAL HOLDING COMPANY.

(a) In this section:

(1) "Intermediate holding company" means a holding company that:

(A) is a subsidiary of a mutual holding company formed to reorganize a mutual insurance company; and

(B) directly or through a subsidiary intermediate holding company, owns the resulting company.

(2) "Majority of the voting shares of the capital stock" means shares of the capital stock of a company that carry the right to cast a majority of the votes entitled to be cast by all of the outstanding shares of the capital stock of the company on all matters submitted to a vote of the shareholders of the company.

(b) All of the initial shares of the capital stock of the resulting company shall be issued to the mutual holding company.

(c) The mutual holding company shall at all times own a majority of the voting shares of the capital stock of the resulting company or of an intermediate holding company established to hold the voting shares of the resulting company. The requirements of this subsection may be satisfied by indirect ownership through one or more intermediate holding companies in a corporate structure approved by the commissioner.

(d) The mutual holding company or intermediate holding company may not convey, transfer, assign, pledge, subject to a security interest or lien, encumber, or otherwise hypothecate or alienate the majority of the voting shares of the capital stock that is required to be owned under Subsection (c).

(e) A violation of Subsection (d) is void in inverse chronological order from the date of the conveyance or activity as to the shares necessary to constitute a majority of the voting shares of the capital stock.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 826.206. CONVERSION OF FOREIGN MUTUAL INSURANCE COMPANY.

(a) On the approval of the commissioner, a foreign mutual insurance company may reorganize in compliance with the requirements of any law or regulation applicable to the foreign mutual insurance company by:

(1) transferring its members' membership interests into a mutual holding company formed under a procedure analogous to that described by this subchapter; and

(2) continuing the corporate existence of the reorganizing foreign mutual insurance company as a foreign stock insurance company

subsidiary of the mutual holding company.

(b) The reorganizing foreign mutual insurance company may remain a foreign company and may be admitted to do business in this state. A foreign mutual insurance company may also redomesticate in this state by complying with the applicable requirements of Chapter 983.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

CHAPTER 827. WITHDRAWAL AND RESTRICTION PLANS

Sec. 827.001. DEFINITIONS. In this chapter:

(1) "Insurer" means an insurance company or other legal entity authorized to engage in the business of insurance in this state, including a reciprocal or interinsurance exchange, a Lloyd's plan, and a county mutual insurance company. The term includes an affiliate. The term does not include a farm mutual insurance company or an eligible surplus lines insurer regulated under Chapter 981.

(2) "Rating territory" means a rating territory established by the department.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 206, Sec. 10.01(a), eff. June 11, 2003.

Sec. 827.002. EXEMPTION. This chapter does not apply to a transfer of business from an insurer to a company that:

(1) is within the same insurance group as the insurer;
(2) is authorized to engage in the business of insurance in this state; and

(3) is not a reciprocal or interinsurance exchange, a Lloyd's plan, a county mutual insurance company, or a farm mutual insurance company.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 206, Sec. 10.02, eff. June 1, 2003.

Sec. 827.003. WITHDRAWAL PLAN REQUIRED. An insurer shall file

with the commissioner a plan for orderly withdrawal if the insurer proposes to:

(1) reduce the insurer's total annual premium volume by 50 percent or more;

(2) reduce the insurer's annual premium by 75 percent or more in a line of insurance in this state; or

(3) reduce in this state, or in any applicable rating territory, the insurer's total annual premium volume in a line of personal automobile or residential property insurance by 50 percent or more.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 206, Sec. 10.03, eff. June 11, 2003.

Sec. 827.004. PROVISIONS OF WITHDRAWAL PLAN. A withdrawal plan filed under Section 827.003 must:

(1) be constructed to protect the interests of the people of this state;

(2) indicate the dates on which the insurer intends to begin and to complete the plan; and

(3) provide for:

(A) meeting the insurer's contractual obligations;

(B) providing service to the insurer's policyholders and claimants in this state; and

(C) meeting any applicable statutory obligations, such as payment of assessments to the guaranty fund and participation in an assigned risk plan or joint underwriting arrangement.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 827.005. APPROVAL OF WITHDRAWAL PLAN. (a) Except as provided by Subsection (b), the commissioner shall approve a withdrawal plan that adequately provides for meeting the requirements prescribed by Section 827.004(3).

(b) The commissioner may modify, restrict, or limit a withdrawal plan under this section as necessary if the commissioner finds that a line of insurance subject to the withdrawal plan is not offered in a quantity or manner to adequately cover the risks in this

state or to adequately protect the residents of this state and policyholders in this state. The commissioner may by order set the date on which the insurer's withdrawal begins.

(c) A withdrawal plan is deemed approved if the commissioner:

- (1) does not hold a hearing on the plan before the 61st day after the date the plan is filed with the commissioner; or
- (2) does not deny approval before the 61st day after the date a hearing on the plan is held.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 206, Sec. 10.04, eff. June 11, 2003.

Sec. 827.006. RESUMPTION OF WRITING INSURANCE AFTER COMPLETE WITHDRAWAL. An insurer that withdraws from writing all lines of insurance in this state may not, without the approval of the commissioner, resume writing insurance in this state before the fifth anniversary of the date of withdrawal.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 827.007. PENALTIES. The commissioner may impose the civil penalties under Chapter 82 on an insurer that fails to obtain the commissioner's approval before the insurer:

- (1) withdraws from writing a line of insurance in this state; or
- (2) reduces the insurer's total annual premium volume by 75 percent or more in any year.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 827.008. RESTRICTION PLAN. (a) Before an insurer, in response to a catastrophic natural event that occurred during the preceding six months, may restrict writing new business in a rating territory in a line of personal automobile or residential property insurance, the insurer must file a proposed restriction plan with the commissioner for the commissioner's review and approval.

(b) The commissioner may modify, restrict, or limit a

restriction plan under this section as necessary if the commissioner finds that a line of insurance subject to the restriction plan is not offered in this state in a quantity or manner to adequately cover the risks in this state or to adequately protect the residents of this state and policyholders in this state in light of the impact of the catastrophic natural event. The commissioner may by order set the date on which the insurer's restriction begins.

(c) A withdrawal plan must be filed and approved under Sections 827.003 and 827.004 if an insurer's decision not to accept new business in a line of personal automobile or residential property insurance results in a reduction of the insurer's total annual premium volume by 50 percent or more.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 206, Sec. 10.05, eff. June 11, 2003.

Sec. 827.009. DEPOSIT OF SECURITIES. Under this chapter, the commissioner may require the deposit of securities in this state in trust in the name of the commissioner if the commissioner determines, after notice and hearing, that there is reasonable cause to conclude that the interests of the people of this state are best served by the deposit.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 827.010. MORATORIUM. (a) The commissioner may impose a moratorium of not longer than two years on:

(1) the approval of withdrawal plans; or
(2) the implementation of plans to restrict the writing of new business described by Section 827.008.

(b) A moratorium under this section may be imposed on plans implemented after the commissioner has published notice of intention to impose a moratorium on plans under Subsection (a)(2).

(c) The commissioner may annually renew a moratorium imposed under this section.

(d) To impose or renew a moratorium under this section, the commissioner must determine, after notice and hearing, that a catastrophic event has occurred and that as a result of that event a

particular line of insurance is not reasonably expected to be available to a substantial number of policyholders or potential policyholders in this state or, in the case of lines of personal automobile or residential property insurance, in a rating territory.

(e) The provisions of Chapter 2001, Government Code, relating to contested cases apply to the notice and hearing.

(f) The commissioner by rule shall establish reasonable criteria for applying the standards for determining whether to impose a moratorium under this section.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 206, Sec. 10.06(a), eff. June 11, 2003.

Sec. 827.011. RULES. The commissioner shall adopt rules as necessary to enforce this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

CHAPTER 828. PURCHASE OF STOCK FOR TOTAL ASSUMPTION REINSURANCE
SUBCHAPTER A. GENERAL PROVISIONS

Sec. 828.001. AUTHORITY TO PURCHASE STOCK FOR TOTAL ASSUMPTION REINSURANCE. This code does not affect the right of a life insurance company organized or operating under Chapter 841, 882, or 982 to purchase or contract to purchase all or part of the outstanding shares of another domestic or foreign life insurance company that engages in a similar line of business in order to:

- (1) reinsure all of the other company's business;
- (2) assume all of the other company's liabilities; and
- (3) take over all of the other company's assets.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 828.002. EFFECT ON ANTITRUST LAWS. This chapter does not affect in any manner the antitrust laws of this state.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 828.003. INVESTMENTS OF REINSURED COMPANY. The investments of a company reinsured under this chapter are subject to Section 824.102 as if the company had been merged or consolidated.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER B. EXCEPTION TO INVESTMENT LIMITATION

Sec. 828.051. EXCEPTION TO LIMITATION ON PURCHASING SHARES OF OTHER COMPANY. Subchapters C and D, Chapter 425, do not apply to a purchase or contract described by Section 828.001 if all requirements of this subchapter are met.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 2E.015, eff. April 1, 2009.

Sec. 828.052. RESOLUTION OF INTENTION TO REINSURE. The intention to reinsure must be evidenced by a resolution adopted by the board of directors of the purchasing company on or before the purchase of the shares or the execution of a contract to purchase the shares.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 828.053. MINIMUM STOCK ACQUISITION. The purchasing company shall obtain or seek to obtain at least the number of shares of the other insurance company necessary to vote an approval of the total assumption reinsurance agreement under the laws of the state in which the other insurance company is organized by one or more of the following means:

(1) initially purchasing or contracting to purchase the shares; or

(2) offering to purchase, making a tender offer for, requesting or inviting tenders of, or otherwise seeking to acquire the shares in the open market or otherwise.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 828.054. APPROVAL REQUIRED. A purchase, offer to purchase, tender offer, request to purchase, or invitation to purchase shares in excess of the limits imposed under Subchapter C or D, Chapter 425, may not be made until it is filed with and approved by the commissioner in accordance with Chapter 823.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.016, eff. April 1, 2009.

Sec. 828.055. RESTRICTIONS ON REINSURED COMPANY. Following the earlier of the date of the contract to purchase the shares or the date of the commissioner's approval of the purchase, offer to purchase, tender offer, request to purchase, or invitation to purchase the shares, the company the shares of which are being purchased may not purchase or contract to purchase any of its own shares as treasury shares, issue or contract to issue any of its authorized but unissued shares, or make any investments in or loans to the purchasing company or an affiliate of the purchasing company unless the investment or loan is otherwise authorized and approved in advance by the commissioner under Chapter 823.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 828.056. REQUIRED EFFECTIVE DATE OF REINSURANCE AGREEMENT; EFFECT OF FAILURE TO MEET REQUIRED EFFECTIVE DATE. (a) The reinsurance agreement must take effect on or before December 31 of the second year after the earlier of the year in which the initial purchase of shares is made or the year in which the initial contract to purchase is executed unless the commissioner for good cause shown extends that period.

(b) If the reinsurance agreement does not take effect within the period finally determined and extended by the commissioner, the purchasing company shall sell or otherwise dispose of the purchased shares that exceed the investment limitations imposed under Subchapter C or D, Chapter 425, within six months of the final

effective date.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.017, eff. April 1, 2009.

Sec. 828.057. PROHIBITION ON USE OF PURCHASING COMPANY'S CAPITAL, SURPLUS, OR RESERVES. Amounts actually paid by the purchasing company for the purchase of shares acquired or obtained under this subchapter may not include the minimum capital, minimum surplus, and policy reserves required by law for the purchasing company.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

CHAPTER 829. CONVERSION OF RECIPROCAL OR INTERINSURANCE EXCHANGE TO STOCK COMPANY THROUGH CREATION OF A MUTUAL HOLDING COMPANY

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 829.001. DEFINITIONS. In this chapter:

- (1) "Attorney in fact" has the meaning assigned by Section 942.001.
- (2) "Board of directors" means, as to an exchange, the board of directors, board of trustees, subscriber advisory committee, or other governing body appointed or elected by the subscribers of an exchange.
- (3) "Conversion plan" means a plan adopted under this chapter to convert an exchange to a stock insurance company and form a mutual holding company to hold, directly or indirectly, shares of the resulting company.
- (4) "Converting exchange" means an exchange that is converting to a stock insurance company under this chapter.
- (5) "Eligible member" means a member of a converting exchange whose policy is in force on the date that the converting exchange's board of directors adopts a conversion plan.
- (6) "Effective date" means the effective date of a conversion plan in accordance with Section 829.108.
- (7) "Exchange" has the meaning assigned by Section 942.001.
- (8) "Intermediate holding company" means a holding company

organized under the laws of this or another state that:

(A) is a subsidiary of a mutual holding company formed to reorganize an exchange; and

(B) directly or through a subsidiary intermediate holding company, owns at least a majority of the voting shares of the capital stock of the resulting company.

(9) "Member" means, as to an exchange, a subscriber of an exchange.

(10) "Mutual holding company" means a holding company based on a mutual plan and formed in connection with the conversion of an exchange to a stock insurance company under this chapter.

(11) "Participating policy" means a policy issued by an exchange that grants the policyholder the right to receive policy dividends if declared by the exchange.

(12) "Resulting company" means a stock insurance company resulting from the conversion of an exchange under this chapter.

(13) "Subscriber" has the meaning assigned by Section 942.001.

Added by Acts 2007, 80th Leg., R.S., Ch. 412 (S.B. 1056), Sec. 1, eff. June 15, 2007.

Sec. 829.002. AUTHORITY TO CONVERT THROUGH CREATION OF A MUTUAL HOLDING COMPANY. (a) An exchange may reorganize by converting to a stock insurance company and forming a mutual holding company to hold, directly or indirectly, shares of the resulting company or intermediate holding company in accordance with this chapter.

(b) A converting exchange may not engage in the business of insurance as a stock insurance company until it complies with the requirements of this chapter.

Added by Acts 2007, 80th Leg., R.S., Ch. 412 (S.B. 1056), Sec. 1, eff. June 15, 2007.

Sec. 829.003. RIGHTS AND PRIVILEGES OF RESULTING COMPANY; LAWS APPLICABLE. Except as provided by this chapter, the resulting company:

(1) may exercise only the rights and privileges of a stock insurance company; and

(2) is subject to:

(A) all of the requirements and rules imposed on stock insurance companies organized under this code; and

(B) the laws of this state relating to the regulation or supervision of insurance companies.

Added by Acts 2007, 80th Leg., R.S., Ch. 412 (S.B. 1056), Sec. 1, eff. June 15, 2007.

Sec. 829.004. MUTUAL HOLDING COMPANY; LAWS APPLICABLE. (a) Except as provided by this chapter, a mutual holding company is considered an insurer subject to this chapter and Chapter 883.

(b) The commissioner has jurisdiction over a mutual holding company organized under this chapter to ensure that member interests are protected.

(c) The mutual holding company is automatically a party to a delinquency proceeding under Subtitle C, Title 4, involving an insurance company that, as a result of a reorganization under this chapter, is a direct or indirect subsidiary of the mutual holding company. In any proceeding described by this subsection involving the resulting company, the assets of the mutual holding company are considered assets of the resulting company for purposes of satisfying the claims of the resulting company's policyholders.

(d) A mutual holding company that results from a reorganization of an exchange must be organized under Sections 883.051, 883.052, 883.054, and 883.056. The articles of incorporation of the mutual holding company, and any amendments to those articles, are subject to approval of the commissioner in the same manner as those of a mutual insurance company.

(e) The mutual holding company may not dissolve or liquidate without the approval of the commissioner.

(f) A mutual holding company formed under a conversion plan is not subject to:

(1) Article 2.11B, Texas Non-Profit Corporation Act (Article 1396-2.11B, Vernon's Texas Civil Statutes);

(2) Section B, Article 2.23, Texas Non-Profit Corporation Act (Article 1396-2.23, Vernon's Texas Civil Statutes);

(3) Section C, Article 2.23A, Texas Non-Profit Corporation Act (Article 1396-2.23A, Vernon's Texas Civil Statutes); or

(4) Sections 22.158, 22.351, and 22.353(b), Business Organizations Code.

Added by Acts 2007, 80th Leg., R.S., Ch. 412 (S.B. 1056), Sec. 1, eff. June 15, 2007.

Sec. 829.005. CONFLICT OF INTEREST. (a) Except as provided by a conversion plan approved by the commissioner or by this section, the following individuals may not receive a fee, commission, stock distribution, stock subscription rights, or other consideration, other than that individual's usual salary or compensation for aiding, promoting, assisting, or participating in a conversion under this chapter:

(1) a director, officer, agent, or employee of a converting exchange or the exchange's attorney in fact; or

(2) the attorney in fact if the attorney in fact is an individual.

(b) Subsection (a) does not apply to consideration received in the individual's capacity as a member.

(c) This section does not prohibit the payment of reasonable fees and compensation to an attorney, accountant, or actuary for professional services performed by that person, without regard to whether the person is also a director or officer of the converting exchange or its attorney in fact.

Added by Acts 2007, 80th Leg., R.S., Ch. 412 (S.B. 1056), Sec. 1, eff. June 15, 2007.

Sec. 829.006. LIMITATION ON ACTIONS. (a) Except as provided by Subsection (b), an action challenging the validity of or arising out of acts taken or proposed to be taken regarding a conversion plan under this chapter must be commenced not later than the 30th day after the date the conversion plan is approved by the commissioner.

(b) An action challenging the validity of or arising out of acts taken or proposed to be taken regarding a conversion plan that contemplates a public offering of debt or equity registered under the federal Securities Act of 1933 (15 U.S.C. Section 77a et seq.), or a similar law of a foreign jurisdiction, must be commenced not later than the 60th day after the date the conversion plan is approved by

the commissioner.

Added by Acts 2007, 80th Leg., R.S., Ch. 412 (S.B. 1056), Sec. 1, eff. June 15, 2007.

Sec. 829.007. SALE OF SECURITIES. (a) A sale, issuance, or offering of securities under this chapter is exempt from the registration and licensing provisions of The Securities Act (Title 12, Government Code).

(b) An officer, director, or employee of an exchange, an intermediate holding company, a mutual holding company, or a resulting company who participates in a conversion under this chapter is exempt from the registration and licensing provisions of The Securities Act (Title 12, Government Code). A person may not receive compensation, other than that person's usual salary or compensation, for services performed under the exemption provided by this subsection.

Added by Acts 2007, 80th Leg., R.S., Ch. 412 (S.B. 1056), Sec. 1, eff. June 15, 2007.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 491 (H.B. 4171), Sec. 2.31, eff. January 1, 2022.

SUBCHAPTER B. MUTUAL HOLDING COMPANY STRUCTURE

Sec. 829.051. CAPITAL STOCK HELD BY MUTUAL HOLDING COMPANY.

(a) In this section, "majority of the voting shares of the capital stock" means shares of the capital stock of a company that carry the right to cast a majority of the votes entitled to be cast by all of the outstanding shares of the capital stock of the company on all matters submitted to a vote of the shareholders of the company.

(b) All of the initial shares of the capital stock of the resulting company shall be issued to the mutual holding company or to an intermediate holding company.

(c) The mutual holding company shall at all times own a majority of the voting shares of the capital stock of the resulting company or of an intermediate holding company. The requirements of this subsection may be satisfied by indirect ownership through one or more intermediate holding companies in a corporate structure approved

by the commissioner.

(d) Except with the consent of the commissioner, the mutual holding company or intermediate holding company may not convey, transfer, assign, pledge, subject to a security interest or lien, encumber, or otherwise hypothecate or alienate the majority of the voting shares of the capital stock that is required to be owned under Subsection (c).

(e) An act of the mutual holding company or intermediate holding company that violates Subsection (d) is void in inverse chronological order from the date of the conveyance or activity as to the shares necessary to constitute a majority of the voting shares of the capital stock.

(f) The remaining minority portion of the voting shares of capital stock of the resulting company, or of an intermediate holding company, may not be assigned, transferred, or pledged to any officer, director or employee of the converting exchange, or persons acting in concert with such persons, without also offering a similar opportunity to participate to all eligible members as required by Section 829.053(g).

Added by Acts 2007, 80th Leg., R.S., Ch. 412 (S.B. 1056), Sec. 1, eff. June 15, 2007.

Sec. 829.052. LIMITATION ON ACQUISITION OF CAPITAL STOCK. (a) The conversion plan must provide that a person or group of persons acting in concert, other than the mutual holding company or an intermediate holding company, may not acquire, in a public or private offering or through an exercise of stock subscription rights, more than 10 percent of the capital stock of the resulting company unless the acquisition of the stock or stock subscription rights is approved in advance by the commissioner.

(b) Subsection (a) does not apply to an entity that purchases and retains at all times a majority of the voting shares of the capital stock of the resulting company as part of the conversion plan approved by the commissioner.

Added by Acts 2007, 80th Leg., R.S., Ch. 412 (S.B. 1056), Sec. 1, eff. June 15, 2007.

Sec. 829.053. DIRECTORS AND OFFICERS. (a) Except as otherwise provided by this section, the conversion plan must provide that a director or officer of the converting exchange, or a person acting in concert with the director or officer, may not acquire, without the permission of the commissioner, any shares of the capital stock of the resulting company, or the shares of the capital stock of another corporation that is participating in the conversion plan, before the third anniversary of the effective date of the conversion. This subsection does not prohibit the director or officer from:

- (1) acquiring capital stock through a broker-dealer;
- (2) making purchases through the exercise of stock subscription rights received under the conversion plan; or
- (3) participating in a stock benefit plan permitted by Section 829.054 or approved by the eligible members under Section 829.107.

(b) A conversion plan may provide that the directors and officers of the converting exchange may receive, without payment, nontransferable subscription rights to purchase shares of the capital stock of the resulting company or the shares of the capital stock of another corporation that is participating in the conversion plan.

(c) The aggregate number of shares that may be purchased by directors and officers under Subsection (b) may not exceed:

- (1) 35 percent of the total number of shares to be issued for the resulting company if the total assets of the converting exchange are less than \$50 million;
- (2) 25 percent of the total number of shares to be issued for the resulting company if the total assets of the converting exchange are more than \$500 million;
- (3) five percent of the total number of shares to be issued for the resulting company if the total assets of the converting exchange are more than \$1 billion; or
- (4) one percent of the total number of shares to be issued for the resulting company if the total assets of the converting exchange are more than \$10 billion.

(d) For a converting exchange with total assets between \$50 million and \$500 million, inclusive, the maximum percentage of the total number of shares that may be purchased shall be interpolated from amounts provided under Subsection (c).

(e) A conversion plan must provide that a director or officer of the converting exchange may not sell stock purchased under the

conversion plan before the first anniversary of the effective date of the conversion.

(f) Notwithstanding Subsection (e), a conversion plan may provide for the purchase or redemption of stock in the event that a director or officer no longer serves as a director or officer of, or no longer is associated with, the resulting company during the period described by Subsection (e).

(g) If, as part of the conversion, any director or officer of the converting exchange, the mutual holding company, or an intermediate holding company receives more than one percent of the shares of the capital stock of the resulting company, or other valuable consideration, which is paid from the surplus of the converting exchange, each eligible member also is entitled to receive an amount of the converting exchange's surplus on hand on the effective date of the conversion computed in the same manner as the amount received by the director or officer, or as otherwise provided in the conversion plan approved by the commissioner.

Added by Acts 2007, 80th Leg., R.S., Ch. 412 (S.B. 1056), Sec. 1, eff. June 15, 2007.

Sec. 829.054. SUBSCRIPTION RIGHTS; TAX-QUALIFIED EMPLOYEE BENEFIT PLAN. The conversion plan may allocate to a tax-qualified employee benefit plan nontransferable subscription rights to purchase not more than 10 percent of the capital stock of the resulting company.

Added by Acts 2007, 80th Leg., R.S., Ch. 412 (S.B. 1056), Sec. 1, eff. June 15, 2007.

SUBCHAPTER C. PLAN ADOPTION AND APPROVAL

Sec. 829.101. PLAN ADOPTION. (a) To convert under this chapter an exchange must adopt a conversion plan consistent with this chapter by the affirmative vote of at least two-thirds of the members of its board of directors or, if the exchange does not have a board of directors, by approval of the attorney in fact. The proposed articles of incorporation of the resulting company and the mutual holding company must be exhibits to the conversion plan.

(b) For a conversion plan to take effect:

(1) the commissioner must approve the conversion plan; and
(2) the eligible members must approve the conversion plan and adopt the articles of incorporation of the resulting company and the mutual holding company.

Added by Acts 2007, 80th Leg., R.S., Ch. 412 (S.B. 1056), Sec. 1, eff. June 15, 2007.

Sec. 829.102. AMENDMENTS; WITHDRAWAL OF PLAN. Before a conversion plan takes effect, a converting exchange may amend or withdraw the plan by the affirmative vote of at least two-thirds of the members of its board of directors or, if the exchange does not have a board of directors, by approval of the attorney in fact. The written consent of the commissioner is required for any amendment to a conversion plan adopted after the commissioner has approved the plan under Section 829.106.

Added by Acts 2007, 80th Leg., R.S., Ch. 412 (S.B. 1056), Sec. 1, eff. June 15, 2007.

Sec. 829.103. FILING OF PLAN AND RELATED DOCUMENTS WITH COMMISSIONER; COMMISSIONER'S POWERS AND DUTIES. (a) Not later than the 90th day after the date on which a converting exchange's board of directors adopts a conversion plan, the converting exchange shall file with the commissioner:

(1) a copy of the conversion plan;
(2) the form of notices required by Section 829.104;
(3) the form of proxy to be solicited from eligible members under Section 829.107(a);
(4) the form of notice required by Section 829.153 to persons whose policies are issued after adoption of the conversion plan but before the effective date of the conversion plan; and
(5) the proposed articles of incorporation of the resulting company and the mutual holding company.

(b) The converting exchange shall promptly provide any other information requested by the commissioner that the commissioner considers necessary to consider the conversion plan.

Added by Acts 2007, 80th Leg., R.S., Ch. 412 (S.B. 1056), Sec. 1, eff.

June 15, 2007.

Sec. 829.104. NOTICE TO ELIGIBLE MEMBERS; COMMENTS. (a) The converting exchange shall give eligible members at least 30 days' written notice of the members' meeting to vote on the conversion plan and advising of the members' right to comment on the plan to the commissioner and the converting exchange, including a description of the procedure to be used in making comments. Notice to the members of the proposed vote on the conversion plan must provide clear and conspicuous language apart from other meeting materials and provide a disclosure statement of the distribution of surplus or stock to directors and officers of the converting exchange, if any.

(b) If the commissioner determines to hold a hearing on the plan, the commissioner must approve the notice of hearing and notify the converting exchange not later than the 45th day following the first day on which all the documents required under Section 829.103 are filed with the commissioner. The converting exchange shall send to eligible members the commissioner's notice of the hearing at least 30 days before the date set for the hearing. The commissioner must approve the content and print layout of the hearing notice before the converting exchange sends notice of the hearing to eligible members. Notice of the hearing may be made through publication in the Texas Register.

(c) The notices required by Subsections (a) and (b) may be combined in a single mailing. The notice or notices must be sent to the member's last known address, as shown on the converting exchange's records. The notice of the members' meeting must:

- (1) describe the proposed conversion plan; and
- (2) inform the member of the member's right to vote on the conversion plan.

(d) If the notice of the meeting to vote on the conversion plan is combined with a notice of the converting exchange's annual meeting of members, the notice of the proposed vote on the conversion plan must be clear and conspicuous and set apart from other meeting materials. A notice that is approved in advance by the commissioner is deemed to be in full compliance with the requirements of this subsection.

Added by Acts 2007, 80th Leg., R.S., Ch. 412 (S.B. [1056](#)), Sec. 1, eff.

June 15, 2007.

Sec. 829.105. SUBSTANTIAL COMPLIANCE WITH NOTICE REQUIREMENTS. If the converting exchange in good faith substantially complies with the notice requirements of this chapter, the converting exchange's failure to send a member the required notice does not impair the validity of an action taken under this chapter.

Added by Acts 2007, 80th Leg., R.S., Ch. 412 (S.B. 1056), Sec. 1, eff. June 15, 2007.

Sec. 829.106. APPROVAL OF PLAN BY COMMISSIONER. (a) The commissioner shall approve a conversion plan if the commissioner determines that:

- (1) the plan complies with this chapter;
- (2) the plan's method of allocating stock subscription rights, stock transfers, or other value, if any, is fair and equitable; and
- (3) the resulting company would satisfy the requirements applicable to a domestic stock insurance company for a certificate of authority on the date of the determination.

(b) Except as otherwise provided by this section, the commissioner shall approve or disapprove a conversion plan not later than the 90th day after the first day on which all the documents required under Section 829.103 are filed with the commissioner.

(c) The commissioner may extend the time for decision by an additional 30 days on written notice to the converting exchange. Except as provided under Subsection (e) or (f), the commissioner may not extend the time for decision beyond that 30-day period.

(d) The commissioner shall immediately give written notice to the converting exchange of the commissioner's decision and, if the commissioner disapproves the plan, a detailed statement of the reasons for the disapproval.

(e) The commissioner may retain, at the converting exchange's expense, a qualified expert who is not a member of the commissioner's staff to assist the commissioner in reviewing whether the conversion plan meets the requirements for approval by the commissioner or the value of the distribution of surplus of the resulting company to the

officers and directors of the converting exchange, if any. If the commissioner retains a qualified expert under this subsection, the commissioner may extend the period for decision by an additional 90 days beyond the initial 90-day period specified in Subsection (b).

(f) If the conversion plan contemplates a public offering of debt or equity registered under the federal Securities Act of 1933 (15 U.S.C. Section 77a et seq.), or a similar law of a foreign jurisdiction, the commissioner may extend the period of time to approve the conversion plan by an additional 180 days beyond the initial 90-day period specified in Subsection (b).

(g) After giving written notice to the converting exchange, the commissioner may hold a hearing on whether the conversion plan complies with this chapter. The converting exchange has the right to appear at the hearing. Other interested persons have the right to attend the hearing and comment on the conversion plan. Notice of the hearing may be made through publication in the Texas Register in accordance with Section 829.104(b).

Added by Acts 2007, 80th Leg., R.S., Ch. 412 (S.B. 1056), Sec. 1, eff. June 15, 2007.

Sec. 829.107. APPROVAL OF PLAN BY ELIGIBLE MEMBERS. (a) After notice that complies with this chapter, the converting exchange may convene a meeting to consider the conversion plan, and any eligible member entitled to vote on the proposed conversion plan may vote in person or by proxy at the meeting. Except as otherwise provided in the bylaws of the converting exchange, each eligible member may cast one vote.

(b) Adoption of the conversion plan requires the affirmative vote of at least two-thirds of the votes cast by eligible members.

Added by Acts 2007, 80th Leg., R.S., Ch. 412 (S.B. 1056), Sec. 1, eff. June 15, 2007.

Sec. 829.108. FILING OF MINUTES, ARTICLES OF INCORPORATION, AND BYLAWS; EFFECTIVE DATE OF CONVERSION. (a) The converting exchange shall file with the commissioner:

(1) the minutes of the meeting at which the plan was approved; and

(2) the articles of incorporation and bylaws of the resulting company and the mutual holding company.

(b) The converting exchange shall make the filing required by Subsection (a) not later than the 30th day after the later of:

(1) the date on which the eligible members approve the conversion plan; or

(2) the date on which the commissioner approves the conversion plan.

(c) The conversion plan approved by the commissioner takes effect on the date specified in the articles of incorporation of the resulting company and the mutual holding company.

Added by Acts 2007, 80th Leg., R.S., Ch. 412 (S.B. 1056), Sec. 1, eff. June 15, 2007.

SUBCHAPTER D. EFFECT OF PLAN; RIGHTS OF MEMBERS

Sec. 829.151. CORPORATE EXISTENCE. (a) On the effective date:

(1) the legal existence of the converting exchange continues in the resulting company;

(2) all assets, rights, franchises, and interests of the converting exchange in and to property and any accompanying thing in action are vested in the resulting company without a deed or transfer;

(3) the resulting company assumes all the obligations and liabilities of the converting exchange; and

(4) the power of attorney or other appropriate authorization granting the attorney in fact the authority to act for the subscribers of the converting exchange is terminated.

(b) Except as otherwise specified by the conversion plan:

(1) the directors and officers of the converting exchange serving on the effective date serve as directors and officers of the resulting company until new directors and officers are elected under the articles of incorporation and bylaws of the resulting company; and

(2) the directors of the converting exchange serving on the effective date serve as directors of the mutual holding company until new directors are elected under the articles of incorporation and bylaws of the mutual holding company.

Added by Acts 2007, 80th Leg., R.S., Ch. 412 (S.B. 1056), Sec. 1, eff.

June 15, 2007.

Sec. 829.152. MEMBERSHIP INTERESTS. (a) The membership interests of the policyholders of the resulting company become membership interests in the mutual holding company. Members of the converting exchange become members of the mutual holding company in accordance with the articles of incorporation and bylaws of the mutual holding company.

(b) A membership interest in a mutual holding company does not constitute a security as defined by Section 4001.068, Government Code.

Added by Acts 2007, 80th Leg., R.S., Ch. 412 (S.B. 1056), Sec. 1, eff. June 15, 2007.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 491 (H.B. 4171), Sec. 2.32, eff. January 1, 2022.

Sec. 829.153. RIGHTS OF MEMBERS WHOSE POLICIES ARE ISSUED AFTER ADOPTION OF CONVERSION PLAN BUT BEFORE EFFECTIVE DATE. (a) On issuance of a policy after a conversion plan has been adopted by the board of directors but before the effective date of the conversion plan, the converting exchange shall send to each member to whom a policy is issued a written notice regarding the conversion plan.

(b) Except as provided by Subsection (c), each member insured under a property or casualty insurance policy is entitled to notice under Subsection (a) and shall be advised in a clear and conspicuous manner of the member's right to:

- (1) cancel the policy; and
- (2) receive a pro rata refund of unearned premiums.

(c) A member who has made or filed a claim under the insurance policy is not entitled to a refund under Subsection (b). A member who has exercised a right provided by Subsection (b) may not make or file a claim under the insurance policy.

Added by Acts 2007, 80th Leg., R.S., Ch. 412 (S.B. 1056), Sec. 1, eff. June 15, 2007.

Sec. 829.154. EFFECT OF CONVERSION ON POLICIES; SUBSCRIBER ACCOUNTS. (a) Each policy in effect on the effective date remains in effect under the terms of that policy, except that the following rights, to the extent they existed in the converting exchange in favor of policyholders or members, are extinguished on the effective date:

(1) any membership and voting rights;

(2) except as provided by Subsection (b) or in the conversion plan approved by the commissioner, a right to share in the surplus or profits of the converting exchange; and

(3) any assessment provisions.

(b) The holder of a participating policy in effect on the effective date of the conversion continues to have a right to receive dividends as provided by the participating policy.

(c) On the renewal date of a participating policy, the resulting company may issue to the insured a nonparticipating policy as a substitute for the participating policy.

(d) All the costs and expenses connected with a conversion plan shall be paid or reimbursed by the converting exchange or the resulting company.

(e) If a converting exchange maintains subscriber accounts as surplus, the subscriber accounts shall continue as surplus in the resulting company, unless otherwise provided in a conversion plan approved by the commissioner. Subject to Subsection (f), the balances of the subscriber accounts are payable to the members to the extent and in the manner as is provided in the conversion plan.

(f) The board of directors of the resulting company may reduce the balances of the subscriber accounts without payment to members of the mutual holding company who were members of the converting exchange if the board of directors of the resulting company determines in the board's discretion that the amounts are necessary to support the operations of the resulting company. The board of directors of the resulting company may not, without the approval of the commissioner, reduce the balance of a subscriber account under this subsection before the third anniversary of the effective date.

Added by Acts 2007, 80th Leg., R.S., Ch. 412 (S.B. 1056), Sec. 1, eff. June 15, 2007.

CHAPTER 830. OWN RISK AND SOLVENCY ASSESSMENT

Sec. 830.001. APPLICABILITY AND PURPOSE. (a) This chapter applies to each domestic insurer unless exempt under Section 830.006.

(b) The purpose of this chapter is to provide the requirements for maintaining a risk management framework and completing an own risk and solvency assessment and to provide guidance and instructions for filing an own risk and solvency assessment summary report with the commissioner.

(c) The own risk and solvency assessment summary report will contain confidential and sensitive information related to an insurer or insurance group's identification of risks material and relevant to the insurer or insurance group filing the report. This information will include proprietary and trade secret information that has the potential for harm and competitive disadvantage to the insurer or insurance group if the information is made public. The summary report is a confidential document filed with the commissioner, and the commissioner may share the summary report only as stated in this chapter in order to assist the commissioner in the performance of the commissioner's duties. An own risk and solvency assessment summary report is not subject to public disclosure in any event.

Added by Acts 2015, 84th Leg., R.S., Ch. 39 (S.B. 655), Sec. 1, eff. May 19, 2015.

Sec. 830.002. DEFINITIONS. In this chapter:

(1) "Guidance manual" means the version of the Own Risk and Solvency Assessment Guidance Manual developed and adopted by the National Association of Insurance Commissioners that is in effect at the time a summary report is provided. A change in the guidance manual becomes effective on the January 1 following the calendar year in which the changes are adopted by the National Association of Insurance Commissioners.

(2) "Insurance group" means the insurers and affiliates included within an insurance holding company system as described by Section 823.006.

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

(4) "Own risk and solvency assessment" means a confidential internal assessment, appropriate to the nature, scale, and complexity

of an insurer or insurance group, conducted by that insurer or insurance group, of the material and relevant risks associated with the insurer or insurance group's current business plan and the sufficiency of capital resources to support those risks.

(5) "Summary report" means a confidential, high-level summary of an insurer's or insurance group's own risk and solvency assessment.

Added by Acts 2015, 84th Leg., R.S., Ch. 39 (S.B. 655), Sec. 1, eff. May 19, 2015.

Sec. 830.003. RISK MANAGEMENT FRAMEWORK. An insurer shall maintain a risk management framework to assist the insurer with identifying, assessing, monitoring, managing, and reporting on the insurer's material and relevant risks. This requirement may be satisfied if the insurance group of which the insurer is a member maintains a risk management framework applicable to the operations of the insurer.

Added by Acts 2015, 84th Leg., R.S., Ch. 39 (S.B. 655), Sec. 1, eff. May 19, 2015.

Sec. 830.004. OWN RISK AND SOLVENCY ASSESSMENT REQUIREMENT.

(a) Subject to Section 830.006, an insurer, or the insurance group of which the insurer is a member, shall regularly conduct, consistent with a process comparable to the guidance manual, an own risk and solvency assessment, appropriate to the nature, scale, and complexity of the insurer or insurance group, of the material and relevant risks associated with the insurer's or insurance group's current business plan and the sufficiency of capital resources to support those risks.

(b) The insurer, or the insurance group of which the insurer is a member, shall conduct the own risk and solvency assessment described by Subsection (a):

(1) annually; and

(2) at any other time there are significant changes to the risk profile of the insurer or the insurance group of which the insurer is a member.

Added by Acts 2015, 84th Leg., R.S., Ch. 39 (S.B. 655), Sec. 1, eff.

May 19, 2015.

Sec. 830.005. SUMMARY REPORT REQUIRED. (a) On the commissioner's request, an insurer shall submit to the commissioner a summary report or a combination of reports that together contain the information described in the guidance manual. The commissioner may not make a request under this subsection more than once each year.

(b) Without regard to whether the commissioner has made a request under Subsection (a), if the insurer is a member of an insurance group, the insurer shall submit to the commissioner the reports required by Subsection (a) if the commissioner is the lead state commissioner of the insurance group.

(c) In determining the lead state commissioner for purposes of this section, the commissioner shall consider the procedures adopted by the National Association of Insurance Commissioners.

(d) The reports must include a signature of the insurer's or insurance group's chief risk officer or other executive responsible for the oversight of the insurer's enterprise risk management process attesting to the best of the officer's or executive's belief and knowledge that:

(1) the insurer applies the enterprise risk management process described in the summary report; and

(2) a copy of the report has been provided to the insurer's board of directors or the appropriate committee of the board of directors.

(e) An insurer may comply with Subsection (a) or (b) by providing the most recent and substantially similar report that the insurer or another member of an insurance group of which the insurer is a member provided to the commissioner of another state or to a supervisor or regulator of a foreign jurisdiction, if that report provides information that is comparable to the information described in the guidance manual. A report in a language other than English must be accompanied by a translation of that report into the English language.

Added by Acts 2015, 84th Leg., R.S., Ch. 39 (S.B. 655), Sec. 1, eff. May 19, 2015.

Sec. 830.006. EXEMPTION. (a) An insurer is exempt from the requirements of this chapter if:

(1) the insurer has annual direct written and unaffiliated assumed premium, including international direct and assumed premium but excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, of less than \$500 million; and

(2) the insurance group of which the insurer is a member has annual direct written and unaffiliated assumed premium, including international direct and assumed premium but excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, of less than \$1 billion.

(b) If an insurer qualifies for exemption under Subsection (a)(1), but the insurance group of which the insurer is a member does not qualify for exemption under Subsection (a)(2), then the summary report required under Section 830.005 must include every insurer within the insurance group.

(c) An insurer may satisfy the requirement under Subsection (b) by submitting more than one summary report for any combination of insurers if the combination of reports includes each insurer within the insurance group.

(d) If an insurer does not qualify for exemption under Subsection (a)(1), but the insurance group of which it is a member qualifies for exemption under Subsection (a)(2), then the insurer must submit a summary report under Section 830.005 that is applicable to that insurer.

(e) An insurer that does not qualify for exemption under Subsection (a) may apply to the commissioner for a waiver from the requirements of this chapter based on unique circumstances. In deciding whether to grant the insurer's request for waiver, the commissioner may consider the type and volume of business written, the ownership and organizational structure, and any other factor the commissioner considers relevant to the insurer or insurance group of which the insurer is a member. If the insurer is part of an insurance group with insurers domiciled in more than one state, the commissioner shall coordinate with the lead state commissioner and with the other domiciliary commissioners in considering whether to grant the insurer's request for a waiver.

(f) Notwithstanding the exemptions stated in this section, the commissioner may require that an insurer maintain a risk management framework, conduct an own risk and solvency assessment, and file a

summary report if:

(1) there are unique circumstances, including the type and volume of business written, the ownership and organizational structure, federal agency requests, and international supervisor requests;

(2) the insurer has risk-based capital for a company action level event as set forth in department rules;

(3) the insurer meets one or more of the standards of an insurer considered to be in hazardous financial condition under Chapter 404 or department rule; or

(4) the insurer otherwise exhibits qualities of a troubled insurer as determined by the commissioner.

(g) If an insurer that qualifies for an exemption under Subsection (a) subsequently ceases to qualify for that exemption due to changes in premium as reflected in the insurer's most recent annual statement or in the most recent annual statements of the insurers within the insurance group of which the insurer is a member, the insurer must comply with the requirements of this chapter not later than December 31 of the calendar year following the calendar year the threshold is exceeded.

Added by Acts 2015, 84th Leg., R.S., Ch. 39 (S.B. 655), Sec. 1, eff. May 19, 2015.

Sec. 830.007. CONTENTS OF SUMMARY REPORT. (a) An insurer shall prepare a summary report in accordance with the guidance manual and subject to the requirements of Subsection (b). An insurer shall maintain documentation and supporting information and shall make the documentation and supporting information available on examination or on request of the commissioner.

(b) When reviewing the summary report or making requests for additional information, the department shall use procedures similar to the procedures currently used in the analysis and examination of multistate or global insurers and insurance groups.

Added by Acts 2015, 84th Leg., R.S., Ch. 39 (S.B. 655), Sec. 1, eff. May 19, 2015.

Sec. 830.008. CONFIDENTIALITY. (a) Documents, materials, or

other information, including a summary report, in the possession or control of the department that is obtained by, created by, or disclosed to the commissioner or any other person under this chapter, including documents, materials, and other information shared or received under Subsection (e), and documents, materials, or other information in the possession or control of the National Association of Insurance Commissioners or third-party consultant under this chapter, are confidential and privileged and not subject to:

- (1) Chapter 552, Government Code;
- (2) a response to subpoena; or
- (3) discovery or admissibility in evidence in any civil

action.

(b) Documents, materials, or other information, including a summary report prepared under this chapter and additional information submitted under Section 830.007, in the possession or control of the department that is obtained by, created by, or disclosed to the commissioner or any other person under this chapter is recognized by this state as being proprietary and to contain trade secrets.

(c) The commissioner may use the documents, materials, or other information described in this section to further any regulatory or legal action brought as part of the commissioner's official duties. The commissioner shall not otherwise make the documents, materials, or other information public without the prior written consent of the insurer.

(d) The commissioner and any other person who receives own risk and solvency assessment-related information under this chapter, in an examination, or otherwise under any other law may not testify or be required to testify in any private civil action concerning any documents, materials, or information subject to Subsection (a) or (b).

(e) In order to assist in the performance of the commissioner's regulatory duties, the commissioner may, on request, share documents, materials, or other own risk and solvency assessment-related information, including confidential and privileged documents, materials, or information subject to Subsection (a) or (b) or confidential or privileged documents, materials, or information subject to Chapter 401, 404, or 823, as necessary, with:

- (1) other state, federal, and international financial regulatory agencies or insurance supervisors;
- (2) members of a supervisory college described in Section

823.0145;

- (3) the National Association of Insurance Commissioners; or
- (4) a third-party consultant designated by the

commissioner.

(f) Before the commissioner may share information under this section, the recipient of the information shall:

(1) agree in writing to maintain the confidential and privileged status of the documents, materials, or other information shared under this section; and

(2) verify in writing the recipient's legal authority to maintain the confidential and privileged status of that information.

(g) The commissioner may receive documents, materials, or other own risk and solvency assessment-related information or any other relevant information, including otherwise confidential and privileged documents, materials, or information and proprietary and trade-secret information or documents, from:

(1) a regulatory official of a foreign or domestic jurisdiction, including a member of a supervisory college described in Section 823.0145; and

- (2) the National Association of Insurance Commissioners.

(h) The commissioner shall maintain as confidential or privileged any documents, materials, or information received under Subsection (g) with notice and understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information.

Added by Acts 2015, 84th Leg., R.S., Ch. 39 (S.B. 655), Sec. 1, eff. May 19, 2015.

Sec. 830.009. AGREEMENT CONCERNING CONFIDENTIAL AND PRIVILEGED INFORMATION. (a) The commissioner shall enter into a written agreement with the National Association of Insurance Commissioners or a third-party consultant that governs the sharing and use of information provided under this chapter. The agreement must comply with and contain all the requirements listed in this section.

(b) The agreement must specify procedures and protocols regarding the confidentiality and security of information shared with the National Association of Insurance Commissioners or third-party consultant under this chapter, including procedures and protocols for

sharing by the National Association of Insurance Commissioners with other state regulators from states in which the insurance group has domiciled insurers.

(c) The agreement must provide that the recipient:

(1) agrees in writing to maintain the confidential and privileged status of the own risk and solvency assessment-related documents, materials, or other information; and

(2) has verified in writing the legal authority to maintain the confidential and privileged status of the information.

(d) The agreement must specify that ownership of information shared with the National Association of Insurance Commissioners or third-party consultant under this chapter remains with the commissioner and that the National Association of Insurance Commissioners' or third-party consultant's use of the information is subject to the direction of the commissioner.

(e) The agreement must prohibit the National Association of Insurance Commissioners or third-party consultant from storing the information shared under this chapter in a permanent database after the underlying analysis is completed.

(f) The agreement must require prompt notice to be given to an insurer whose confidential information in the possession of the National Association of Insurance Commissioners or third-party consultant under this chapter is subject to a request or subpoena to the National Association of Insurance Commissioners or third-party consultant for disclosure or production.

(g) The agreement must require the National Association of Insurance Commissioners or third-party consultant to consent to intervention by an insurer in any judicial or administrative action in which the National Association of Insurance Commissioners or third-party consultant may be required to disclose confidential information about the insurer shared with the National Association of Insurance Commissioners or third-party consultant under this chapter.

(h) The agreement must provide for the insurer's written consent in the case of an agreement involving a third-party consultant.

Added by Acts 2015, 84th Leg., R.S., Ch. 39 (S.B. 655), Sec. 1, eff. May 19, 2015.

Sec. 830.010. AUTHORITY OF COMMISSIONER NOT AFFECTED. The commissioner's sharing of information and documents under this chapter does not constitute a delegation of regulatory authority or rulemaking, and the commissioner is solely responsible for the administration, execution, and enforcement of the provisions of this chapter.

Added by Acts 2015, 84th Leg., R.S., Ch. 39 (S.B. 655), Sec. 1, eff. May 19, 2015.

Sec. 830.011. PRIVILEGE AND CONFIDENTIALITY NOT WAIVED. A waiver of an applicable privilege or claim of confidentiality in a document, proprietary and trade-secret materials, or other own risk and solvency assessment-related information does not occur as a result of disclosure of the document, materials, or other information to the commissioner under this chapter or as a result of sharing as authorized by this chapter.

Added by Acts 2015, 84th Leg., R.S., Ch. 39 (S.B. 655), Sec. 1, eff. May 19, 2015.

Sec. 830.012. ADMINISTRATIVE PENALTY. (a) An insurer that, without good cause, fails to timely file the summary report as required by this chapter commits a violation subject to an administrative penalty under Chapter 84.

(b) Each day the violation continues is a separate violation for purposes of this section.

(c) The commissioner may reduce the amount of the penalty assessed under this section if the insurer demonstrates to the commissioner that the imposition of the penalty would constitute a financial hardship to the insurer.

Added by Acts 2015, 84th Leg., R.S., Ch. 39 (S.B. 655), Sec. 1, eff. May 19, 2015.

CHAPTER 831. CORPORATE GOVERNANCE ANNUAL DISCLOSURE

Sec. 831.0001. APPLICABILITY AND PURPOSE. (a) The purpose of this chapter is to promote the public interest by:

(1) requiring annual disclosure of an insurer or insurance group's corporate governance structure, policies, and practices to permit the commissioner to gain and maintain an understanding of the insurer's corporate governance framework; and

(2) providing for the confidential treatment of the corporate governance annual disclosure and related information as the disclosure and related information will contain confidential and sensitive information related to an insurer or insurance group's internal operations and proprietary and trade-secret information which, if made public, could potentially cause the insurer or insurance group competitive harm or disadvantage.

(b) This chapter may not be construed to prescribe or impose corporate governance standards and internal procedures beyond that which is required under applicable state corporate law.

(c) Notwithstanding Subsection (b), this chapter may not be construed to limit the commissioner's authority, or the rights or obligations of third parties, under Chapter 401.

(d) This chapter applies to each insurer domiciled in this state, except that this chapter does not apply to a domestic insurer that is authorized, admitted, or eligible to engage in the business of insurance only in this state. For the purposes of this chapter, an insurer is not considered to be authorized, admitted, or eligible to engage in the business of insurance only in this state if the insurer is a member of an insurance group that writes or assumes insurance in any manner in another state.

Added by Acts 2019, 86th Leg., R.S., Ch. 1170 (H.B. [3306](#)), Sec. 1, eff. September 1, 2019.

Sec. 831.0002. DEFINITIONS. In this chapter:

(1) "Disclosure" means the confidential corporate governance annual disclosure filed by the insurer or insurance group in accordance with the requirements of this chapter.

(2) "Insurance group" means the insurers and affiliates included within an insurance holding company system as described by Section 823.006.

(3) "Insurer" has the meaning assigned by Section 823.002. The term includes a health maintenance organization authorized to engage in business under Chapter 843.

Added by Acts 2019, 86th Leg., R.S., Ch. 1170 (H.B. 3306), Sec. 1, eff. September 1, 2019.

Sec. 831.0003. DISCLOSURE REQUIRED. (a) Except as provided by Subsection (b), an insurer, or the insurance group of which the insurer is a member, shall, not later than June 1 of each calendar year, submit to the commissioner a corporate governance annual disclosure that contains the information described by Section 831.0008(c).

(b) Notwithstanding any request from the commissioner under Subsection (d), an insurer that is a member of an insurance group shall submit the report required by Subsection (a) to the commissioner of the lead state for the insurance group, in accordance with the laws of the lead state, as determined by the procedures adopted by the National Association of Insurance Commissioners.

(c) The disclosure must include a signature of the insurer or insurance group's chief executive officer or corporate secretary attesting to the best of that individual's belief and knowledge that the insurer has implemented the corporate governance practices described in the disclosure and that a copy of the disclosure has been provided to the insurer's board of directors or the appropriate committee of the insurer's board of directors.

(d) An insurer not otherwise required to submit a disclosure under this chapter shall submit a disclosure on the commissioner's request.

Added by Acts 2019, 86th Leg., R.S., Ch. 1170 (H.B. 3306), Sec. 1, eff. September 1, 2019.

Sec. 831.0004. LEVEL OF REPORTING. (a) For purposes of completing the disclosure under Section 831.0003, an insurer or insurance group may provide information regarding corporate governance at the ultimate controlling parent level, an intermediate holding company level, or the individual legal entity level, depending on how the insurer or insurance group has structured the insurer's or insurance group's system of corporate governance.

(b) An insurer or insurance group is encouraged to make the disclosure:

(1) at the level at which the insurer's or insurance group's risk appetite is determined;

(2) at the level at which the earnings, capital, liquidity, operations, and reputation of the insurer are overseen collectively and at which the supervision of those factors are coordinated and exercised; or

(3) at the level at which legal liability for failure of general corporate governance duties would be placed.

(c) If an insurer or insurance group determines the level of reporting based on the criteria described by Subsection (b), the insurer or insurance group shall indicate which of the three criteria was used to determine the level of reporting and explain any subsequent changes in level of reporting.

Added by Acts 2019, 86th Leg., R.S., Ch. 1170 (H.B. 3306), Sec. 1, eff. September 1, 2019.

Sec. 831.0005. REVIEW OF DISCLOSURE; REQUEST FOR ADDITIONAL INFORMATION. The review of the disclosure and any additional requests for information shall be made through the lead state as determined by the procedures adopted by the National Association of Insurance Commissioners described by Section 831.0003(b).

Added by Acts 2019, 86th Leg., R.S., Ch. 1170 (H.B. 3306), Sec. 1, eff. September 1, 2019.

Sec. 831.0006. SUBSTANTIALLY SIMILAR INFORMATION. An insurer that provides information substantially similar to the information required by this chapter in other documents provided to the commissioner, including proxy statements filed in conjunction with Form B requirements or other state or federal filings provided to the department, is not required to duplicate that information in the disclosure but is required only to cross-reference the document in which the information is included.

Added by Acts 2019, 86th Leg., R.S., Ch. 1170 (H.B. 3306), Sec. 1, eff. September 1, 2019.

Sec. 831.0007. PART OF EXAMINATION PROCESS. The disclosure and any additional information requested by the commissioner and provided to the department as described by this chapter is considered part of the process of examination of insurers under this code, including Chapter 401.

Added by Acts 2019, 86th Leg., R.S., Ch. 1170 (H.B. 3306), Sec. 1, eff. September 1, 2019.

Sec. 831.0008. CONTENTS OF DISCLOSURE. (a) An insurer or insurance group has discretion over the responses to the disclosure inquiries, provided the disclosure must contain the material information necessary to permit the commissioner to gain an understanding of the insurer's or insurance group's corporate governance structure, policies, and practices.

(b) The commissioner may request additional information that the commissioner considers material and necessary to provide the commissioner with a clear understanding of:

- (1) the corporate governance policies; and
- (2) the reporting, information system, or controls implementing those policies.

(c) Notwithstanding Subsections (a) and (b), the disclosure shall be prepared consistent with rules adopted by the commissioner. Documentation and supporting information must be maintained and made available on examination or on request of the commissioner.

Added by Acts 2019, 86th Leg., R.S., Ch. 1170 (H.B. 3306), Sec. 1, eff. September 1, 2019.

Sec. 831.0009. CONFIDENTIALITY. (a) Documents, materials, or other information, including a disclosure, in the possession or control of the department that is obtained by, created by, or disclosed to the commissioner or any other person under this chapter is confidential and privileged and is:

- (1) not subject to disclosure under Chapter 552, Government Code;
- (2) not subject to subpoena; and
- (3) not subject to discovery or admissible in evidence in any private civil action.

(b) Documents, materials, or other information, including a disclosure, in the possession or control of the department that is obtained by, created by, or disclosed to the commissioner or any other person under this chapter is recognized by this state as being proprietary and to contain trade secrets.

(c) The commissioner may use the documents, materials, or other information described in this section to further any regulatory or legal action brought as part of the commissioner's official duties. The commissioner may not otherwise make the documents, materials, or other information public without the prior written consent of the insurer. Nothing in this section may be construed to require written consent of the insurer before the commissioner may share or receive documents, materials, or other information under Subsection (e).

(d) The commissioner and any other person who receives documents, materials, or other information under this chapter, through examination, or otherwise under any other law, while acting under the authority of the commissioner, or with whom the documents, materials, or other information is shared under this chapter may not testify or be required to testify in any private civil action concerning any documents, materials, or other information subject to Subsection (a) or (b).

(e) In order to assist in the performance of the commissioner's regulatory duties, the commissioner may, on request, share documents, materials, or other information, including confidential and privileged documents, materials, or information subject to Subsection (a) or (b) and proprietary and trade-secret documents, materials, or information, with:

(1) other state, federal, and international financial regulatory agencies, including members of a supervisory college described by Section 823.0145;

(2) the National Association of Insurance Commissioners;
and

(3) a third-party consultant under Section 831.0012.

(f) Before the commissioner may share information under this section, the recipient shall:

(1) agree in writing to maintain the confidential and privileged status of the documents, materials, or other information shared under this section; and

(2) verify in writing the recipient's legal authority to maintain the confidential and privileged status of that information.

(g) In order to assist in the performance of the commissioner's regulatory duties, the commissioner may receive documents, materials, or other governance-related information, including confidential and privileged documents, materials, or information and proprietary and trade-secret documents, materials, or information from:

(1) regulatory officials of other state, federal, and international financial regulatory agencies, including members of a supervisory college described by Section 823.0145; and

(2) the National Association of Insurance Commissioners.

(h) The commissioner shall maintain as confidential or privileged any documents, materials, or information received under Subsection (g) with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information.

Added by Acts 2019, 86th Leg., R.S., Ch. 1170 (H.B. [3306](#)), Sec. 1, eff. September 1, 2019.

Sec. 831.0010. AUTHORITY OF COMMISSIONER NOT AFFECTED. The sharing of documents, materials, or other information by the commissioner under this chapter does not constitute a delegation of regulatory authority or rulemaking, and the commissioner is solely responsible for the administration, execution, and enforcement of the provisions of this chapter.

Added by Acts 2019, 86th Leg., R.S., Ch. 1170 (H.B. [3306](#)), Sec. 1, eff. September 1, 2019.

Sec. 831.0011. PRIVILEGE AND CONFIDENTIALITY NOT WAIVED. A waiver of an applicable privilege or claim of confidentiality in documents, materials, or other information, including proprietary and trade-secret materials, does not occur as a result of disclosure of the document, materials, or information to the commissioner under this chapter or as a result of sharing as authorized by this chapter.

Added by Acts 2019, 86th Leg., R.S., Ch. 1170 (H.B. [3306](#)), Sec. 1, eff. September 1, 2019.

Sec. 831.0012. NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS AND THIRD-PARTY CONSULTANTS. (a) The commissioner may retain, at the insurer's expense, third-party consultants, including attorneys, actuaries, accountants, and other experts not otherwise part of the commissioner's staff as may be reasonably necessary to assist the commissioner in reviewing the disclosure and related information or the insurer's compliance with this chapter.

(b) A person retained under Subsection (a) is under the direction and control of the commissioner and acts in a purely advisory capacity.

(c) The National Association of Insurance Commissioners and a third-party consultant are subject to the same confidentiality standards and requirements as the commissioner.

(d) As part of the retention process, a third-party consultant shall verify to the commissioner, with notice to the insurer, that the consultant:

- (1) is free of a conflict of interest; and
- (2) has internal procedures in place to:
 - (A) monitor compliance with a conflict; and
 - (B) comply with the confidentiality standards and

requirements of this chapter.

(e) A written agreement with the National Association of Insurance Commissioners or a third-party consultant governing sharing and use of information provided under this chapter must expressly require the written consent of the insurer before information provided under this chapter is made public and contain:

(1) specific procedures and protocols for maintaining the confidentiality and security of disclosure-related information shared with the National Association of Insurance Commissioners or the third-party consultant under this chapter;

(2) procedures and protocols for the sharing by the National Association of Insurance Commissioners of disclosure-related documents, materials, or other information only with other state regulators from states in which an affected insurance group has domiciled insurers, including a requirement that the recipient agrees in writing to maintain the confidential and privileged status of the shared documents, materials, or other information and has verified in writing the recipient's legal authority to maintain the confidential and privileged status of that information;

- (3) a provision specifying that ownership of disclosure-

related documents, materials, or other information shared with the National Association of Insurance Commissioners or a third-party consultant remains with the department and the use of the information by the National Association of Insurance Commissioners or third-party consultant is subject to the direction of the commissioner;

(4) a provision that prohibits the National Association of Insurance Commissioners or third-party consultant from storing disclosure-related documents, materials, or other information shared under this chapter in a permanent database after the underlying analysis is completed;

(5) a provision requiring the National Association of Insurance Commissioners or third-party consultant to provide prompt notice to the commissioner and to the insurer or insurance group regarding any subpoena, request for disclosure, or request for production of the insurer's disclosure-related documents, materials, or other information; and

(6) a requirement that the National Association of Insurance Commissioners or third-party consultant consents to intervention by an insurer in any judicial or administrative action in which the National Association of Insurance Commissioners or third-party consultant may be required to disclose confidential information about the insurer shared with the National Association of Insurance Commissioners or third-party consultant under this chapter.

Added by Acts 2019, 86th Leg., R.S., Ch. 1170 (H.B. 3306), Sec. 1, eff. September 1, 2019.

Sec. 831.0013. ADMINISTRATIVE PENALTY. (a) An insurer that, without good cause, fails to timely file the disclosure as required by this chapter commits a violation subject to an administrative penalty under Chapter 84.

(b) Each day the violation continues is a separate violation for purposes of this section.

(c) The commissioner may reduce the amount of the penalty assessed under this section if the insurer demonstrates to the commissioner that the imposition of the penalty would constitute a financial hardship to the insurer.

Added by Acts 2019, 86th Leg., R.S., Ch. 1170 (H.B. 3306), Sec. 1, eff. September 1, 2019.

Sec. 831.0014. RULES. (a) The commissioner shall adopt rules as necessary to enforce this chapter.

(b) A rule adopted under Subsection (a) is not subject to Section 2001.0045, Government Code.

Added by Acts 2019, 86th Leg., R.S., Ch. 1170 (H.B. 3306), Sec. 1, eff. September 1, 2019.

SUBTITLE C. LIFE, HEALTH, AND ACCIDENT INSURERS AND RELATED ENTITIES
CHAPTER 841. LIFE, HEALTH, OR ACCIDENT INSURANCE COMPANIES
SUBCHAPTER A. GENERAL PROVISIONS

Sec. 841.001. DEFINITIONS.

(1) "Accident insurance company" means a corporation authorized under a charter to engage in business involving the payment of money or another thing of value in the event of an injury to or the disablement or death of an individual as a result of travel or a general accident by land or water.

(2) "Alien company" means a life, accident, or health insurance company organized under the laws of a foreign country.

(3) "Beneficiary" is the person to whom an insurance policy is payable.

(4) "Domestic insurance company," in this chapter and another law described by Section 841.002, means an insurance company organized under the laws of this state as:

- (A) a life insurance company;
- (B) an accident insurance company;
- (C) a life and accident insurance company;
- (D) a health and accident insurance company; or
- (E) a life, health, and accident insurance company.

(5) "Foreign company" means a life, accident, or health insurance company organized under the laws of another state.

(6) "Health insurance company" means a corporation authorized under a charter to engage in business involving the payment of money or another thing of value in the event of loss resulting from disability incurred as a result of sickness or ill health.

(7) "Home office," with respect to an insurance company,

means the principal office of the company in the state or country under whose laws the company is organized.

(8) "Insurance company" and "company" include all corporations engaged as a principal in the business of life, accident, or health insurance.

(9) "Life insurance company" means a corporation authorized under a charter to engage in business involving the payment of money or another thing of value conditioned on the continuance or cessation of human life or involving an insurance, guaranty, or contract for the payment of an endowment or annuity.

(10) "Policyholder" and "insured" mean the individual on whose life an insurance policy is effected.

(11) "Profits," with respect to an insurance company, means the portion of the company's funds that are not:

(A) required for the payment of losses and expenses;
or

(B) set aside for any other purpose required by law.

(12) "United States branch" means:

(A) the business unit through which business is transacted within the United States by an alien company;

(B) the assets and liabilities of the company within the United States pertaining to the business;

(C) the management powers pertaining to the business and to the assets and liabilities; or

(D) any combination of the items described by Paragraphs (A)-(C).

(13) The definitions of "company" and "insurance company" apply to this chapter and another law described by Section 841.002 unless a different meaning is plainly required by the context in which the term appears.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 841.002. APPLICABILITY OF CHAPTER AND OTHER LAW. Except as otherwise expressly provided by this code, each insurance company incorporated or engaging in business in this state as a life insurance company, an accident insurance company, a life and accident insurance company, a health and accident insurance company, or a life, health, and accident insurance company is subject to:

- (1) this chapter;
- (2) Chapter 3;
- (3) Chapters 425 and 493;
- (4) Title 7;
- (5) Sections 1202.051, 1204.151, 1204.153, and 1204.154;
- (6) Subchapter A, Chapter 1202, Subchapters A and F, Chapter 1204, Subchapter A, Chapter 1273, Subchapters A, B, and D, Chapter 1355, and Subchapter A, Chapter 1366;
- (7) Subchapter A, Chapter 1507;
- (8) Chapters 1203, 1210, 1251-1254, 1301, 1351, 1354, 1359, 1364, 1368, 1505, 1651, 1652, and 1701; and
- (9) Chapter 177, Local Government Code.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.018, eff. April 1, 2009.

Acts 2017, 85th Leg., R.S., Ch. 594 (S.B. 1070), Sec. 3.03, eff. September 1, 2017.

Sec. 841.003. APPLICABILITY OF LAW GOVERNING CORPORATIONS. An insurance company operating under this chapter is subject to the Texas Business Corporation Act, the Texas Miscellaneous Corporation Laws Act (Article 1302-1.01 et seq., Vernon's Texas Civil Statutes), and any other law of this state that governs corporations in general to the extent those laws are not inconsistent with this chapter or another law described by Section 841.002.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 841.004. NET ASSETS DEFINED; RULES. (a) A company's "net assets" consist of the company's funds that are available for the payment of a company's obligations in this state, including:

(1) uncollected premiums that are not more than three months past due and deferred premiums on policies actually in force, after the deduction of:

- (A) all unpaid losses and claims;
- (B) all claims for losses; and
- (C) all other debts, exclusive of capital stock; and

(2) if the total value of the equipment exceeds \$2,000, the value of all electronic machines that comprise a data processing system or systems and of all other office equipment, furniture, machines, and labor-saving devices purchased for and used in connection with the business of the insurance company to the extent that the total actual cash market value of those assets is less than 10 percent of the other admitted assets of the company.

(b) The commissioner may adopt rules defining electronic machines and systems, office equipment, furniture, machines, and labor-saving devices described by Subsection (a) and stating the maximum period for which each class of equipment may be amortized.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER B. FORMATION AND STRUCTURE OF DOMESTIC COMPANIES

Sec. 841.051. FORMATION OF COMPANY. (a) Three or more residents of this state may form:

- (1) a life insurance company;
- (2) an accident insurance company;
- (3) a life and accident insurance company;
- (4) a health and accident insurance company; or
- (5) a life, health, and accident insurance company.

(b) To form a domestic insurance company:

- (1) each incorporator must sign and acknowledge the articles of incorporation of the company; and
- (2) the incorporators must file the articles of incorporation with the department.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 841.052. ARTICLES OF INCORPORATION. (a) Articles of incorporation of a proposed domestic insurance company must state:

- (1) the name of the company;
- (2) the location of the company's home office;
- (3) the kinds of insurance business in which the company proposes to engage;
- (4) the name and place of residence of each incorporator;
- (5) the amount of the company's capital stock;
- (6) the number of shares of the company's capital stock;

(7) the amount of the company's surplus; and

(8) the period of the company's duration, which may be perpetual.

(b) The incorporators of a domestic insurance company may include in the articles of incorporation other provisions that are not inconsistent with law.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 841.053. COMPANY NAME. (a) The name of a domestic insurance company must contain the words "Insurance Company."

(b) A domestic insurance company's name may not be so similar to the name of another domestic insurance company as to likely mislead the public.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 841.054. CAPITAL STOCK AND SURPLUS REQUIREMENTS. (a) A domestic insurance company must have capital stock in an amount of at least \$700,000 and surplus in an amount of at least \$700,000.

(b) All of the capital stock required by Subsection (a) must be fully subscribed and paid up and delivered to the incorporators before the articles of incorporation are filed.

(c) At the time of incorporation, the required capital and surplus shall consist only of:

(1) United States currency;

(2) bonds of the United States, this state, or a county or municipality of this state; or

(3) government insured mortgage loans that are authorized by this chapter or Chapter 425, with not more than 50 percent of the required capital invested in first mortgage real property loans.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 2E.019, eff. April 1, 2009.

Sec. 841.055. SHARES OF STOCK. (a) The shares of stock of an

insurance company operating under this chapter may be divided or converted into shares of stock with a par value or shares of stock without par value or into a combination of shares with or without par value.

(b) Each issued share of stock must be fully paid for and nonassessable.

(c) Repealed by Acts 2023, 88th Leg., R.S., Ch. 825 (H.B. 1903), Sec. 3(2), eff. September 1, 2023.

(d) Authorized but unissued shares of stock of an insurance company are not considered capital, stock, or capital stock of the company.

(e) This section and Sections 841.056 and 841.057 do not impair the charter rights of an insurance company authorized to issue shares of stock with or without a par value before September 6, 1955.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 825 (H.B. 1903), Sec. 3(2), eff. September 1, 2023.

Sec. 841.056. REQUIREMENTS FOR SHARES OF STOCK WITH PAR VALUE.

(a) The shares of stock of an insurance company operating under this chapter that are divided or converted into par value shares, if any, must have a par value of not less than \$1 or more than \$100.

(b) Each par value share of stock must be fully paid for before issuance in an amount that is not less than the share's par value.

(c) When an application for charter or an amendment to the charter authorizing the issuance of shares of stock with a par value is filed, the insurance company shall file with the department a statement under oath stating:

(1) the total number of par value shares subscribed; and

(2) the actual total consideration the company received for those shares.

(d) Repealed by Acts 2023, 88th Leg., R.S., Ch. 825 (H.B. 1903), Sec. 3(3), eff. September 1, 2023.

(e) If all of the authorized par value shares of stock are not subscribed and paid for when the charter is granted or the amendment is filed, respectively, the insurance company shall file with the department a certificate authenticated by a majority of the directors

stating the total number of par value shares issued and the actual total consideration received for those shares. The company shall file the certificate not later than the 90th day after the date of issuance of those remaining shares. The company is not required to file an amendment to its charter or take further action to effect the increase in the capital and surplus of the company.

(f) The actual consideration received by an insurance company for a par value share constitutes capital to the extent of its par value and the remainder, if any, constitutes surplus.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by:

Acts 2023, 88th Leg., R.S., Ch. 825 (H.B. 1903), Sec. 3(3), eff. September 1, 2023.

Sec. 841.057. REQUIREMENTS FOR SHARES OF STOCK WITHOUT PAR VALUE. (a) The shares of stock of an insurance company operating under this chapter that are divided or converted into shares without par value, if any, must be equal in all respects.

(b) An insurance company may issue and dispose of authorized shares without par value for money or for notes, mortgages, and stocks in the form authorized by law for capital stock of insurance companies. Each share of stock without par value must be fully paid before issuance. After the company receives payment for a share of stock issued under this section, the share is not subject to additional call or assessment, and the subscriber or holder of the share is not required to make an additional payment with respect to the share.

(c) The shareholders of an insurance company authorizing shares of stock without par value must pay a total amount of at least \$250,000 for the shares before the company is granted a charter or has its charter amended to authorize the issuance of shares without par value.

(d) When an application for charter or an amendment to the charter authorizing the issuance of shares without par value is filed, the insurance company shall file with the department a statement under oath stating:

- (1) the number of shares without par value subscribed; and
- (2) the actual consideration the company received for those

shares.

(e) If all of the authorized shares of stock without par value are not subscribed and paid for when the charter is granted or the amendment is filed, respectively, the insurance company shall file with the department a certificate authenticated by a majority of the directors stating the number of shares without par value issued and the consideration received for those shares.

(f) The insurance company shall file the certificate required by Subsection (e) not later than the 90th day after the date of issuance of those remaining shares. The portion of the consideration received for shares without par value that is designated as capital by the company's directors, or by the company's shareholders if the charter or articles of incorporation reserve the right to make that determination to the shareholders, constitutes capital and the remainder, if any, constitutes surplus. The company is not required to file an amendment to its charter or take further action to effect the increase in the capital and surplus of the company.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 825 (H.B. 1903), Sec. 2, eff. September 1, 2023.

Sec. 841.058. APPLICATION FOR CHARTER. (a) To obtain a charter for a domestic insurance company, the incorporators must pay to the department the charter fee in an amount determined under Chapter 202 and file with the department:

(1) an application for charter on the form and containing the information prescribed by the commissioner;

(2) the company's articles of incorporation; and

(3) an affidavit made by two or more of the incorporators that states that:

(A) the minimum capital and surplus requirements of Section 841.054 are satisfied;

(B) the capital and surplus are the bona fide property of the company; and

(C) the information in the articles of incorporation is true and correct.

(b) The commissioner may require that the incorporators provide

at their expense additional evidence of a matter required in the affidavit before the commissioner takes further action on the application for charter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.020, eff. April 1, 2009.

Sec. 841.059. ACTION BY COMMISSIONER AND DEPARTMENT AFTER FILING. (a) After the charter fee is paid and all items required for a charter under Section 841.058 are filed with the department, the department shall make or cause to be made a full and thorough examination of the domestic insurance company.

(b) The domestic insurance company shall pay for the examination under Subsection (a)(2).

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1022 (H.B. 4291), Sec. 8, eff. June 19, 2009.

Sec. 841.061. ACTION ON APPLICATION. (a) In considering the application, the commissioner shall determine if:

(1) the minimum capital and surplus required by Section 841.054 are the bona fide property of the domestic insurance company;

(2) the proposed officers, directors, and managing executive of the company have sufficient insurance experience, ability, and standing to make success of the proposed company probable; and

(3) the applicants are acting in good faith.

(b) If the commissioner determines that the applicant has not met the standards set out by Subsection (a), the commissioner shall deny the application in writing, giving the reason for the denial. An application may not be granted unless it is adequately supported by competent evidence.

(b-1) On the applicant's request, the commissioner shall hold a hearing on a denial. Not later than the 30th day after the date of the applicant's request for a hearing, the commissioner shall request

a hearing date.

(b-2) An interested party may participate fully and in all respects in any proceeding related to the application. An intervenor has the rights and privileges of a proper or necessary party in a civil suit in the courts of this state, including the right to be represented by counsel.

(c) If the commissioner does not deny the application under Subsection (b), the commissioner shall approve the application. On approval of an application, the department shall record the information required by Section 841.058 in records maintained for that purpose. On receipt of a fee in the amount determined under Chapter 202, the commissioner shall provide to the incorporators a certified copy of the application, articles of incorporation, and submitted affidavit.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.021, eff. April 1, 2009.

Acts 2009, 81st Leg., R.S., Ch. 1022 (H.B. 4291), Sec. 9, eff. June 19, 2009.

Acts 2009, 81st Leg., R.S., Ch. 1022 (H.B. 4291), Sec. 10, eff. June 19, 2009.

Sec. 841.062. BEGINNING OF CORPORATE EXISTENCE. On receipt of the certified copy of documents under Section 841.061(c), the domestic insurance company becomes a body politic and corporate, and the incorporators may complete organization of the company under Section 841.063.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 841.063. ORGANIZATION MEETING. (a) After receipt of the certified copy of documents under Section 841.061(c), the incorporators shall promptly call a meeting of the domestic insurance company's shareholders. The shareholders shall:

- (1) adopt bylaws to govern the company; and
- (2) elect the company's initial board of directors.

(b) The directors elected under this section serve until

directors are first elected under Section 841.153.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER C. AUTHORITY TO ENGAGE IN BUSINESS

Sec. 841.101. CERTIFICATE OF AUTHORITY REQUIRED. A domestic insurance company may not engage in the business of insurance in this state, except for the lending of money, without first obtaining from the commissioner a certificate of authority that:

(1) shows that the company has fully complied with the laws of this state; and

(2) authorizes the company to engage in the business of insurance in this state.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 841.102. SCHEDULE OF ASSETS. Two or more officers of the domestic insurance company shall execute and file with the department:

(1) a sworn schedule of each of the assets of the company exhibited to the department during the examination under Section 841.059 showing the value of the assets; and

(2) a sworn statement that the assets are the bona fide, unconditional, and unencumbered property of the company and are worth the amount stated in the schedule.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 841.103. ISSUANCE OF CERTIFICATE OF AUTHORITY. (a) If the commissioner makes a determination favorable to the applicants on all issues under Section 841.061(a), the commissioner, on compliance with the requirements of Section 841.102, shall issue to the domestic insurance company a certificate of authority authorizing the company to engage in the kinds of business authorized by the company's charter.

(b) On written request of a domestic insurance company, the commissioner shall provide a certified copy of the company's certificate of authority to the company for each of the company's

agents in this state.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 841.104. TAX PAYMENT REQUIRED FOR ISSUANCE OF CERTAIN CERTIFICATES OF AUTHORITY. (a) This section applies to a life insurance company that:

(1) has previously held a certificate of authority to engage in the business of life insurance in this state;

(2) ceased to write new business in this state under that certificate of authority; and

(3) after ceasing to write new business, continued to collect from residents of this state renewal or other premiums on policies written under that certificate of authority.

(b) A life insurance company to which this section applies may not obtain a new certificate of authority to engage in the business of life insurance in this state until the company:

(1) files with the department under oath a report that discloses the gross amount of renewal or other premiums received each calendar year from residents of this state after the period covered by the company's last tax report of gross premium receipts filed under this code; and

(2) pays to the state occupation taxes on those premiums.

(c) The life insurance company shall pay the occupation tax for each year of nonpayment. The company shall pay the tax for each year at the same rate for that year as a company engaged in the business of life insurance in this state during that year.

(d) The life insurance company shall remit the penalties for failure to pay the taxes and file required reports when the company pays the taxes and receives a certificate of authority.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 17, eff. April 1, 2005.

SUBCHAPTER D. MANAGEMENT OF COMPANY

Sec. 841.151. CONDUCTING SHAREHOLDERS' MEETING. (a) At a meeting of a domestic insurance company's shareholders, each shareholder is entitled to one vote for each fully paid up share of stock appearing in the shareholder's name on the company's books, except to the extent that the articles of incorporation increase,

limit, or deny voting rights to the holders of the shares of a class of stock as authorized by the Texas Business Corporation Act.

(b) A shareholder may vote in person or by written proxy.

(c) At a shareholders' meeting, a quorum is any number of shareholders whose cumulative stock ownership in the domestic insurance company represents a majority of the company's paid up capital stock.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 841.152. BOARD OF DIRECTORS. (a) Subject to the bylaws of the domestic insurance company, as adopted or amended by the shareholders or directors, the board of directors has full management and control of the company.

(b) The board consists of not fewer than five directors. A director is not required to be a shareholder unless such a qualification is required by the articles of incorporation or bylaws of the company.

(c) The directors shall keep a full and correct record of the board's transactions. The shareholders may inspect those records during business hours.

(d) The directors shall fill a vacancy that occurs on the board or in any office of the company.

(e) A majority of the board is a quorum.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 841.153. ELECTION OF DIRECTORS. (a) After a domestic insurance company completes the organization of the company under Section 841.063, the company shall hold an annual meeting of the company's shareholders on the fourth Tuesday in April at the home office of the company to elect the company's board of directors.

(b) After the directors are first elected under this section, the annual meeting must be held each year as established by the company's bylaws. The directors serve one-year terms beginning immediately after the election, except as provided by Section 841.154.

(c) If the shareholders do not elect directors at an annual meeting, the shareholders may elect the directors at a special

shareholders' meeting called for that purpose.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2021, 87th Leg., R.S., Ch. 380 (S.B. 918), Sec. 3, eff. September 1, 2021.

Sec. 841.154. STAGGERED TERMS FOR DIRECTORS. (a) Repealed by Acts 2021, 87th Leg., R.S., Ch. 380 (S.B. 918), Sec. 5, eff. September 1, 2021.

(b) The bylaws of a domestic insurance company may provide that the company's directors, other than initial directors, may be elected to serve staggered terms as provided by this section.

(c) The company's directors shall be divided into two or three classes, with each class consisting of an equal number of directors to the extent possible. After the directors are divided into classes:

(1) the terms of the directors in the first class expire on the first annual meeting date after their initial election;

(2) the terms of the directors in the second class expire on the second annual meeting date after their initial election; and

(3) the terms of the directors in the third class, if any, expire on the third annual meeting date after their initial election.

(d) At each annual meeting after the directors are first elected, the shareholders shall elect the number of directors whose terms expire on that date. Directors are elected for:

(1) staggered two-year terms, if the board is divided into two classes; or

(2) staggered three-year terms, if the board is divided into three classes.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2021, 87th Leg., R.S., Ch. 380 (S.B. 918), Sec. 4, eff. September 1, 2021.

Acts 2021, 87th Leg., R.S., Ch. 380 (S.B. 918), Sec. 5, eff. September 1, 2021.

Sec. 841.155. OFFICERS. (a) A domestic insurance company's

directors shall choose one of the directors to serve as the company's president.

(b) Other officers of the domestic insurance company shall be chosen in accordance with the company's bylaws. An officer is not required to be a shareholder unless such a qualification is required by the company's articles of incorporation or bylaws. An officer other than the president is not required to be a director unless such a qualification is required by the company's bylaws.

(c) The duties and compensation of a domestic insurance company's officers are as stated in the company's bylaws. If the bylaws do not state the duties or compensation of the officers, the directors shall establish the duties or compensation.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 841.156. AMENDMENT OF CHARTER OR ARTICLES. (a) The shareholders of a domestic insurance company by resolution may amend the company's charter or articles of incorporation at any shareholders' meeting.

(b) The amendment and a copy of the resolution certified by the president and secretary of the domestic insurance company shall be filed and recorded in the same manner as the charter.

(c) An amendment of the charter or articles takes effect when it is recorded.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER E. CAPITAL AND SURPLUS

Sec. 841.201. FORM OF REQUIRED CAPITAL AND SURPLUS.

Notwithstanding any other provision of this code, after a charter is granted under this chapter, the domestic insurance company:

(1) shall maintain the company's minimum capital at all times in a form described by Section 841.054(c); and

(2) may invest the company's surplus as provided by this code.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 841.202. AUTHORIZED SHARES. (a) At any shareholders' meeting, shareholders of a domestic insurance company whose cumulative stock ownership represents a majority of the capital stock of the company by resolution may increase or decrease the amount of the company's capital stock, subject to this section.

(b) Capital stock may never be decreased to an amount that is less than the minimum amount of paid-up stock required by Section 841.054.

(c) Two officers of the domestic insurance company must sign and acknowledge a statement of the increase or decrease. The acknowledged statement and a certified copy of the resolution shall be filed and recorded in the same manner as the charter.

(d) For an increase or decrease of capital stock, the domestic insurance company may require the return of the original certificates evidencing the stock in exchange for new certificates. An issuance of new certificates that results in a transfer of stock is subject to Section 841.254.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 841.203. COMPANY'S REPURCHASE OF STOCK. (a) A legal reserve life insurance company may purchase in the name of the company outstanding shares of the company's capital stock as provided by the Texas Business Corporation Act.

(b) A purchase of stock under this section is not considered an investment and does not violate the provisions of this code relating to eligible investments for a legal reserve life insurance company.

(c) A legal reserve life insurance company that purchases stock under this section shall file with the department not later than the 10th day after the date of the purchase a statement that contains:

(1) the name of each shareholder from whom the shares were purchased; and

(2) the sum of money paid for those shares.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 841.204. EXEMPTION FROM REQUIRED INCREASE OF CAPITAL AND SURPLUS. (a) Except as otherwise provided by this chapter, a domestic insurance company that after September 1, 1991, had less

than the minimum amount of capital and surplus required for a newly incorporated company under Section 841.054 may continue to transact the kinds of business for which it holds a certificate of authority.

(b) The insurance company shall immediately increase the amount of its capital to the required amount of capital under Section 841.054 if there is:

(1) a change in the control of at least 50 percent of the voting securities of the insurance company;

(2) a change in the control of at least 50 percent of the voting securities of a holding company controlling the insurance company; or

(3) a change in control of at least 50 percent by any other method of control if the insurance company or holding company is not controlled by voting securities.

(c) For purposes of Subsection (b), a transfer of ownership that occurs because of death, regardless of whether the decedent died testate or intestate, may not be considered a change in the control of an insurance company or holding company if ownership is transferred solely to one or more individuals, each of whom would be an heir of the decedent if the decedent had died intestate.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 841.205. COMMISSIONER MAY REQUIRE LARGER CAPITAL AND SURPLUS AMOUNTS. (a) The commissioner by rule or guideline may require a domestic insurance company that writes or assumes a life insurance or annuity contract or assumes liability on or indemnifies one person for any risk under an accident and health insurance policy, or a combination of these policies, in an amount that exceeds \$10,000, to maintain capital and surplus in amounts that exceed the minimum amounts required by this chapter because of:

(1) the nature and kind of risks the company underwrites or reinsures;

(2) the premium volume of risks the company underwrites or reinsures;

(3) the composition, quality, duration, or liquidity of the company's investment portfolio;

(4) fluctuations in the market value of securities the company holds; or

(5) the adequacy of the company's reserves.

(b) A rule adopted under Subsection (a) must be designed to ensure the financial solvency of an insurance company for the protection of policyholders but may not require that the total admitted assets of a company exceed 106 percent of its total liabilities.

(c) A fraternal benefit society operating under Chapter 885 and a mutual life insurance company operating under Chapter 882 are subject to a rule adopted under this section.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 841.206. IMPAIRMENT OF CAPITAL AND SURPLUS. (a) An insurance company incorporated or authorized to do the lines of business authorized in this chapter may not have:

(1) the company's required capital impaired;

(2) more than 90 percent of the company's required minimum surplus impaired; or

(3) the surplus required under Section 841.205 impaired.

(b) If the commissioner determines that an insurance company's capital or surplus is impaired in violation of this section, the commissioner shall:

(1) order the company to immediately reduce the level of impairment to an acceptable level of impairment as specified by the commissioner or prohibit the company from engaging in the business of insurance in this state; and

(2) begin proceedings as necessary to determine any further actions with respect to the impairment.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.021, eff. September 1, 2005.

Sec. 841.207. ACTIONS OF COMMISSIONER WHEN CAPITAL AND SURPLUS REQUIREMENTS NOT SATISFIED. If an insurance company does not comply with the capital and surplus requirements of this chapter, the commissioner may order the insurance company to cease writing new business and may:

(1) place the insurance company under state supervision or conservatorship;

(2) declare the insurance company to be in a hazardous condition as provided by Subchapter A, Chapter 404;

(3) declare the insurance company to be impaired as provided by Section 841.206; or

(4) apply to the insurance company any other applicable sanction provided by this code.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.022, eff. April 1, 2009.

SUBCHAPTER F. GENERAL POWERS, DUTIES, AND LIMITATIONS

Sec. 841.251. EVIDENCE OF EXPENDITURES. (a) A domestic insurance company may not make an expenditure of \$100 or more unless the expenditure is evidenced by a voucher that:

(1) is signed by or on behalf of the individual, firm, or corporation that receives the money; and

(2) describes the consideration received for the payment correctly.

(b) For an expenditure for both services and disbursements, the voucher must state the services rendered and disbursement made.

(c) For an expenditure related to a matter pending before a legislature or public body or a department or officer of a state or government, the voucher must describe both the nature of the matter and the interest of the company in the matter correctly.

(d) If the domestic insurance company cannot obtain a voucher as required by this section, the expenditure must be evidenced by:

(1) a paid check; or

(2) an affidavit that:

(A) describes the nature and purpose of the expenditure; and

(B) states the reason the voucher was not obtained.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 841.252. PAYMENTS TO OFFICERS, DIRECTORS, AND EMPLOYEES.

(a) Unless first authorized by a vote of a domestic insurance company's board of directors or a committee of the board that has the duty to authorize the payments, the company may not pay any compensation or emolument in an amount that, when added to any compensation or emolument paid to the person by an affiliated domestic insurance company, exceeds \$150,000 in any year to an individual, firm, or corporation, including an officer or director of the company.

(b) Subsection (a) does not prevent a domestic insurance company from contracting with its agents for the payment of renewal commissions.

(c) The shareholders of a domestic insurance company may authorize the creation of one or more plans for the payment of pensions, retirement benefits, or group insurance for the company's officers and employees. The shareholders may delegate to the company's board of directors the power and duty to prepare, effect, finally approve, administer, and amend a plan.

(d) A mutual insurance company, acting through the company's policyholders, may exercise the same discretion, and has the same powers, privileges, and rights, as are conferred on a domestic insurance company under Subsection (c).

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by:

Acts 2009, 81st Leg., R.S., Ch. 94 (H.B. 651), Sec. 1, eff. September 1, 2009.

Sec. 841.253. LIFE INSURANCE COMPANY'S PAYMENT OF DIVIDENDS.

(a) A life insurance company may declare or pay a dividend to its:

(1) policyholders only from the expense loading and profits made by the company; and

(2) shareholders only from the company's earned surplus, as defined by the commissioner.

(b) A life insurance company that is not showing a profit may pay a dividend on its participating policies from the expense loading on those policies.

(c) A life insurance company may not discriminate between policyholders in paying a dividend from the expense loading under this section.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 841.254. TRANSFER OF STOCK. (a) A domestic insurance company's shares of stock are transferrable on the company's books, in accordance with law and the bylaws of the company, by the owner or the owner's authorized agent.

(b) Each person who becomes a shareholder by a transfer of shares succeeds to all rights of the former holder of those shares, by reason of that ownership.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 841.255. ANNUAL STATEMENT; FILING FEE. (a) Not later than March 1 of each year, a domestic insurance company shall:

(1) prepare a statement showing the condition of the company on December 31 of the preceding year; and

(2) deliver the statement to the department accompanied by a filing fee in the amount determined under Chapter 202.

(b) The statement must be under oath of two of the domestic insurance company's officers and show in detail:

(1) the character of the company's assets and liabilities on December 31 of the preceding year;

(2) the amount and character of business transacted and money received during the preceding year;

(3) how money was spent during the preceding year;

(4) the number and amount of the company's policies in force in this state on that date; and

(5) the total amount of the company's policies in force on that date.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 2E.023, eff. April 1, 2009.

Sec. 841.256. BUSINESS IN SEPARATE DEPARTMENTS OF DOMESTIC INSURANCE COMPANY. A domestic insurance company may not transact more than one of the kinds of insurance business described by Section

841.051(a) unless the company establishes separate departments to transact each kind of business.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 841.257. KINDS OF BUSINESS LIMITED. An insurance company authorized to engage in the business of insurance under this chapter or in accordance with Section 982.051 may not accept a risk or write an insurance policy in this state or any other state or country other than:

- (1) a life, accident, or health insurance policy;
- (2) reinsurance under Chapter 493 by a life insurance company authorized to engage in the business of insurance in this state; or
- (3) reinsurance under Chapter 494 by a domestic insurance company.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.022, eff. September 1, 2005.

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.024, eff. April 1, 2009.

Acts 2017, 85th Leg., R.S., Ch. 594 (S.B. 1070), Sec. 3.04, eff. September 1, 2017.

Sec. 841.258. AGENTS FOR COMPANY THAT CEASES WRITING NEW BUSINESS. An insurance company that ceases to write new business in this state may maintain in this state agents to collect renewal premiums on outstanding policies the company has written under its certificate of authority.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.022, eff. September 1, 2005.

Sec. 841.259. ACTIVITIES OF DIRECTORS AND OFFICERS. (a) A

director or officer of an insurance company may not:

(1) receive money or another valuable thing for negotiating, procuring, recommending, or aiding in a purchase or sale of property by or a loan from the company; or

(2) have a pecuniary interest, as a principal, coprincipal, agent, or beneficiary, in a purchase, sale, or loan described by Subdivision (1).

(b) This section does not prohibit:

(1) a life insurance company from making a loan to a policyholder in an amount that is not greater than the reserve value of the policy; or

(2) a transaction, purchase, sale, or loan approved by the commissioner under Subchapter A of Chapter 805 or Chapter 823.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 841.260. PROHIBITED COMMISSIONS. (a) In this section, "contingent compensation" means a commission or other compensation an insurance company pays to a person that is contingent on:

(1) the writing or procurement of an insurance policy in the company;

(2) the procurement of an application for an insurance policy in the company;

(3) the payment of a renewal premium; or

(4) the assumption of an insurance risk by the company.

(b) A life insurance company that engages in the business of insurance in this state may not, directly or indirectly, pay or contract to pay a contingent compensation to:

(1) the president, vice president, secretary, or treasurer of the company;

(2) any other officer of the company, other than an agent or solicitor;

(3) an actuary of the company; or

(4) a medical director or other physician of the company whose duty is to examine risks or applications for insurance for the company.

(c) This section does not prohibit a plan of compensation to a marketing officer according to the total amount of insurance the insurance company writes or to the total amount of insurance in force

with the insurance company during a specified period if:

(1) the commissioner approves the plan under Subchapter A, Chapter 805;

(2) the marketing officer is not responsible for underwriting, rating, or otherwise approving the acceptability of insurance risks; and

(3) the plan does not compensate the marketing officer according to commissions on individual sales of any insurance product.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 841.261. CAUSES OF ACTION. (a) A domestic insurance company may bring an action against any person, including a policyholder or shareholder of the company, for any cause related to the company's business.

(b) A policyholder or an heir or legal representative of a policyholder may bring an action against a domestic insurance company for a loss that accrues on a policy.

(c) An action enjoining, restraining, or interfering with the prosecution of a domestic insurance company's business may be brought only by the department.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER G. ISSUANCE OF POLICIES

Sec. 841.301. LIMITS ON AMOUNT OF ACCIDENT AND HEALTH INSURANCE POLICIES. (a) A domestic insurance company may not assume liability on or indemnify one person for any risk under one or more accident, health, or hospitalization insurance policies, or a combination of those policies, in an amount that exceeds \$10,000, unless the amount of the issued, outstanding, and stated capital of the company is at least equal to the minimum amount of capital required for a newly incorporated company under Section 841.054.

(b) A domestic insurance company that before January 1, 2002, ceases to write or assume liability on, or indemnify any risk under, a policy described by Subsection (a) in the amount specified by Subsection (a) and notifies the commissioner of that action is exempt from the requirements of Subsection (a) until the date the company

resumes writing those policies. A company that resumes assuming liability on or indemnifying risks under those policies shall comply with Subsections (a) and (c).

(c) A domestic insurance company that is exempt under Subsection (b) shall maintain its issued, outstanding, and stated capital in an amount that is at least \$100,000 and is at least:

(1) the amount of capital held by the company on December 31, 1991, plus 10 percent of the difference between that amount and an amount equal to the minimum amount of capital required for a newly incorporated company under Section 841.054, if the last date that the company writes a policy described by Subsection (a) is during 1993;

(2) the amount of capital held by the company on December 31, 1991, plus 20 percent of the difference between that amount and an amount equal to the minimum amount of capital required for a newly incorporated company under Section 841.054, if the last date that the company writes a policy described by Subsection (a) is during 1994;

(3) the amount of capital held by the company on December 31, 1991, plus 30 percent of the difference between that amount and an amount equal to the minimum amount of capital required for a newly incorporated company under Section 841.054, if the last date that the company writes a policy described by Subsection (a) is during 1995;

(4) the amount of capital held by the company on December 31, 1991, plus 40 percent of the difference between that amount and an amount equal to the minimum amount of capital required for a newly incorporated company under Section 841.054, if the last date that the company writes a policy described by Subsection (a) is during 1996;

(5) the amount of capital held by the company on December 31, 1991, plus 50 percent of the difference between that amount and an amount equal to the minimum amount of capital required for a newly incorporated company under Section 841.054, if the last date that the company writes a policy described by Subsection (a) is during 1997;

(6) the amount of capital held by the company on December 31, 1991, plus 60 percent of the difference between that amount and an amount equal to the minimum amount of capital required for a newly incorporated company under Section 841.054, if the last date that the company writes a policy described by Subsection (a) is during 1998;

(7) the amount of capital held by the company on December 31, 1991, plus 70 percent of the difference between that amount and an amount equal to the minimum amount of capital required for a newly incorporated company under Section 841.054, if the last date that the

company writes a policy described by Subsection (a) is during 1999;

(8) the amount of capital held by the company on December 31, 1991, plus 80 percent of the difference between that amount and an amount equal to the minimum amount of capital required for a newly incorporated company under Section 841.054, if the last date that the company writes a policy described by Subsection (a) is during 2000; and

(9) the amount of capital held by the company on December 31, 1991, plus 90 percent of the difference between that amount and an amount equal to the minimum amount of capital required for a newly incorporated company under Section 841.054, if the last date that the company writes a policy described by Subsection (a) is during 2001.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 841.302. LIMITS ON LIFE OR ACCIDENTAL DEATH INSURANCE.

(a) Until the amount of the capital and surplus of a domestic insurance company is at least \$100,000, the company may not insure any one life for more than \$20,000 in the event of death from natural causes or more than \$40,000 in the event of death from accidental causes.

(b) If the net capital and surplus of a domestic insurance company is at least \$75,001 but less than \$100,000, the company, for any policy issued by the company, shall reinsure the amount of the benefit that exceeds \$4,000 in the event of death from natural causes and the amount of the benefit that exceeds \$8,000 in the event of death from accidental causes.

(c) If the net capital and surplus of a domestic insurance company is at least \$50,001 but less than \$75,001, the company, for any policy issued by the company, shall reinsure the amount of the benefit that exceeds \$3,000 in the event of death from natural causes and the amount of the benefit that exceeds \$6,000 in the event of death from accidental causes.

(d) If the net capital and surplus of a domestic insurance company is at least \$35,001 but less than \$50,001, the company, for any policy issued by the company, shall reinsure the amount of the benefit that exceeds \$2,000 in the event of death from natural causes and the amount of the benefit that exceeds \$4,000 in the event of death from accidental causes.

(e) If the net capital and surplus of a domestic insurance company is \$35,000 or less, the company, for any policy issued by the company, shall reinsure the amount of the benefit that exceeds \$1,000 in the event of death from natural causes and the amount of the benefit that exceeds \$2,000 in the event of death from accidental causes.

(f) Benefits under this section must be reinsured with a legal reserve company that is authorized to engage in the business of insurance in this state.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 841.303. ENTIRE CONTRACT. Each policy of insurance issued or delivered in this state by any life insurance company engaged in business in this state constitutes the entire contract between the parties, except that if the application is made a part of the contract, the policy and the application constitute the entire contract.

Redesignated from Insurance Code Sec. 1101.003(a) and amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.204(a), eff. Sept. 1, 2003.

SUBCHAPTER H. DEPOSIT OF SECURITIES

Sec. 841.351. DEPOSIT WITH COMPTROLLER. (a) A domestic insurance company may, at its option, deposit with the comptroller either:

(1) securities in which the company's capital stock is invested; or

(2) securities in an amount equal to the amount of the company's capital stock.

(b) Securities deposited under Subsection (a) must be securities of a class authorized by the laws of this state for investments of a domestic insurance company's capital stock.

(c) A domestic insurance company may, at its option, withdraw a deposit made under Subsection (a), or any portion of the deposit, after substituting a deposit of securities of a like class and of an amount and value equal to the withdrawn deposit or portion of deposit.

(d) The commissioner must first approve any securities

deposited or being substituted under this section.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 841.352. ISSUANCE OF RECEIPT FOR DEPOSIT. When a domestic insurance company deposits securities under this subchapter, the comptroller shall issue to the company a receipt that:

(1) describes the deposit in a manner that identifies the securities; and

(2) states that the securities are held on deposit as capital stock investments of the company.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 841.353. ADVERTISEMENT OF DEPOSIT. A domestic insurance company that makes a deposit under this subchapter may:

(1) advertise the fact that a deposit has been made; or

(2) print a copy of the receipt for the deposit on any policy the company issues.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 841.354. ACCESS TO DEPOSIT. In accordance with reasonable rules adopted by the comptroller and the commissioner, the proper officer or agent of a domestic insurance company making a deposit of securities under this subchapter may at a reasonable time:

(1) examine the deposit;

(2) detach coupons from the securities; and

(3) collect interest on the deposit.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 841.355. WITHDRAWAL OF DEPOSIT AFTER MERGER, CONSOLIDATION, OR TOTAL REINSURANCE. (a) When two or more domestic insurance companies that have two or more deposits of securities under this subchapter merge, consolidate, or enter into a total reinsurance contract by which the ceding company is dissolved and its

assets and liabilities are acquired or assumed by the surviving company, the new, surviving, or reinsuring insurance company, on approval of the commissioner, may withdraw all of the deposits, except for the deposit of the greatest amount and value. The new, surviving, or reinsuring insurance company must demonstrate to the commissioner that the company is the owner of the deposited securities before the commissioner approves the withdrawal of those securities.

(b) In accordance with an order of the commissioner approving a withdrawal of securities under this section, the comptroller shall release, transfer, and deliver the withdrawn securities to their owner.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 841.356. SITUS OF DEPOSIT FOR TAX PURPOSES. For purposes of state, county, or municipal taxation, the situs of deposited securities is the municipality and county in which the depositing company's home office is located.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 841.357. MAINTENANCE OF DEPOSIT. A domestic insurance company must maintain a deposit of securities under this subchapter as long as the company has outstanding any liability to a policyholder in this state.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER I. LIMITED PURPOSE SUBSIDIARY LIFE INSURANCE COMPANIES

Sec. 841.401. PURPOSE. The purpose of this subchapter is to authorize the establishment of domestic limited purpose subsidiary life insurance companies to enable those companies to support excess reserves for certain life insurance policies.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1173 (H.B. [3161](#)), Sec. 1, eff. June 17, 2011.

Sec. 841.402. DEFINITIONS. In this subchapter:

(1) "Affiliated company" means:

(A) domestic life insurance companies that are directly or indirectly wholly owned subsidiaries of the same holding company; or

(B) controlled persons.

(2) "Appointed actuary" means the actuary who is appointed by a limited purpose subsidiary life insurance company to render the actuarial opinion required by Subchapter B, Chapter 425.

(3) "Ceding insurer" means a company that cedes risk to a limited purpose subsidiary life insurance company under a reinsurance contract and that is:

(A) a domestic life insurance company that is the parent of a limited purpose subsidiary life insurance company; or

(B) an affiliated company of a limited purpose subsidiary life insurance company.

(4) "Controlled person" means a person organized or authorized to do business under the laws of this state that is controlled directly or indirectly by a holding company.

(5) "Excess reserves" means the amount of statutory reserves determined to be redundant by the appointed actuary for life insurance policies whose reserves are calculated under 28 T.A.C. Chapter 3, Subchapter EE. Excess reserves may not be an amount greater than the difference between the reserves calculated using 28 T.A.C. Chapter 3, Subchapter EE, and the reserves calculated using generally accepted accounting principles.

(6) "Guarantor" means a holding company or an affiliated company under Section 841.417 of the limited purpose subsidiary life insurance company that is a party to a guaranty.

(7) "Guaranty" means a commissioner-approved agreement by a guarantor with sufficient equity and financial strength to pay, during the life of the guaranty, an amount equal to the specified obligations of a limited purpose subsidiary life insurance company, less the equity of all ceding insurers that are subsidiaries of the guarantor, to satisfy the agreement.

(8) "Holding company" means a person that directly or indirectly controls an insurer.

(9) "Insurer" means a domestic life insurance company organized under this chapter.

(10) "Letter of credit" means a clean, unconditional,

irrevocable letter of credit issued or confirmed by a qualified United States financial institution, as defined by Section 493.104(b)(2)(C).

(11) "Limited purpose subsidiary life insurance company" means a limited purpose subsidiary life insurance company organized under this subchapter:

(A) that is wholly owned by a life insurance company or an affiliated company; and

(B) to which the commissioner issues a certificate of authority under this chapter.

(12) "Material transaction" means a transaction or series of transactions involving amounts equal to or exceeding three percent of a limited purpose subsidiary life insurance company's admitted assets.

(13) "Organizational document" means a limited purpose subsidiary life insurance company's articles of incorporation and the company's bylaws.

(14) "Organizing company" means the company that organizes a limited purpose subsidiary life insurance company under this subchapter.

(15) "Parent" means a person that directly or indirectly controls through one or more intermediaries, or wholly owns, a limited purpose subsidiary life insurance company.

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

(17) "Reinsurance contract" means a contract between a limited purpose subsidiary life insurance company and a ceding insurer under which the limited purpose subsidiary life insurance company agrees to provide reinsurance to the ceding insurer for certain risks.

(18) "Risk" means a risk associated with life insurance policies written on or after the effective date of this chapter by a ceding insurer, or assumed by a ceding insurer from an affiliated company under life insurance policies which were written on or after the effective date of this chapter, by the affiliated company and for which the ceding insurer calculates statutory reserves for those policies pursuant to 28 T.A.C. Chapter 3, Subchapter EE.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1173 (H.B. [3161](#)), Sec. 1, eff. June 17, 2011.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 594 (S.B. 1070), Sec. 3.05, eff. September 1, 2017.

Sec. 841.403. ORGANIZATIONAL DOCUMENTS. (a) A wholly owned domestic insurer authorized to transact the business of insurance under this chapter or an affiliated company organized or authorized to conduct business under the laws of this state may organize a limited purpose subsidiary life insurance company under this subchapter.

(b) A limited purpose subsidiary life insurance company may reinsure risks of the organizing company and of an affiliated company.

(c) A limited purpose subsidiary life insurance company's organizational documents must:

(1) limit the company's authority to transact the business of insurance to reinsuring only the risks of a ceding insurer;

(2) provide that the limited purpose subsidiary life insurance company may not otherwise engage in the business of insurance; and

(3) provide that the limited purpose subsidiary life insurance company must always be wholly owned by a domestic insurer authorized to transact the business of insurance under this chapter or by an affiliated company organized or authorized to do business under the laws of this state.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1173 (H.B. 3161), Sec. 1, eff. June 17, 2011.

Sec. 841.404. CERTIFICATE OF AUTHORITY REQUIRED. A limited purpose subsidiary life insurance company may not engage in the business of reinsurance in this state unless the limited purpose subsidiary life insurance company obtains from the commissioner a certificate of authority under this subchapter.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1173 (H.B. 3161), Sec. 1, eff. June 17, 2011.

Sec. 841.405. APPLICATION FOR CERTIFICATE OF AUTHORITY. To

obtain a charter for a limited purpose subsidiary life insurance company, the incorporators of the company shall pay to the department a charter fee in an amount determined under Chapter 202 and file with the department:

- (1) an application for charter on the form prescribed by, and containing the information prescribed by, the commissioner;
- (2) the company's articles of incorporation;
- (3) an affidavit made by the company's president, vice president, treasurer, or chief financial officer stating that:
 - (A) the minimum capital and surplus requirements of this subchapter are satisfied;
 - (B) the capital and surplus are the bona fide property of the company;
 - (C) the information in the articles of incorporation is true and correct;
 - (D) the proposed organization and operation of the limited purpose subsidiary life insurance company comply with all applicable provisions of this subchapter;
 - (E) the limited purpose subsidiary life insurance company's investment policy reflects and takes into account the liquidity of assets and the reasonable preservation, administration, and management of those assets with respect to the risks associated with the reinsurance contract; and
 - (F) any reinsurance contract and any arrangement for securing the limited purpose subsidiary life insurance company's obligations under the reinsurance contract, including any agreements or other documentation to implement the arrangement;
- (4) a business plan that includes pro forma financial statement projections that demonstrate how the limited purpose subsidiary life insurance company will comply with Section 841.412;
- (5) a copy of any proposed guaranty that demonstrates how compliance with Sections 841.412 and 841.417 will be achieved;
- (6) an opinion of a qualified independent actuary acceptable to the commissioner that the methodology and assumptions used to set and discount reserves make good and sufficient provision for the risk assumed by the limited purpose subsidiary life insurance company, including significant stress tests on key assumptions; and
- (7) any other statement or document required by the commissioner to evaluate the limited purpose subsidiary life insurance company's application for a certificate of authority.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1173 (H.B. 3161), Sec. 1, eff. June 17, 2011.

Sec. 841.406. INVESTMENT OF CERTAIN SURPLUS BY ORGANIZING COMPANY. If the company that organizes a limited purpose subsidiary life insurance company is a domestic life insurance company, the organizing company may invest funds from the organizing company's surplus in the limited purpose subsidiary life insurance company.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1173 (H.B. 3161), Sec. 1, eff. June 17, 2011.

Sec. 841.407. OFFICERS AND DIRECTORS. The officers and directors of a company that organizes a limited purpose subsidiary life insurance company may serve as officers and directors of the limited purpose subsidiary life insurance company.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1173 (H.B. 3161), Sec. 1, eff. June 17, 2011.

Sec. 841.408. ISSUANCE OF CERTIFICATE OF AUTHORITY. (a) The commissioner may issue a certificate of authority to a limited purpose subsidiary life insurance company, authorizing the company to transact reinsurance business in this state as a limited purpose subsidiary life insurance company based on a finding that:

(1) the company's application meets the criteria contained in this subsection;

(2) the proposed plan of the limited purpose subsidiary life insurance company provides for viable operation of the company, including a determination by the commissioner that the limited purpose subsidiary life insurance company applicant has sufficiently strong financial support;

(3) the guaranties meet the requirements of Section 841.417;

(4) the terms of any reinsurance arrangement, including the reinsurance contract and related transactions, comply with this subchapter and all applicable insurance laws and rules;

(5) the proposed application and reinsurance arrangement is

not hazardous to any ceding insurer; and

(6) the proposed application and reinsurance contract will always fund authorized investments that comply with Section 841.412, including statutory reserves for life insurance with invested assets at least equal to the amount of reserves required under generally accepted accounting principles.

(b) In conjunction with the issuance of a certificate of authority under this section, the commissioner may issue an order that includes any provisions, terms, and conditions regarding the organization, licensing, and operation of the limited purpose subsidiary life insurance company that the commissioner deems appropriate and that are not inconsistent with this chapter, including requesting from the company information to monitor the financial strength of guarantors and requiring the periodic reporting and monitoring of assets behind any guaranties issued.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1173 (H.B. [3161](#)), Sec. 1, eff. June 17, 2011.

Sec. 841.409. SCOPE OF CERTIFICATE OF AUTHORITY. (a) A limited purpose subsidiary life insurance company that has been issued a certificate of authority may reinsure only the risks of a ceding insurer. A limited purpose subsidiary life insurance company may not otherwise engage in the business of insurance.

(b) A limited purpose subsidiary life insurance company may purchase reinsurance to cede the risks assumed under a reinsurance contract.

(c) A limited purpose subsidiary life insurance company organized under this subchapter is considered to be licensed to transact the business of reinsurance for the purposes of Section 493.051, but may only reinsure risks of the company's affiliated companies.

(d) A limited purpose subsidiary life insurance company shall provide the commissioner with notice of any change in the company's business plan required by Section 841.405, including any material change in the methods used to comply with Section 841.413.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1173 (H.B. [3161](#)), Sec. 1, eff. June 17, 2011.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 594 (S.B. 1070), Sec. 3.06, eff. September 1, 2017.

Sec. 841.410. CAPITAL AND SURPLUS. (a) The commissioner may not issue a certificate of authority to a limited purpose subsidiary life insurance company unless the company possesses and maintains unimpaired paid-in capital and surplus of not less than \$10 million.

(b) A limited purpose subsidiary life insurance company shall comply with the risk-based capital requirements adopted by the commissioner by rule.

(c) A limited purpose subsidiary life insurance company shall maintain risk-based capital in an amount that is at least equal to 300 percent of the authorized control level of risk-based capital adopted by the commissioner.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1173 (H.B. 3161), Sec. 1, eff. June 17, 2011.

Sec. 841.411. FORECLOSURE ON COLLATERAL. A limited purpose subsidiary life insurance company shall immediately notify the commissioner of any action by a ceding insurer or any other person to foreclose on, or otherwise take possession of, collateral provided by the limited purpose subsidiary life insurance company to secure an obligation of the company.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1173 (H.B. 3161), Sec. 1, eff. June 17, 2011.

Sec. 841.412. MINIMUM AUTHORIZED INVESTMENT REQUIREMENT AFTER CREDIT FOR REINSURANCE; LETTERS OF CREDIT; GUARANTIES. (a) A limited purpose subsidiary life insurance company shall hold investments authorized under Subchapters C and D, Chapter 425, exclusive of investments in affiliates, in an amount that at least equals the sum of:

(1) the minimum capital and surplus requirements of Section 841.410;

(2) the risk-based capital requirements adopted by the commissioner; and

(3) reserves calculated using generally accepted accounting principles.

(b) Subject to compliance with Subsection (a) and notwithstanding Chapter 425, a limited purpose subsidiary life insurance company may reduce the amount of the company's excess reserves on account of:

(1) reinsurance that complies with Chapter 493;

(2) a letter of credit that complies with Section 493.104(b)(2)(C); or

(3) guaranties from a holding company or an affiliated company as provided by Section 841.417.

(c) Notwithstanding Subsection (b), a limited purpose subsidiary life insurance company may hold guaranties from a holding company or an affiliated company as provided by Section 841.417 as an admitted asset with an offsetting increase in special surplus funds to support excess reserves only.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1173 (H.B. 3161), Sec. 1, eff. June 17, 2011.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 594 (S.B. 1070), Sec. 3.07, eff. September 1, 2017.

Sec. 841.413. PERMITTED REINSURANCE. (a) A limited purpose subsidiary life insurance company may only reinsure the risks of a ceding insurer under a reinsurance contract.

(b) Unless otherwise approved in advance by the commissioner, a limited purpose subsidiary life insurance company may not assume or retain exposure to reinsurance losses for the company's own account that are not funded by:

(1) premium and other amounts payable by the ceding insurer to the limited purpose subsidiary life insurance company under the reinsurance contract, or any return on the investment of the premiums or other amounts;

(2) letters of credit that qualify under Section 493.104(b)(2)(C); or

(3) guaranties of a holding company or an affiliated company as provided by Section 841.417.

(c) A limited purpose subsidiary life insurance company may

cede risks assumed under a reinsurance contract to one or more reinsurers through the purchase of reinsurance, subject to the prior approval of the commissioner. The commissioner may approve a reinsurance contract under this subsection if the commissioner finds that:

- (1) the proposed reinsurance complies with Chapter 493;
- (2) the proposed reinsurer has sufficient liquidity, admitted assets, and policyholder surplus to support the liabilities assumed under the reinsurance contract; and
- (3) the proposed reinsurance contract would not result in a hazardous financial condition for the limited purpose subsidiary life insurance company.

(d) A limited purpose subsidiary life insurance company may enter into contracts and conduct other commercial activities related or incidental to, and necessary to fulfill the purposes of, a reinsurance contract.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1173 (H.B. [3161](#)), Sec. 1, eff. June 17, 2011.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 594 (S.B. [1070](#)), Sec. 3.08, eff. September 1, 2017.

Sec. 841.414. REPORTS ON RESERVES AND RISK-BASED CAPITAL. (a) A limited purpose subsidiary life insurance company annually shall file an opinion of the appointed actuary acceptable to the commissioner concerning the methods and assumptions used to set reserves. The opinion must demonstrate that the limited purpose subsidiary life insurance company holds risk-based capital and invested admitted assets that are at least equal to reserves specified by generally accepted accounting principles.

(b) The commissioner may reject the opinion of the appointed actuary if the commissioner determines that accepting the opinion would be hazardous to policyholders, enrollees, creditors, or the public.

(c) A limited purpose subsidiary life insurance company annually shall file with the commissioner a report of the limited purpose subsidiary life insurance company's risk-based capital level as of the end of the preceding calendar year containing the

information required by the risk-based capital instructions adopted by the commissioner.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1173 (H.B. 3161), Sec. 1, eff. June 17, 2011.

Sec. 841.415. OTHER LAWS NOT APPLICABLE. The deposit requirements in Subchapter H do not apply to a limited purpose subsidiary life insurance company.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1173 (H.B. 3161), Sec. 1, eff. June 17, 2011.

Sec. 841.416. APPLICABILITY OF OTHER LAW. Except as specifically provided by law, all provisions of this code apply to a limited purpose subsidiary life insurance company formed under this subchapter.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1173 (H.B. 3161), Sec. 1, eff. June 17, 2011.

Sec. 841.417. GUARANTY REQUIREMENTS. (a) A guaranty may not be used to comply with this chapter without the prior written approval of the commissioner.

(b) Before approving a guaranty, the commissioner must find that:

(1) the guarantor has capital and surplus of \$100 million, exclusive of investments in subsidiaries and affiliates;

(2) the guarantor has admitted assets backing capital and surplus in an amount sufficient to fulfill the guaranty, and the sufficiency on an ongoing basis is demonstrated to the satisfaction of the commissioner;

(3) the guarantor and all affiliates are in good standing with the department;

(4) the guarantor has provided all information requested by the commissioner; and

(5) the guarantor is otherwise acceptable to the commissioner.

(c) Notwithstanding Subsection (b), the commissioner may allow, subject to the commissioner's prior approval, an affiliated company of the holding company to serve as guarantor. The commissioner may approve an affiliated company as a guarantor on a finding that the affiliated company possesses the independent financial means to discharge the guaranty using the affiliated company's own financial resources.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1173 (H.B. 3161), Sec. 1, eff. June 17, 2011.

Sec. 841.418. SUNSET PROVISION. This subchapter is valid for business sold only until January 1 of the year in which principle-based reserve requirements become operative in Texas under the adoption of the National Association of Insurance Commissioners' 2009 amendments to the NAIC Model Standard Valuation Law. After that January 1, the limited purpose subsidiary life insurance company may not assume new risks of a ceding insurer relating to business sold after that date.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1173 (H.B. 3161), Sec. 1, eff. June 17, 2011.

Sec. 841.419. CERTIFICATION OF ACTUARIAL OFFICER. (a) At the time a limited purpose subsidiary life insurance company files an application for a certificate of authority under this subchapter, and not later than March 1 of each year that a limited purpose subsidiary life insurance company is in operation and is ceded new business from a ceding insurer, a senior actuarial officer of each ceding insurer shall file with the commissioner a certification that the ceding insurer's transactions with the limited purpose subsidiary life insurance company are not being used to gain an unfair advantage in the pricing of the ceding insurer's products.

(b) A ceding insurer may not be deemed to have an unfair advantage if the pricing of the policies and contracts reinsured by the limited purpose subsidiary life insurance company reflects, at the time the policies and contracts were issued, a reasonable long-term estimate of the cost to the ceding insurer of an alternative third-party transaction, and uses current pricing assumptions.

(c) The ceding insurer shall keep documentation between examinations that sets forth the manner in which a senior actuarial officer arrived at the conclusions in the certification.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1173 (H.B. 3161), Sec. 1, eff. June 17, 2011.

Sec. 841.420. ACCOUNTING AND FINANCIAL REPORTING. The commissioner shall prescribe accounting and financial reporting requirements with regard to the limited purpose subsidiary life insurance company and any insurer as defined by Section 841.402 that organizes a limited purpose subsidiary life insurance company.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1173 (H.B. 3161), Sec. 1, eff. June 17, 2011.

SUBCHAPTER O. ENFORCEMENT AND INTERVENTION

Sec. 841.701. REVOCATION OF CERTIFICATE OF AUTHORITY. (a) If the commissioner determines that an insurance company that holds a certificate of authority does not comply with this chapter or another law described by Section 841.002, the commissioner shall notify the company that the commissioner intends to revoke its certificate of authority on the expiration of the 30-day period after the date actual notice is delivered or mailed under this section.

(b) Notice under this section must:

- (1) be in writing; and
- (2) be delivered to an executive officer of the company by personal service or by registered mail.

(c) If an insurance company receiving notice under this section does not fully comply before the expiration of the period prescribed by Subsection (a), the commissioner shall revoke the company's certificate of authority.

(d) An insurance company whose certificate of authority is revoked under this section is not entitled to receive another certificate of authority for a period of one year and until the company has fully and in good faith complied with this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 841.702. APPEAL OF DETERMINATION TO REVOKE CERTIFICATE. An insurance company aggrieved by an order of the commissioner to revoke the company's certificate of authority under Section 841.701 may file suit in a court in Travis County to vacate the order.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.022, eff. September 1, 2005.

Sec. 841.703. CERTIFICATE OF AUTHORITY VOID ON FAILURE TO SATISFY JUDGMENT. (a) If an officer holding an execution issued on a final judgment rendered against an insurance company demands payment of the judgment from an officer or attorney of record of the company and the company does not fully satisfy the judgment before the 31st day after the date the demand is made, the officer shall certify the demand and failure to the commissioner, regardless of whether the demand is made in this state.

(b) On receipt of a certification under Subsection (a), the commissioner shall declare void the certificate of authority issued to the company under this chapter.

(c) An insurance company whose certificate of authority is declared void under this section may not engage in the business of insurance in this state until:

- (1) the judgment is fully satisfied and discharged; and
- (2) the commissioner renews the company's certificate of authority.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 841.704. FALSE STATEMENT, REPORT, OR OTHER DOCUMENT; CRIMINAL PENALTY. (a) A person commits an offense if the person executes or causes to be executed a statement, report, or other document required by law to be filed with the commissioner that contains a material statement or fact that the person knows to be false.

(b) A person commits an offense if the person is an officer of an insurance company that is not organized under the laws of this state and the person files a statement, report, or other document

required by law to be filed with the commissioner that contains a material statement or fact that the person knows to be false.

(c) An offense under this section is punishable by imprisonment in the Texas Department of Criminal Justice for a term of not less than one year.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 87 (S.B. 1969), Sec. 25.120, eff. September 1, 2009.

Sec. 841.705. PENALTY FOR FAILURE TO INVEST OR REPORT. (a) In addition to the penalty provided by this subchapter, an insurance company is subject to a penalty as prescribed by Subsection (b) if, while holding a certificate of authority to engage in the business of insurance in this state, or after the company ceases to write new business or ceases to hold a certificate of authority, the company intentionally fails or refuses to:

- (1) make the investments required by Chapter 425;
- (2) make a report required by a law described by Section 841.002;
- (3) make any special report requested by the commissioner under a law described by Section 841.002; or
- (4) comply with another provision of a law described by Section 841.002.

(b) A penalty under this section is in the amount of \$25 per day for each day the company remains in default after the commissioner notifies the company of the default in the manner provided by this subchapter.

(c) A penalty under this section may be recovered in a suit brought by the attorney general on behalf of the state in a district court of Travis County.

- (d) In a suit brought to recover a penalty under this section:
- (1) there are rebuttable presumptions that:
 - (A) any default that may have occurred was intentional;
 and
 - (B) the notice required by Subsection (b) was given;
 and
 - (2) if the question of whether the investments required by

Chapter 425 were made is at issue, the defendant insurance company has the burden of proving that the investments were made as required by that chapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 15, eff. April 1, 2007.

CHAPTER 842. GROUP HOSPITAL SERVICE CORPORATIONS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 842.001. DEFINITIONS. In this chapter:

(1) "Group hospital service corporation" means a corporation organized under this chapter to establish and operate a nonprofit hospital service plan, under which hospital care may be provided by the corporation through one or more hospitals and sanitariums with which the corporation has contracted for the provision of that care.

(2) "Health care provider" means a person, association, partnership, corporation, or other entity that provides a service or supplies to prevent, alleviate, cure, or heal human illness or injury.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 842.002. APPLICABILITY OF OTHER LAWS. (a) Except as otherwise required by this chapter, a state agency may not require a group hospital service corporation to post a bond or place a deposit with the agency or another agency of this state to begin or maintain operations authorized under this chapter.

(b) The group hospital service corporation is exempt from a provision of this code that is not expressly made applicable to the corporation.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 842.003. CORPORATION SUBJECT TO REGULATION BY COMMISSIONER AND DEPARTMENT. Each group hospital service corporation is subject to regulation by the department and the commissioner.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER B. FORMATION AND STRUCTURE OF GROUP HOSPITAL SERVICE CORPORATION

Sec. 842.051. APPLICATION FOR CORPORATE CHARTER; NONPROFIT STATUS REQUIRED. (a) Seven or more persons, a majority of whom are superintendents of hospitals or physicians licensed by the Texas State Board of Medical Examiners, may apply to the secretary of state for a corporate charter to operate a group hospital service corporation.

(b) A group hospital service corporation must be governed and operated as a nonprofit organization.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 842.052. MINIMUM MEMBERSHIP REQUIREMENTS. (a) Before a group hospital service corporation may be incorporated, the corporation must have collected in advance from at least 500 applicants for membership:

(1) the application fee; and

(2) an amount at least equal to the amount charged by the corporation for one month's premium for coverage.

(b) A group hospital service corporation must maintain a membership of at least 500 as a condition of continued operation.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER C. AUTHORITY TO ENGAGE IN BUSINESS

Sec. 842.101. ISSUANCE OF CERTIFICATE OF AUTHORITY. (a) The department shall issue to a group hospital service corporation a certificate of authority that authorizes the corporation to engage in the business of a group hospital service corporation if the corporation:

(1) files a statement acceptable to the department showing solvency; and

(2) complies with this chapter.

(b) The department shall charge the fee prescribed by law for the issuance of the certificate of authority.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER D. BOARD OF DIRECTORS; PERSONNEL

Sec. 842.151. BOARD OF DIRECTORS. (a) Each group hospital service corporation is governed by a board of directors that has full control over its management affairs.

(b) A board of directors must be composed of at least 12 but not more than 20 directors. A majority of the directors must be persons who:

(1) are not health care providers or employees of health care providers; and

(2) do not have a financial interest in a health care provider.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 842.152. COMPENSATION OF DIRECTORS. A director of a group hospital service corporation may not receive compensation for the director's services but is entitled to receive reimbursement for reasonable and necessary expenses incurred in attending a meeting called to manage or direct the affairs of the corporation.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 842.153. BOARD MEETINGS. The board of directors of a group hospital service corporation may not meet more frequently than once a month. A meeting may not last more than five days.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 842.154. BOND REQUIREMENTS FOR CERTAIN OFFICERS AND EMPLOYEES. (a) Each group hospital service corporation shall post a bond for the officer or employee responsible for the handling of the corporation's money. The bond must be:

(1) issued by a surety company licensed by the department to do business in this state; and

(2) at all times in an amount at least equal to \$25,000.

(b) In addition to the bond required under Subsection (a), the corporation shall post a separate bond or a blanket bond for all employees who have access to the money of the corporation. The bond must be in a reasonable amount set by the commissioner in the amount of at least \$500, not to exceed \$10,000.

(c) A bond required by this section must be payable to the commissioner for the use and benefit of the corporation.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 842.155. TREASURER'S BOND. The treasurer of each group hospital service corporation shall post a fidelity bond with a corporation surety. The bond must be in the amount determined by the officers of the corporation as necessary to secure the faithful handling of the corporation's money.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 842.156. COMPENSATION OF CERTAIN OFFICERS AND EMPLOYEES. A paid officer or employee of a group hospital service corporation may not receive more than \$20,000 annually as compensation for the officer's or employee's services unless a higher amount is first authorized by a vote of:

- (1) the board of directors of the corporation; or
- (2) a committee of the board of directors that is charged with the duty of authorizing that compensation.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER E. REGULATION OF GROUP HOSPITAL SERVICE CORPORATIONS

Sec. 842.201. ANNUAL STATEMENT; FILING FEE. (a) Not later than March 1 of each year, each group hospital service corporation shall file with the department an annual statement that covers the operations for the preceding calendar year.

(b) The statement must be in the form prescribed by and provide the information required by the commissioner.

(c) The department shall charge a fee in an amount determined under Chapter 202 for filing the statement.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.025,
eff. April 1, 2009.

Sec. 842.202. RESERVE REQUIREMENTS. (a) Each group hospital service corporation shall maintain reserves sufficient to cover liability for claims incurred but not yet paid and the expenses incurred in settling those claims.

(b) A group hospital service corporation shall estimate the amount necessary to satisfy the reserve requirements using a method submitted to the commissioner for approval. The estimate method used by the corporation is considered approved on the 30th day after the date filed with the commissioner unless the commissioner affirmatively approves or disapproves the method before that date.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 842.203. FINAL JUDGMENT DEPOSIT. (a) For each 1,000 members and fraction of 1,000 members, a group hospital service corporation shall deposit \$100 with the comptroller through the commissioner. The total deposit required under this subsection may not exceed \$2,000.

(b) The deposit required under Subsection (a) shall be used to pay any judgment entered against the group hospital service corporation and is subject to garnishment after a final judgment is entered.

(c) The group hospital service corporation shall immediately replenish the amount on deposit if the amount is impounded or impaired. If the amount is not replenished immediately on the demand of the commissioner, the corporation may be regarded as insolvent and treated accordingly.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 842.204. INVESTMENT LIMITATIONS. The investment limitations that apply to a life, health, and accident insurance company apply to the investments of a group hospital service

corporation.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 842.205. INCURRED EXPENSES. (a) In this section, "general expenses" means expenses incurred by a group hospital service corporation in the operation of its business other than:

- (1) a tax;
- (2) a license fee;
- (3) a commission; or
- (4) an expense incurred in the performance of a contract:

(A) made directly or indirectly with this state or the United States; and

(B) under which the corporation does not assume an insurance risk.

(b) Subject to Subsection (c), a group hospital service corporation may not incur during a calendar year general expenses that exceed 20 percent of the premiums earned in that calendar year.

(c) For a group hospital service corporation earning \$500 million or more in premiums in a calendar year, the maximum percentage of general expenses that may be incurred during a calendar year is reduced by one-half percent for each \$50 million of premiums earned to a maximum percentage of 15 percent.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 842.206. MINIMUM SURPLUS REQUIREMENT. Each group hospital service corporation shall maintain a surplus of at least \$100,000 to meet adverse contingencies.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 842.207. CONTRACTS; REINSURANCE; OTHER AGREEMENTS. (a) Subject to Subsection (b), a group hospital service corporation may:

(1) contract with another organization similar in character for joint participation through:

- (A) a mutualization contract agreement;
- (B) a reinsurance treaty; or

(C) another arrangement; and
 (2) cede or accept risks from an insurer on all or part of a risk.

(b) Each document used for a purpose described by Subsection (a) must be filed with the department and approved by the commissioner for use in that purpose.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 842.208. BOOKS AND RECORDS. Each group hospital service corporation shall keep complete books and records.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 842.209. EXAMINATIONS. The following laws apply to a group hospital service corporation:

- (1) Subchapter A, Chapter 86; and
- (2) Sections 401.051, 401.052, 401.054-401.062, 401.151, 401.152, 401.155, and 401.156.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
 Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.026, eff. April 1, 2009.

Sec. 842.210. LIQUIDATION, REHABILITATION, OR CONSERVATION OF GROUP HOSPITAL SERVICE CORPORATION. The dissolution, liquidation, rehabilitation, or conservation of a group hospital service corporation is subject to Chapters 441 and 443.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
 Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.027, eff. April 1, 2009.

SUBCHAPTER F. PLAN OF OPERATION; PROVISION OF BENEFITS TO MEMBERS

Sec. 842.251. PLAN OF OPERATION. (a) Before accepting

applications for membership in its hospital service plan, a group hospital service corporation must submit to the commissioner a plan of operation. The plan of operation must be accompanied by a schedule of the dues to be charged to members and a statement of the amount of hospital services that the corporation contracts to provide.

(b) The commissioner must approve the plan of operation as fair and reasonable before the corporation may engage in business.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 842.252. MEMBERSHIP CERTIFICATE; CONTRACT. (a) A group hospital service corporation shall issue to each member a membership certificate that states the benefits to which the member is or may become entitled.

(b) The department must approve the form of:

(1) the membership certificate; and

(2) any contract made between the group hospital service corporation and the member's employer or group representative.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 842.253. POLICY, CERTIFICATE, AND APPLICATION FORMS. A policy, certificate, or application form used by a group hospital service corporation is subject to Chapter 1701.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 2E.028, eff. April 1, 2009.

Sec. 842.254. DEPOSIT REQUIREMENTS. A group hospital service corporation shall deposit in the account of the corporation in a bank money collected by the corporation from a member or subscriber. The bank must be a state depository.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 842.255. ADVANCE PAYMENTS TO HOSPITAL PROHIBITED. A group hospital service corporation may not pay to a hospital any money collected by the corporation from a member or subscriber before the hospital provides necessary care to that member or subscriber.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 842.256. CONTRACTS WITH HEALTH CARE PROVIDERS. (a) A group hospital service corporation may contract with health care providers as necessary to ensure to each member or subscriber the provision of services and supplies covered by the membership certificate or policy of the corporation.

(b) A group hospital service corporation may not be required to contract with any particular health care provider.

(c) This section does not authorize a group hospital service corporation to contract with a health care provider in a manner prohibited by a licensing law of this state under which that health care provider operates.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 842.257. MAY LIMIT BENEFITS. A policy or certificate issued by a group hospital service corporation may limit the types of disease for which benefits are provided.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 842.258. LIMITATIONS ON CONTRACTS FOR MEDICAL SERVICES.

(a) A group hospital service corporation may not:

- (1) contract to provide to a member a physician or any medical services;
- (2) contract to practice medicine in any manner;
- (3) control or attempt to control the relations existing between a member and the member's physician; or
- (4) restrict the right of a patient to obtain the services of any licensed physician.

(b) This section does not prohibit a group hospital service corporation from contracting with:

(1) a health organization certified under Chapter 162, Occupations Code; or

(2) a physician or other health care provider under rules adopted for preferred provider plans.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 842.259. USE OF INDEMNITY PLAN AUTHORIZED. A group hospital service corporation may provide benefits for medical care, surgical care, or both medical and surgical care on the basis of indemnity payments for incurred expenses.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 842.260. PAYMENT OF CLAIM; PROOF OF CLAIM. (a) After receipt of due proof of claim, a group hospital service corporation shall pay each claim presented under a membership certificate in full not later than the 60th day after the date on which the applicable services prescribed in the certificate have been provided.

(b) Written notice of a claim given to a group hospital service corporation is considered due proof of claim under this section if the corporation does not provide the claimant with the forms usually provided by the corporation for filing a claim before the 16th day after the date notice is received.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 842.261. INFORMATION AVAILABLE THROUGH INTERNET SITE. (a) A group hospital service corporation that maintains an Internet site shall list on the Internet site the physicians and health care providers, including, if appropriate, mental health providers and substance abuse treatment providers, that may be used by members in accordance with the terms of the policy or certificate applicable to the member. The listing must identify those physicians and health care providers who continue to be available to provide services to new patients or clients.

(b) The group hospital service corporation shall update at least quarterly an Internet site subject to this section.

(c) The commissioner may adopt rules as necessary to implement this section. The rules may govern the form and content of the information required to be provided under Subsection (a).

Acts 2003, 78th Leg., ch. 1177, Sec. 2, eff. Sept. 1, 2003.

SUBCHAPTER G. DISCIPLINARY PROCEDURES

Sec. 842.301. REVOCATION OF CERTIFICATE OF AUTHORITY. The commissioner shall revoke the certificate of authority of a group hospital service corporation that:

- (1) is determined to be:
 - (A) operating fraudulently; or
 - (B) improperly contesting claims; or
- (2) fails to pay valid claims in accordance with this

chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

CHAPTER 843. HEALTH MAINTENANCE ORGANIZATIONS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 843.001. SHORT TITLE. This chapter may be cited as the Texas Health Maintenance Organization Act.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.002. DEFINITIONS. In this chapter:

- (1) "Adverse determination" means a determination by a health maintenance organization or a utilization review agent that health care services provided or proposed to be provided to an enrollee are not medically necessary or are not appropriate.
- (2) "Basic health care services" means health care services that the commissioner determines an enrolled population might reasonably need to be maintained in good health.
- (3) "Blended contract" means a single document that provides a combination of indemnity and health maintenance organization benefits. The term includes a single contract policy, certificate, or evidence of coverage.
- (4) "Capitation" means a method of compensating a physician

or provider for arranging for or providing a defined set of covered health care services to certain enrollees for a specified period that is based on a predetermined payment per enrollee for the specified period, without regard to the quantity of services actually provided.

(5) "Complainant" means an enrollee, or a physician, provider, or other person designated to act on behalf of an enrollee, who files a complaint.

(6) "Complaint" means any dissatisfaction expressed orally or in writing by a complainant to a health maintenance organization regarding any aspect of the health maintenance organization's operation. The term includes dissatisfaction relating to plan administration, procedures related to review or appeal of an adverse determination under Section 843.261, the denial, reduction, or termination of a service for reasons not related to medical necessity, the manner in which a service is provided, and a disenrollment decision. The term does not include:

(A) a misunderstanding or a problem of misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information to the satisfaction of the enrollee; or

(B) a provider's or enrollee's oral or written expression of dissatisfaction or disagreement with an adverse determination.

(7) "Emergency care" means health care services provided in a hospital emergency facility, freestanding emergency medical care facility, or comparable emergency facility to evaluate and stabilize medical conditions of a recent onset and severity, including severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the individual's condition, sickness, or injury is of such a nature that failure to get immediate medical care could:

(A) place the individual's health in serious jeopardy;

(B) result in serious impairment to bodily functions;

(C) result in serious dysfunction of a bodily organ or part;

(D) result in serious disfigurement; or

(E) for a pregnant woman, result in serious jeopardy to the health of the fetus.

(8) "Enrollee" means an individual who is enrolled in a health care plan and includes covered dependents.

(9) "Evidence of coverage" means any certificate, agreement, or contract, including a blended contract, that:

(A) is issued to an enrollee; and

(B) states the coverage to which the enrollee is entitled.

(9-a) Repealed by Acts 2013, 83rd Leg., R.S., Ch. 915, Sec. 3(1), eff. September 1, 2013.

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

(10) "Group hospital service corporation" means a corporation operating under Chapter 842.

(11) "Health care" means prevention, maintenance, rehabilitation, pharmaceutical, and chiropractic services, other than medical care, provided by qualified persons.

(12) "Health care plan" means a plan:

(A) under which a person undertakes to provide, arrange for, pay for, or reimburse any part of the cost of health care services; and

(B) that consists in part of providing or arranging for health care services on a prepaid basis through insurance or otherwise, as distinguished from indemnifying for the cost of health care services.

(13) "Health care services" means services provided to an individual to prevent, alleviate, cure, or heal human illness or injury. The term includes:

(A) pharmaceutical services;

(B) medical, chiropractic, or dental care;

(C) hospitalization;

(D) care or services incidental to the health care services described by Paragraphs (A)-(C); and

(E) services provided under a limited health care service plan or a single health care service plan.

(14) "Health maintenance organization" means a person who arranges for or provides to enrollees on a prepaid basis a health care plan, a limited health care service plan, or a single health care service plan.

(15) "Health maintenance organization delivery network" means a health care delivery system in which a health maintenance organization arranges for health care services directly or indirectly through contracts and subcontracts with physicians and providers.

(16) "Life-threatening" means a disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

(17) "Limited health care service plan" means a plan:

(A) under which a person undertakes to provide, arrange for, pay for, or reimburse any part of the cost of limited health care services; and

(B) that consists in part of providing or arranging for limited health care services on a prepaid basis through insurance or otherwise, as distinguished from indemnifying for the cost of limited health care services.

(18) "Limited health care services" means:

(A) services for mental health, chemical dependency, or intellectual disability, or any combination of those services; or

(B) an organized long-term care service delivery system that provides for diagnostic, preventive, therapeutic, rehabilitative, and personal care services required by an individual with a loss in functional capacity on a long-term basis.

(19) "Medical care" means the provision of those services defined as practicing medicine under Section 151.002, Occupations Code.

(20) "Net worth" means the amount by which total liabilities, excluding liability for subordinated debt issued in compliance with Chapter 427, is exceeded by total admitted assets.

(21) "Person" means any natural or artificial person, including an individual, partnership, association, corporation, organization, trust, hospital district, community mental health center, intellectual disability center, mental health center, limited liability company, or limited liability partnership or the statewide rural health care system under Chapter 845.

(22) "Physician" means:

(A) an individual licensed to practice medicine in this state;

(B) a professional association organized under the Texas Professional Association Act (Article 1528f, Vernon's Texas Civil Statutes);

(C) an approved nonprofit health corporation certified under Chapter 162, Occupations Code;

(D) a medical school or medical and dental unit, as defined or described by Section 61.003, 61.501, or 74.601, Education

Code, that employs or contracts with physicians to teach or provide medical services or employs physicians and contracts with physicians in a practice plan; or

(E) another person wholly owned by physicians.

(23) "Prospective enrollee" means:

(A) an individual eligible to enroll in a health maintenance organization purchased through a group of which the individual is a member; or

(B) for an individual who is not a member of a group or whose group has not purchased or does not intend to purchase a health maintenance organization's health care plan, an individual who has expressed an interest in purchasing individual health maintenance organization coverage and is eligible for coverage by a health maintenance organization.

(24) "Provider" means:

(A) a person, other than a physician, who is licensed or otherwise authorized to provide a health care service in this state, including:

(i) a chiropractor, registered nurse, pharmacist, optometrist, or acupuncturist; or

(ii) a pharmacy, hospital, or other institution or organization;

(B) a person who is wholly owned or controlled by a provider or by a group of providers who are licensed or otherwise authorized to provide the same health care service; or

(C) a person who is wholly owned or controlled by one or more hospitals and physicians, including a physician-hospital organization.

(25) "Single health care service" means a health care service:

(A) that an enrolled population may reasonably need to be maintained in good health with respect to a particular health care need to prevent, alleviate, cure, or heal human illness or injury of a single specified nature; and

(B) that is provided by one or more persons licensed or otherwise authorized by the state to provide that service.

(26) "Single health care service plan" means a plan:

(A) under which a person undertakes to provide, arrange for, pay for, or reimburse any part of the cost of a single health care service;

(B) that consists in part of providing or arranging for the single health care service on a prepaid basis through insurance or otherwise, as distinguished from indemnifying for the cost of that service; and

(C) that does not include arranging for the provision of more than one health care need of a single specified nature.

(27) "Sponsoring organization" means a person who guarantees the uncovered expenses of a health maintenance organization and who is financially capable, as determined by the commissioner, of meeting the obligations resulting from that guarantee.

(28) "Uncovered expenses" means the estimated amount of administrative expenses and the estimated cost of health care services that are not guaranteed, insured, or assumed by a person other than the health maintenance organization. The term does not include the cost of health care services if the physician or provider agrees in writing that an enrollee is not liable, assessable, or in any way subject to making payment for the services except as described in the evidence of coverage issued to the enrollee under Chapter 1271. The term includes any amount due on loans in the next calendar year unless the amount is specifically subordinated to uncovered medical and health care expenses or the amount is guaranteed by a sponsoring organization.

(29) "Uncovered liabilities" means obligations resulting from unpaid uncovered expenses, the outstanding indebtedness of loans that are not specifically subordinated to uncovered medical and health care expenses or guaranteed by the sponsoring organization, and all other monetary obligations that are not similarly subordinated or guaranteed.

(30) "Delegated entity" means an entity, other than a health maintenance organization authorized to engage in business under this chapter, that by itself, or through subcontracts with one or more entities, undertakes to arrange for or provide medical care or health care to an enrollee in exchange for a predetermined payment on a prospective basis and that accepts responsibility for performing on behalf of the health maintenance organization a function regulated by this chapter, Section 1367.053, Subchapter A, Chapter 1452, Subchapter B, Chapter 1507, Chapter 222, 251, or 258, as applicable to a health maintenance organization, or Chapter 1271 or 1272. The term does not include:

(A) an individual physician; or

(B) a group of employed physicians, practicing medicine under one federal tax identification number, whose total claims paid to providers not employed by the group constitute less than 20 percent of the group's total collected revenue computed on a calendar year basis.

(31) "Limited provider network" means a subnetwork within a health maintenance organization delivery network in which contractual relationships exist between physicians, certain providers, independent physician associations, or physician groups that limits an enrollee's access to physicians and providers to those physicians and providers in the subnetwork.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1179, Sec. 8, eff. Sept. 1, 2003; Acts 2003, 78th Leg., ch. 1276, Sec. 10A.205(a), 10A.206, eff. Sept. 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.029, eff. April 1, 2009.

Acts 2009, 81st Leg., R.S., Ch. 1273 (H.B. 1357), Sec. 2, eff. March 1, 2010.

Acts 2011, 82nd Leg., R.S., Ch. 798 (H.B. 2292), Sec. 1, eff. September 1, 2011.

Acts 2013, 83rd Leg., R.S., Ch. 915 (H.B. 1358), Sec. 3(1), eff. September 1, 2013.

Acts 2015, 84th Leg., R.S., Ch. 838 (S.B. 202), Sec. 3.022, eff. September 1, 2015.

Acts 2023, 88th Leg., R.S., Ch. 30 (H.B. 446), Sec. 8.01, eff. September 1, 2023.

Sec. 843.003. POWERS OF INSURERS AND GROUP HOSPITAL SERVICE CORPORATIONS. (a) An insurer authorized to engage in the business of insurance in this state under Chapter 822, 841, or 883, an accident insurance company, health insurance company, or life insurance company authorized to engage in the business of insurance in this state under Chapter 982, or a group hospital service corporation may, either directly or through a subsidiary or affiliate, organize and operate a health maintenance organization

under this chapter.

(b) Any two or more insurers or group hospital service corporations described by Subsection (a), or their subsidiaries or affiliates, may jointly organize and operate a health maintenance organization under this chapter.

(c) An insurer or group hospital service corporation may contract with a health maintenance organization to provide:

(1) insurance or similar protection against the cost of care provided by the health maintenance organization; and

(2) coverage if the health maintenance organization does not meet its obligations.

(d) The authority of an insurer or group hospital service corporation under a contract described by Subsection (c) may include the authority to make benefit payments to a health maintenance organization for health care services provided by physicians or providers under a health care plan.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.004. GOVERNING BODY OF HEALTH MAINTENANCE ORGANIZATION. The governing body of a health maintenance organization may include physicians, providers, or other individuals, or any combination of physicians, providers, and other individuals.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.005. USE OF INSURANCE-RELATED TERMS BY HEALTH MAINTENANCE ORGANIZATION. A health maintenance organization that is not authorized as an insurer may not use in its name, contracts, or literature the word "insurance," "casualty," "surety," or "mutual," or any other words that are:

(1) descriptive of the insurance, casualty, or surety business; or

(2) deceptively similar to the name or description of an insurer or surety corporation engaging in business in this state.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.006. PUBLIC DOCUMENTS. (a) Except as provided by Subsection (b), each application, filing, and report required under this chapter, Section 1367.053, Subchapter A, Chapter 1452, Subchapter B, Chapter 1507, Chapter 222, 251, or 258, as applicable to a health maintenance organization, or Chapter 1271 or 1272 is a public document.

(b) An examination report is confidential but may be released if, in the opinion of the commissioner, the release is in the public interest.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.030, eff. April 1, 2009.

Sec. 843.007. CONFIDENTIALITY OF MEDICAL AND HEALTH INFORMATION. (a) Any information relating to the diagnosis, treatment, or health of an enrollee or applicant obtained by a health maintenance organization from the enrollee or applicant or from a physician or provider shall be held in confidence and may not be disclosed to any person except:

(1) to the extent necessary to accomplish the purposes of this chapter or:

(A) Section 1367.053;

(B) Subchapter A, Chapter 1452;

(C) Subchapter B, Chapter 1507;

(D) Chapter 222, 251, or 258, as applicable to a health maintenance organization; or

(E) Chapter 1271 or 1272;

(2) with the express consent of the enrollee or applicant;

(3) in compliance with a statute or court order for the production or discovery of evidence; or

(4) in the event of a claim or litigation between the enrollee or applicant and the health maintenance organization in which the information is pertinent.

(b) A health maintenance organization is entitled to claim the statutory privilege against disclosure that the physician or provider who provides the information to the health maintenance organization is entitled to claim.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.031,
eff. April 1, 2009.

Sec. 843.008. COSTS OF ADMINISTERING HEALTH MAINTENANCE ORGANIZATION LAWS. Money collected under this chapter and Chapters 222, 251, and 258, as applicable to a health maintenance organization, must be sufficient to administer this chapter and:

- (1) Section 1367.053;
- (2) Subchapter A, Chapter 1452;
- (3) Subchapter B, Chapter 1507;
- (4) Chapters 222, 251, and 258, as applicable to a health maintenance organization; and
- (5) Chapters 1271 and 1272.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.032,
eff. April 1, 2009.

Sec. 843.009. APPEALS; JUDICIAL REVIEW. (a) A person who is affected by a rule, ruling, or decision of the department or the commissioner is entitled to have the rule, ruling, or decision reviewed by the commissioner by applying to the commissioner.

- (b) An application must identify:
- (1) the applicant;
 - (2) the rule, ruling, or decision affecting the applicant;
 - (3) the interest of the applicant in the rule, ruling, or decision;
 - (4) the grounds of the applicant's objection;
 - (5) the action sought of the commissioner; and
 - (6) the reasons and grounds for the commissioner to take the action.

(c) An applicant shall file the original application with the chief clerk of the department with a certification that a true and correct copy of the application has been filed with the commissioner.

(d) Not later than the 30th day after the date the application

is filed, and after 10 days' written notice to each party of record, the commissioner shall review the action in a hearing. In the hearing, any evidence and any matter pertinent to the application may be submitted to the commissioner regardless of whether it was included in the application.

(e) After the hearing, the commissioner shall render a decision at the earliest possible date. The application has precedence over all other business of a different nature pending before the commissioner.

(f) The commissioner shall adopt rules, consistent with this section, relating to applications under this section and consideration of those applications that the commissioner considers advisable.

(g) A person who is affected by a rule, ruling, or decision of the commissioner and is dissatisfied with the rule, ruling, or decision may, after failing to get relief from the commissioner, file a petition seeking judicial review of the rule, ruling, or decision under Subchapter D, Chapter 36. The action has precedence over all other causes on the docket of a different nature.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Text of section effective until April 1, 2025

Sec. 843.010. APPLICABILITY OF CERTAIN PROVISIONS TO GOVERNMENTAL HEALTH BENEFIT PLANS. Sections 843.306(f) and 843.363(a)(4) do not apply to coverage under:

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

(2) a Medicaid program, including a Medicaid managed care program operated under Chapter 533, Government Code.

Added by Acts 2015, 84th Leg., R.S., Ch. 275 (H.B. 574), Sec. 1, eff. September 1, 2015.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 2.119, eff. April 1, 2025.

Text of section effective on April 1, 2025

Sec. 843.010. APPLICABILITY OF CERTAIN PROVISIONS TO GOVERNMENTAL HEALTH BENEFIT PLANS. Sections 843.306(f) and 843.363(a)(4) do not apply to coverage under:

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

(2) a Medicaid program, including a Medicaid managed care program operated under Chapter 540 or 540A, Government Code, as applicable.

Added by Acts 2015, 84th Leg., R.S., Ch. 275 (H.B. 574), Sec. 1, eff. September 1, 2015.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 2.119, eff. April 1, 2025.

SUBCHAPTER B. APPLICABILITY OF AND CONSTRUCTION WITH OTHER LAWS

Sec. 843.051. APPLICABILITY OF INSURANCE AND GROUP HOSPITAL SERVICE CORPORATION LAWS. (a) Except to the extent that the commissioner determines that the nature of health maintenance organizations, health care plans, or evidences of coverage renders a provision of the following laws clearly inappropriate, Subchapter A, Chapter 542, Subchapters D and E, Chapter 544, and Chapters 541, 543, and 547 apply to:

(1) health maintenance organizations that offer basic, limited, and single health care coverages;

(2) basic, limited, and single health care plans; and

(3) evidences of coverage under basic, limited, and single health care plans.

(b) A health maintenance organization is subject to:

(1) Chapter 402;

(2) Chapter 827 and is an authorized insurer for purposes of that chapter; and

(3) Subchapter G, Chapter 1251, and Section 1551.064.

(c) Except as otherwise provided by this chapter or other law, insurance laws and group hospital service corporation laws do not apply to a health maintenance organization that holds a certificate of authority under this chapter. This subsection applies to an

insurer or a group hospital service corporation only with respect to the health maintenance organization activities of the insurer or corporation.

(d) Activities permitted under other chapters of this code are not subject to this chapter.

(e) Except for Chapter 251, as applicable to a third-party administrator, and Chapters 259, 4151, and 4201, insurance laws and group hospital service corporation laws do not apply to a physician or provider. Notwithstanding this subsection, a physician or provider who conducts a utilization review during the ordinary course of treatment of patients under a joint or delegated review agreement with a health maintenance organization on services provided by the physician or provider is not required to obtain certification under Subchapter C, Chapter 4201.

(f) A health maintenance organization is subject to Chapter 823 as if the health maintenance organization were an insurer under that chapter.

(g) The merger of a health maintenance organization with another health maintenance organization is subject to Chapter 824 as if the health maintenance organizations were insurance corporations under that chapter. The commissioner may adopt rules as necessary to implement this subsection in a way that reflects the nature of health maintenance organizations, health care plans, or evidences of coverage.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2005, 79th Leg., Ch. 364 (S.B. [1284](#)), Sec. 1, eff. September 1, 2005.

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 2E.033, eff. April 1, 2009.

Sec. 843.052. LAWS RELATING TO SOLICITATION OR ADVERTISING.

(a) Solicitation of enrollees by a health maintenance organization or its representative or agent does not violate a law relating to solicitation or advertising by a physician or provider.

(b) The provision of factually accurate information by a health maintenance organization or its personnel to prospective enrollees regarding coverage, rates, location and hours of service, and names

of affiliated institutions, physicians, and providers does not violate any law relating to solicitation or advertising by a physician or provider. The provision of that information with respect to a physician or provider may not be contrary to or in conflict with any law or ethical provision regulating the practice of a practitioner of any professional service provided through or in connection with the physician or provider.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.053. LAWS RELATING TO RESTRAINT OF TRADE. (a) A health maintenance organization that contracts with a health facility or enters into an independent contractual arrangement with physicians or providers practicing individually or as a group is not, because of the contract or arrangement, considered to have entered into a conspiracy in restraint of trade in violation of Sections 15.01-15.26, Business & Commerce Code.

(b) Notwithstanding any other law, a physician who contracts with one or more physicians in the process of conducting activities that are permitted by law but that do not require a certificate of authority under this chapter is not, because of the contract, considered to have entered into a conspiracy in restraint of trade in violation of Sections 15.01-15.26, Business & Commerce Code.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.054. LAWS REQUIRING CERTIFICATE OF NEED FOR HEALTH CARE FACILITY OR SERVICE. (a) A health maintenance organization is not exempt from any statute that provides for the regulation and certification of need of health care facility construction, expansion, or other modification, or the institution of a health care service through the issuance of a certificate of need, if at the time of establishment of operation or during the course of operation of the health maintenance organization it becomes subject to the provisions of that statute.

(b) If the proposed plan of operation of a health maintenance organization includes providing a health care facility or service that makes the health maintenance organization subject to a statute described by Subsection (a), the commissioner may not issue a

certificate of authority until the commissioner has received a certified copy of the certificate of need granted to the health maintenance organization by the appropriate agency.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.055. LAWS RELATING TO PRACTICE OF MEDICINE. (a) This chapter does not authorize the practice of medicine as defined by state law.

(b) This chapter does not repeal, modify, or amend Section 164.051, 164.052, 164.053, 164.054, or 164.056, Occupations Code, and a health maintenance organization is not exempt from those sections.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.056. INAPPLICABILITY OF BANKRUPTCY LAW. By applying for and receiving a certificate of authority to engage in business in this state, a health maintenance organization agrees and admits that it is not subject to and is not eligible to proceed under the United States Bankruptcy Code.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER C. AUTHORITY TO ENGAGE IN BUSINESS

Sec. 843.071. CERTIFICATE OF AUTHORITY REQUIRED; USE OF "HEALTH MAINTENANCE ORGANIZATION" OR "HMO". (a) A person may not organize or operate a health maintenance organization in this state, or sell or offer to sell or solicit offers to purchase or receive advance or periodic consideration in conjunction with a health maintenance organization, without obtaining a certificate of authority under this chapter.

(b) A person may not use "health maintenance organization" or "HMO" in the course of operation unless the person:

- (1) complies with this chapter and:
 - (A) Section 1367.053;
 - (B) Subchapter A, Chapter 1452;
 - (C) Subchapter B, Chapter 1507;
 - (D) Chapters 222, 251, and 258, as applicable to a

health maintenance organization; and

(E) Chapters 1271 and 1272; and

(2) holds a certificate of authority under this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.034, eff. April 1, 2009.

Sec. 843.072. AUTHORIZATION REQUIRED TO ACT AS HEALTH MAINTENANCE ORGANIZATION. (a) A person, including a physician or provider, may not perform any act of a health maintenance organization except in accordance with the specific authorization of this chapter or other law.

(b) A person, including a physician or provider, who performs an act of a health maintenance organization that requires a certificate of authority under this chapter without first obtaining the certificate is subject to all enforcement processes and procedures available against an unauthorized insurer under Chapter 101 and Subchapter C, Chapter 36.

(c) This section does not apply to an activity exempt from regulation under Section 843.051(e), 843.053, 843.073, or 843.318.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.073. CERTIFICATE OF AUTHORITY REQUIREMENT: APPLICABILITY TO PHYSICIANS AND PROVIDERS. (a) A person is not required to obtain a certificate of authority under this chapter to the extent that the person is:

(1) a physician engaged in the delivery of medical care; or

(2) a provider engaged in the delivery of health care services other than medical care as part of a health maintenance organization delivery network.

(b) Except as provided by Section 843.101 or 843.318(a), a physician or provider that employs or enters into a contractual arrangement with a provider or group of providers to provide basic or limited health care services or a single health care service is subject to this chapter and the following provisions and is required

to obtain a certificate of authority under this chapter:

- (1) Section 1367.053;
- (2) Subchapter A, Chapter 1452;
- (3) Subchapter B, Chapter 1507;
- (4) Chapters 222, 251, and 258, as applicable to a health maintenance organization; and
- (5) Chapters 1271 and 1272.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.035, eff. April 1, 2009.

Sec. 843.074. CERTIFICATE OF AUTHORITY REQUIREMENT: APPLICABILITY TO MEDICAL SCHOOL AND MEDICAL AND DENTAL UNIT. A medical school or medical and dental unit, as defined or described by Section 61.003, 61.501, or 74.601, Education Code, is not required to obtain a certificate of authority under this chapter to the extent that the medical school or medical and dental unit contracts to deliver medical care within a health maintenance organization delivery network. This chapter is otherwise applicable to the medical school or medical and dental unit.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.075. CERTIFICATE OF AUTHORITY FOR SINGLE HEALTH CARE SERVICE PLAN. The commissioner may issue a certificate of authority to a health maintenance organization organized and operated solely to provide a single health care service plan.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.076. APPLICATION. (a) Any person may apply to the commissioner for and obtain a certificate of authority to organize and operate a health maintenance organization.

- (b) An application for a certificate of authority must:
 - (1) be on a form prescribed by rules adopted by the commissioner; and

(2) be verified by the applicant or an officer or other authorized representative of the applicant.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.077. ELIGIBILITY OF FOREIGN CORPORATION. A foreign corporation may qualify for a certificate of authority under this chapter, including a certificate of authority for a single health care service plan, subject to the corporation's:

- (1) registration to engage in business in this state as a foreign corporation under the Texas Business Corporation Act; and
- (2) compliance with this chapter and other applicable state laws.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.078. CONTENTS OF APPLICATION. (a) An application for a certificate of authority must include:

- (1) a copy of the applicant's basic organizational document, if any, such as the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents;
- (2) all amendments to the applicant's basic organizational document; and
- (3) a copy of the bylaws, rules and regulations, or similar documents, if any, regulating the conduct of the applicant's internal affairs.

(b) An application for a certificate of authority must include a list of the names, addresses, and official positions of the persons responsible for the conduct of the applicant's affairs, including:

- (1) each member of the board of directors, board of trustees, executive committee, or other governing body or committee;
- (2) the principal officer, if the applicant is a corporation; and
- (3) each partner or member, if the applicant is a partnership or association.

(c) An application for a certificate of authority must include a copy of any independent contract or other contract made or to be made between the applicant and any physician, provider, or person

listed under Subsection (b).

(d) An application for a certificate of authority must include:

(1) a copy of the form of evidence of coverage to be issued to an enrollee;

(2) a copy of the form of the group contract, if any, to be issued to an employer, union, trustee, or other organization; and

(3) a written description of health care plan terms made available to any current or prospective group contract holder or current or prospective enrollee of the health maintenance organization in accordance with Section 843.201.

(e) An application for a certificate of authority must include a financial statement that is current on the date of the application and that includes:

(1) the sources and application of funds;

(2) projected financial statements during the initial period of operations;

(3) a balance sheet reflecting the condition of the applicant on the date operations are expected to start;

(4) a statement of revenue and expenses with expected member months; and

(5) a cash flow statement that states any capital expenditures, purchase and sale of investments, and deposits with the state.

(f) An application for a certificate of authority must include the schedule of charges to be used during the first 12 months of operation.

(g) An application for a certificate of authority must include a statement acknowledging that lawful process in a legal action or proceeding against the health maintenance organization on a cause of action arising in this state is valid if served in accordance with Chapter 804.

(h) An application for a certificate of authority must include a statement reasonably describing the service area or areas to be served by the applicant.

(i) An application for a certificate of authority must include a description of the complaint procedures the applicant will use.

(j) An application for a certificate of authority must include a description of the procedures and programs to be implemented by the applicant to meet the quality of health care requirements of this chapter and:

- (1) Section 1367.053;
- (2) Subchapter A, Chapter 1452;
- (3) Subchapter B, Chapter 1507; and
- (4) Chapters 1271 and 1272.

(k) An application for a certificate of authority must include network configuration information, including an explanation of the adequacy of the physician and other provider network configuration. The information provided must:

- (1) include the names of physicians, specialty physicians, and other providers by zip code or zip code map; and
- (2) indicate whether each physician or other provider is accepting new patients from the health maintenance organization.

(l) An application for a certificate of authority must include a written description of the types of compensation arrangements, such as compensation based on fee-for-service arrangements, risk-sharing arrangements, or capitated risk arrangements, made or to be made with physicians and providers in exchange for the provision of or an arrangement to provide health care services to enrollees, including any financial incentives for physicians and providers. The compensation arrangements are confidential and are not subject to the public information law, Chapter 552, Government Code.

(m) An application for a certificate of authority must include documentation demonstrating that the applicant will comply with Section 1271.005(c).

(n) An application for a certificate of authority must include any other information that the commissioner requires to make the determinations required by this chapter and:

- (1) Section 1367.053;
- (2) Subchapter A, Chapter 1452;
- (3) Subchapter B, Chapter 1507;
- (4) Chapters 222, 251, and 258, as applicable to a health maintenance organization; and
- (5) Chapters 1271 and 1272.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 2E.036, eff. April 1, 2009.

Sec. 843.079. CONTENTS OF APPLICATION: LIMITED HEALTH CARE SERVICE PLAN. In addition to the items required under Section 843.078, an application for a certificate of authority for a limited health care service plan must include a specific description of the health care services to be provided by the applicant.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.080. MODIFICATION OR AMENDMENT OF APPLICATION INFORMATION. (a) The commissioner may adopt reasonable rules that the commissioner considers necessary for the proper administration of this chapter to require a health maintenance organization, after receiving its certificate of authority, to submit modifications or amendments to the operations or documents described in Sections 843.078 and 843.079 to the commissioner, for the commissioner's approval or only to provide information, before implementing the modification or amendment or to require the health maintenance organization to indicate the modifications to the commissioner at the time of the next site visit or examination.

(b) As soon as reasonably possible after any filing for approval required under this section is made, the commissioner shall approve or disapprove the filing in writing. If, before the 31st day after the date a modification or amendment for which the commissioner's approval is required is filed, the commissioner does not disapprove the modification or amendment, it is considered approved. The commissioner may delay action as necessary for proper consideration for not more than an additional 30 days.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.082. REQUIREMENTS FOR APPROVAL OF APPLICATION. The commissioner shall issue a certificate of authority on payment of the application fee prescribed by Section 843.154(c) if the commissioner is satisfied that:

(1) with respect to health care services to be provided, the applicant:

(A) has demonstrated the willingness and potential ability to ensure that the health care services will be provided in a manner to:

(i) ensure both availability and accessibility of adequate personnel and facilities; and

(ii) enhance availability, accessibility, quality of care, and continuity of services;

(B) has arrangements, established in accordance with rules adopted by the commissioner, for a continuing quality of health care assurance program concerning health care processes and outcomes; and

(C) has a procedure, that is in accordance with rules adopted by the commissioner, to develop, compile, evaluate, and report statistics relating to the cost of operation, the pattern of utilization of services, and availability and accessibility of services;

(2) the person responsible for the conduct of the affairs of the applicant is competent, is trustworthy, and has a good reputation;

(3) the health care plan, limited health care service plan, or single health care service plan is an appropriate mechanism through which the health maintenance organization will effectively provide or arrange for the provision of basic health care services, limited health care services, or a single health care service on a prepaid basis, through insurance or otherwise, except to the extent of reasonable requirements for copayments;

(4) the health maintenance organization is fully responsible and may reasonably be expected to meet its obligations to enrollees and prospective enrollees, after considering:

(A) the financial soundness of the health care plan's arrangement for health care services and the schedule of charges used in connection with the arrangement;

(B) the adequacy of working capital;

(C) any agreement with an insurer, a group hospital service corporation, a political subdivision of government, or any other organization for insuring the payment of the cost of health care services or providing for automatic applicability of an alternative coverage in the event the plan is discontinued;

(D) any agreement that provides for the provision of health care services; and

(E) any deposit of cash or securities submitted in accordance with Section 843.405 as a guarantee that the obligations will be performed; and

(5) the proposed plan of operation, as shown by the information submitted under Section 843.078 and, if applicable, Section 843.079, or by independent investigation, does not violate state law.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.083. DENIAL OF CERTIFICATE OF AUTHORITY. (a) If the commissioner certifies that the health maintenance organization's proposed plan of operation does not meet the requirements of Section 843.082, the commissioner may not issue a certificate of authority.

(b) The commissioner shall notify the applicant that the plan is deficient and specify the deficiencies.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.084. DURATION OF CERTIFICATE OF AUTHORITY. A certificate of authority continues in effect:

(1) while the certificate holder meets the requirements of this chapter and:

(A) Section 1367.053;

(B) Subchapter A, Chapter 1452;

(C) Subchapter B, Chapter 1507;

(D) Chapters 222, 251, and 258, as applicable to a health maintenance organization; and

(E) Chapters 1271 and 1272; or

(2) until the commissioner suspends or revokes the certificate or the commissioner terminates the certificate at the request of the certificate holder.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 2E.037, eff. April 1, 2009.

Sec. 843.085. CHANGE IN CONTROL: COMMISSIONER APPROVAL. Any change in control, as defined by Chapter 823, of a health maintenance organization is subject to the approval of the commissioner.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

**SUBCHAPTER D. GENERAL POWERS AND DUTIES OF HEALTH MAINTENANCE
ORGANIZATIONS**

Sec. 843.101. PROVIDING OR ARRANGING FOR CARE. (a) A health maintenance organization may provide or arrange for medical care services only through:

(1) other health maintenance organizations; or

(2) physicians or groups of physicians who have independent contracts with the health maintenance organizations.

(b) A health maintenance organization may provide or arrange for health care services only through:

(1) other health maintenance organizations;

(2) providers or groups of providers who are:

(A) under contract with or are employed by the health maintenance organization; or

(B) under contract with an entity that is under contract with the health maintenance organization to provide a network of providers to provide health care services only if the contract between the entity and the health maintenance organization:

(i) does not limit the health maintenance organization's authority or responsibility, including financial responsibility, to comply with any regulatory requirement that applies to a function performed by the entity;

(ii) requires the entity to comply with all regulatory requirements that apply to a function performed by the entity; and

(iii) expressly sets forth the requirements of Subparagraphs (i) and (ii); or

(3) additional health maintenance organizations or physicians or providers who have contracted for health care services with:

(A) the other health maintenance organizations;

(B) physicians with whom the health maintenance organization has contracted; or

(C) providers who are under contract with or are employed by the health maintenance organization.

(b-1) Except as provided by Subsection (b-2) and notwithstanding any other law, an entity described by Subsection

(b)(2)(B) and the health maintenance organization with which the entity contracts are subject to Chapter 1272 as if the entity were a delegated entity unless the entity:

(1) is a delegated network or delegated third party as defined by Section 1272.001; or

(2) is not a delegated entity as provided by Section 1272.001(a)(1)(A) or (B).

(b-2) An entity subject to Chapter 1272 under Subsection (b-1) that does not assume risk and the health maintenance organization with which the entity contracts are not subject to the following provisions:

(1) Section 1272.053(1);

(2) Section 1272.057(1);

(3) Section 1272.061(1)(C); and

(4) Subchapter D, Chapter 1272.

(c) Notwithstanding Subsections (a) and (b), a health maintenance organization may provide or authorize the following in a manner approved by the commissioner:

(1) emergency care;

(2) services by referral; and

(3) services provided outside the service area.

(d) A health maintenance organization may not employ or contract with other health maintenance organizations or physicians or providers in a manner that is prohibited by a law of this state under which those health maintenance organizations or physicians or providers are licensed or otherwise authorized.

(e) A health maintenance organization may serve as a workers' compensation health care network, as defined by Section 1305.004, in accordance with Chapter 1305.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 6.060, eff. September 1, 2005.

Acts 2017, 85th Leg., R.S., Ch. 366 (H.B. 3218), Sec. 1, eff. September 1, 2017.

Sec. 843.102. HEALTH MAINTENANCE ORGANIZATION QUALITY ASSURANCE. (a) A health maintenance organization shall establish

procedures to ensure that health care services are provided to enrollees under reasonable standards of quality of care that are consistent with prevailing professionally recognized standards of medical practice. The procedures must include mechanisms to ensure availability, accessibility, quality, and continuity of care.

(b) A health maintenance organization shall operate a continuing internal quality assurance program to monitor and evaluate its health care services, including primary and specialist physician services and ancillary and preventive health care services, in all institutional and noninstitutional settings.

(c) The commissioner by rule may establish minimum standards and requirements for the quality assurance programs, including standards for ensuring availability, accessibility, quality, and continuity of care.

(d) A health maintenance organization shall record formal proceedings of quality assurance program activities and maintain documentation in a confidential manner. The health maintenance organization shall make the quality assurance program minutes available to the commissioner.

(e) A health maintenance organization shall establish and maintain a physician review panel to assist in:

- (1) reviewing medical guidelines or criteria; and
- (2) determining prescription drugs to be covered by the health maintenance organization, if the health maintenance organization offers a prescription drug benefit.

(f) A health maintenance organization shall ensure the use and maintenance of an adequate patient record system to facilitate documentation and retrieval of clinical information for the health maintenance organization's evaluation of continuity and coordination of patient care and assessment of the quality of health and medical care provided to enrollees.

(g) The clinical records of enrollees shall be available to the commissioner for examination and review to determine compliance. The records are confidential and privileged and are not subject to the public information law, Chapter 552, Government Code, or to subpoena, except to the extent necessary to enable the commissioner to enforce this section.

(h) A health maintenance organization shall establish a mechanism for the periodic reporting of quality assurance program activities to its governing body, providers, and appropriate health

maintenance organization staff.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.103. ACQUISITION AND OPERATION OF FACILITIES; CERTAIN LOANS; COMMISSIONER APPROVAL OF AFFILIATE TRANSACTIONS. (a) A health maintenance organization may:

(1) purchase, lease, construct, renovate, operate, or maintain hospitals or medical facilities and ancillary equipment and other property reasonably required for the principal office of the health maintenance organization or for another purpose necessary in engaging in the business of the health maintenance organization; and

(2) make loans to a medical group, under an independent contract with the group to further its program, or corporations under its control, to acquire or construct medical facilities and hospitals, or to further a program providing health care services to enrollees.

(b) If the exercise of a power granted under Subsection (a) involves an affiliate, as described by Section 823.003, the health maintenance organization before exercising that power shall file notice and adequate supporting information with the commissioner for approval.

(c) The commissioner shall disapprove the exercise of a power described by Subsection (a) that would in the commissioner's opinion:

(1) substantially and adversely affect the financial soundness of the health maintenance organization and endanger its ability to meet its obligations; or

(2) impair the interests of the public or the health maintenance organization's enrollees or creditors in this state.

(d) If the commissioner does not disapprove the exercise of a power described by Subsection (a) before the 31st day after the date notice is filed under this section, the exercise of the power is considered approved. The commissioner may, by official order, delay action as necessary for proper consideration for not more than an additional 30 days.

(e) The commissioner may adopt rules exempting from the filing requirements of Subsection (b) an activity that has a de minimis effect.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.104. CONTRACTS FOR CERTAIN ADMINISTRATIVE FUNCTIONS. A health maintenance organization may contract with any person to perform functions such as marketing, enrollment, and administration on behalf of the health maintenance organization.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.105. MANAGEMENT AND EXCLUSIVE AGENCY CONTRACTS. (a) A health maintenance organization may not enter into a management contract or exclusive agency contract unless the proposed contract is first filed with and approved by the commissioner.

(b) The commissioner must approve or disapprove the contract not later than the 30th day after the date the contract is filed or within a reasonable extended period that the commissioner specifies by notice given within the 30-day period.

(c) The commissioner shall disapprove the proposed contract if the commissioner determines that the contract:

(1) subjects the health maintenance organization to excessive charges;

(2) extends for an unreasonable time;

(3) does not contain fair and adequate standards of performance;

(4) authorizes persons to manage the health maintenance organization who are not sufficiently trustworthy, competent, experienced, and free from conflict of interest to manage the health maintenance organization with due regard for the interests of the health maintenance organization's enrollees or creditors or the public; or

(5) contains provisions that impair the interests of the public in this state or the health maintenance organization's enrollees or creditors.

(d) The commissioner shall disapprove a proposed management contract unless the commissioner determines that the management contractor has in force in its own name a fidelity bond on its officers and employees in the amount of at least \$100,000 or another amount prescribed by the commissioner.

(e) The fidelity bond must be issued by an insurer that holds a

certificate of authority in this state. If, after notice and hearing, the commissioner determines that a fidelity bond is not available from an insurer that holds a certificate of authority in this state, the management contractor may obtain a fidelity bond procured by a surplus lines agent resident in this state in compliance with Chapter 981.

(f) The fidelity bond must obligate the surety to pay any loss of money or other property that the health maintenance organization sustains because of an act of fraud or dishonesty by an employee or officer of the management contractor during the period that the management contract is in effect.

(g) Instead of a fidelity bond, the management contractor may deposit with the comptroller cash or securities acceptable to the commissioner. The deposit must be maintained in the amount and is subject to the same conditions required for a fidelity bond under this section.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.106. INSURANCE, REINSURANCE, INDEMNITY, AND REIMBURSEMENT. A health maintenance organization may contract with an insurer or group hospital service corporation authorized to engage in business in this state to provide insurance, reinsurance, indemnification, or reimbursement against the cost of health care and medical care services provided by the health maintenance organization.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.107. INDEMNITY BENEFITS; POINT-OF-SERVICE PROVISIONS. A health maintenance organization may offer:

- (1) indemnity benefits covering out-of-area emergency care;
- (2) indemnity benefits, in addition to those relating to out-of-area and emergency care, provided through an insurer or group hospital service corporation;
- (3) a point-of-service plan under Subchapter A, Chapter 1273; or
- (4) a point-of-service rider under Section 843.108.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.038,
eff. April 1, 2009.

Sec. 843.108. POINT-OF-SERVICE RIDER. (a) In this section, "point-of-service rider" means a rider under which indemnity benefits for the cost of health care services are provided by a health maintenance organization in conjunction with corresponding benefits arranged for or provided by a health maintenance organization.

(b) A health maintenance organization may offer a point-of-service rider for out-of-network coverage without obtaining a separate certificate of authority as an insurer if the expenses incurred under the point-of-service rider do not exceed 10 percent of the total medical and hospital expenses incurred for all health plan products sold by the health maintenance organization. If the expenses exceed that level, the health maintenance organization may not issue new point-of-service riders until the expenses fall below that level or until the health maintenance organization obtains a certificate of authority as an insurer.

(c) Indemnity benefits for services provided under a point-of-service rider may be limited to those services defined in the evidence of coverage and may be subject to different cost-sharing provisions. The cost-sharing provisions for indemnity benefits may be higher than the cost-sharing provisions for in-network health maintenance organization coverage. For enrollees in a limited provider network, higher cost-sharing may be imposed only when benefits or services are obtained outside the health maintenance organization delivery network.

(d) A health maintenance organization that issues a point-of-service rider under this section must meet additional net worth requirements prescribed by the commissioner. The commissioner shall base the net worth requirements on the actuarial relation of the amount of insurance risk assumed through the point-of-service rider to the amount of solvency and reserve requirements otherwise required of the health maintenance organization.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.109. PAYMENT BY GOVERNMENTAL OR PRIVATE ENTITY. A health maintenance organization may accept from a governmental or private entity payments for all or part of the cost of services provided or arranged for by the health maintenance organization.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.110. CORPORATION, PARTNERSHIP, OR ASSOCIATION POWERS. A health maintenance organization has all powers of a partnership, association, or corporation, including a professional association or corporation, as appropriate under the organizational documents of the health maintenance organization, that are not in conflict with this chapter or other applicable law.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.111. GROUP MODEL HEALTH MAINTENANCE ORGANIZATIONS.

(a) In this section, "group model health maintenance organization" means a health maintenance organization that provides the majority of its professional services through a single group medical practice that is formally affiliated with the medical school component of a state-supported public college or university in this state.

(b) Unless this section and a power specified in Section 843.101, 843.103, 843.104, 843.106, 843.107, 843.109, or 843.110 are specifically amended by law, a law, without regard to the time of enactment, may not be construed to prohibit or restrict a group model health maintenance organization from:

(1) selectively contracting with or declining to contract with a provider as the group model health maintenance organization considers necessary;

(2) contracting for or declining to contract for an individual health care service or full range of health care services as the group model health maintenance organization considers necessary, if the service or services may be legally provided by the contracting provider; or

(3) requiring enrolled members of the group model health maintenance organization who wish to obtain the services covered by the group model health maintenance organization to use the providers specified by the group model health maintenance organization.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.112. DENTAL POINT-OF-SERVICE OPTION. (a) In this section:

(1) "Point-of-service option" means a plan provided through a contractual arrangement under which:

(A) indemnity benefits for the cost of dental care services, other than emergency care or emergency dental care, are provided by an insurer or group hospital service corporation in conjunction with corresponding benefits arranged or provided by a health maintenance organization; and

(B) an enrollee may choose to obtain benefits or services under the indemnity plan or the health maintenance organization plan in accordance with specific provisions of a point-of-service contract.

(2) "Provider panel" means the providers with whom a health maintenance organization contracts to provide dental services to enrollees covered under a dental benefit plan.

(b) This section applies to a dental health maintenance organization or another single service health maintenance organization that provides dental benefits. This section does not apply to a health maintenance organization that has 10,000 or fewer enrollees in this state who are enrolled in dental benefit plans based on a provider panel.

(c) If an employer, association, or other private group arrangement that employs 25 or more employees or has 25 or more members offers and contributes to the cost of dental benefit plan coverage to employees or individuals only through a provider panel, the health maintenance organization with which the employer, association, or other private group arrangement is contracting for the coverage shall offer, or contract with another entity to offer, a dental point-of-service option to the employer, association, or other private group arrangement. The employer may offer the dental point-of-service option to the employee or individual to accept or reject.

(d) If a health maintenance organization's dental provider panel is the sole delivery system offered to employees by an employer, the health maintenance organization:

(1) shall offer the employer a dental point-of-service option;

(2) may not impose a minimum participation level on the dental point-of-service option; and

(3) as part of the group enrollment application, shall provide to each employer disclosure statements as required by rules adopted under this code for each dental plan offered.

(e) An employer may require an employee or individual who accepts the point-of-service option to be responsible for the payment of a premium, over the amount of the premium for the coverage provided to employees or members under the dental benefit plan offered through a provider panel, directly or by payroll deduction in the same manner in which the other premium is paid. The premium for the point-of-service option must be based on the actuarial value of that coverage.

(f) Different cost-sharing provisions may be imposed for the point-of-service option.

(g) An employer may charge an employee or individual who accepts the point-of-service option a reasonable administrative fee for costs associated with the employer's reasonable administration of the point-of-service option.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.113. SPECIFIED POWERS NOT EXCLUSIVE. The powers of a health maintenance organization are not limited to the powers specified by this subchapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER E. REGULATION OF HEALTH MAINTENANCE ORGANIZATIONS

Sec. 843.151. RULES. The commissioner may adopt reasonable rules as necessary and proper to:

(1) implement this chapter and Section 1367.053, Subchapter A, Chapter 1452, Subchapter B, Chapter 1507, Chapters 222, 251, and 258, as applicable to a health maintenance organization, and Chapters 1271 and 1272, including rules to:

(A) prescribe authorized investments for a health maintenance organization for all investments not otherwise addressed in this chapter;

(B) ensure that enrollees have adequate access to

health care services; and

(C) establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and

(2) meet the requirements of federal law and regulations.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.039, eff. April 1, 2009.

Sec. 843.152. SUBPOENA AUTHORITY. In implementing this chapter and the following provisions, the commissioner may exercise subpoena authority in accordance with Subchapter C, Chapter 36:

(1) Section 1367.053;

(2) Subchapter A, Chapter 1452;

(3) Subchapter B, Chapter 1507;

(4) Chapters 222, 251, and 258, as applicable to a health maintenance organization; and

(5) Chapters 1271 and 1272.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.040, eff. April 1, 2009.

Sec. 843.153. AUTHORITY TO CONTRACT. In performing duties under this chapter and the following provisions, the commissioner may contract with a state agency or, after notice and opportunity for hearing, with a qualified person to make recommendations concerning determinations to be made by the commissioner:

(1) Section 1367.053;

(2) Subchapter A, Chapter 1452;

(3) Subchapter B, Chapter 1507;

(4) Chapters 222, 251, and 258, as applicable to a health maintenance organization; and

(5) Chapters 1271 and 1272.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.041, eff. April 1, 2009.

Sec. 843.154. FEES. (a) The commissioner shall, within the limits prescribed by this section, prescribe the fees to be charged under this section.

(b) Except for fees collected under Subsections (e) and (f), fees collected under this section shall be deposited to the credit of the Texas Department of Insurance operating account.

(b-1) A fee collected under Subsection (e) or (f) shall be deposited to the credit of the account described by Section 401.156(a).

(c) A health maintenance organization shall pay to the commissioner a fee in an amount not to exceed:

(1) \$18,000 for filing and review of its original application for a certificate of authority;

(2) \$200 for filing of an evidence of coverage that requires approval; and

(3) \$100 for a filing that is required by rule but does not require approval.

(d) A health maintenance organization shall pay to the comptroller a fee in an amount not to exceed \$500 for filing of an annual report under Section 843.155.

(e) A health maintenance organization shall pay to the commissioner a fee, in an amount certified by the commissioner to be just and reasonable, for the expenses of all examinations of health maintenance organizations made on behalf of the state by the commissioner or under the commissioner's authority.

(f) A health maintenance organization shall pay to the commissioner a fee in an amount assessed by the commissioner and paid in accordance with rules adopted by the commissioner for the expenses of an examination under Section 843.156(a) that:

(1) are incurred by the commissioner or under the commissioner's authority; and

(2) are directly attributable to that examination, including the actual salaries and expenses of the examiners directly attributable to that examination, as determined under rules adopted by the commissioner.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 659 (S.B. 1291), Sec. 5, eff.
September 1, 2011.

Sec. 843.155. ANNUAL REPORT. (a) Not later than March 1 of each year, a health maintenance organization shall file with the commissioner a report covering the preceding calendar year.

Text of subsection as amended by Acts 2007, 80th Leg., R.S., Ch. 997
(S.B. 1731), Sec. 9

(b) The report shall:

- (1) be verified by at least two principal officers;
- (2) be in a form prescribed by the commissioner; and
- (3) include:

(A) a financial statement of the health maintenance organization, including its balance sheet and receipts and disbursements for the preceding calendar year, certified by an independent public accountant;

(B) the number of individuals enrolled during the preceding calendar year, the number of enrollees as of the end of that year, and the number of enrollments terminated during that year;

(C) a statement of:

- (i) an evaluation of enrollee satisfaction;
- (ii) an evaluation of quality of care;
- (iii) coverage areas;
- (iv) accreditation status;
- (v) premium costs;
- (vi) plan costs;
- (vii) premium increases;
- (viii) the range of benefits provided;
- (ix) copayments and deductibles;
- (x) the accuracy and speed of claims payment by the

organization;

(xi) the credentials of physicians of the organization; and

(xii) the number of providers;

(D) updated financial projections for the next calendar year of the type described in Section 843.078(e), until the health maintenance organization has had a net income for 12 consecutive

months; and

(E) other information relating to the performance of the health maintenance organization as necessary to enable the commissioner to perform the commissioner's duties under this chapter and Chapter 20A.

Text of subsection as amended by Acts 2007, 80th Leg., R.S., Ch. 730
(H.B. 2636), Sec. 2E.042

(b) The report shall:

- (1) be verified by at least two principal officers;
- (2) be in a form prescribed by the commissioner; and
- (3) include:

(A) a financial statement of the health maintenance organization, including its balance sheet and receipts and disbursements for the preceding calendar year, certified by an independent public accountant;

(B) the number of individuals enrolled during the preceding calendar year, the number of enrollees as of the end of that year, and the number of enrollments terminated during that year;

(C) updated financial projections for the next calendar year of the type described in Section 843.078(e), until the health maintenance organization has had a net income for 12 consecutive months; and

(D) other information relating to the performance of the health maintenance organization as necessary to enable the commissioner to perform the commissioner's duties under:

- (i) this chapter;
- (ii) Section 1367.053;
- (iii) Subchapter A, Chapter 1452;
- (iv) Subchapter B, Chapter 1507;
- (v) Chapters 222, 251, and 258, as applicable to a health maintenance organization; and
- (vi) Chapters 1271 and 1272.

(c) Sections 36.108 and 201.055 and Chapter 802 apply to the annual report of a health maintenance organization.

(d) The annual report filed by the health maintenance organization shall be made publicly available on the department's Internet website in a user-friendly format that allows consumers to make direct comparisons of the financial and other data reported by health maintenance organizations under this section.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.042,
eff. April 1, 2009.

Acts 2007, 80th Leg., R.S., Ch. 997 (S.B. 1731), Sec. 9, eff.
September 1, 2007.

Sec. 843.156. EXAMINATIONS. (a) The commissioner may examine the quality of health care services and the affairs of any health maintenance organization or applicant for a certificate of authority under this chapter. The commissioner may conduct an examination as often as the commissioner considers necessary, but shall conduct an examination at least once every three years.

(b) A health maintenance organization shall make its books and records relating to its operations available for an examination and shall facilitate an examination in every way.

(c) Each physician and provider with whom the health maintenance organization has a contract, agreement, or other arrangement is required to make available for an examination only that portion of the physician's or provider's books and records that is relevant to the physician's or provider's relationship with the health maintenance organization.

(d) On request of the commissioner, a health maintenance organization shall provide to the commissioner a copy of any contract, agreement, or other arrangement between the health maintenance organization and a physician or provider. Documentation provided to the commissioner under this subsection is confidential and is not subject to the public information law, Chapter 552, Government Code.

(e) Medical, hospital, and health records of enrollees and records of physicians and providers providing service under an independent contract with a health maintenance organization are subject to an examination only as necessary for a continuing quality of health assurance program concerning health care procedures and outcomes that is established in accordance with an approved plan under this chapter. The plan shall provide for adequate protection of the confidentiality of medical information. Medical information may be disclosed only in accordance with this chapter and other applicable law and is subject to subpoena only on a showing of good

cause.

(f) The commissioner may examine and use the records of a health maintenance organization, including records of a quality of care assurance program and records of a medical peer review committee, as necessary to implement the purposes of this chapter, Section 1367.053, Subchapter A, Chapter 1452, Subchapter B, Chapter 1507, Chapters 222, 251, and 258, as applicable to a health maintenance organization, and Chapters 1271 and 1272, including commencement of an enforcement action under Section 843.461 or 843.462. Information obtained under this subsection is confidential and privileged and is not subject to the public information law, Chapter 552, Government Code, or to subpoena except as necessary for the commissioner to enforce this chapter, Section 1367.053, Subchapter A, Chapter 1452, Subchapter B, Chapter 1507, Chapter 222, 251, or 258, as applicable to a health maintenance organization, or Chapter 1271 or 1272. In this subsection, "medical peer review committee" has the meaning assigned by Section 151.002, Occupations Code.

(g) For the purpose of an examination, the commissioner may administer oaths to and examine the officers and agents of a health maintenance organization and the principals of physicians and providers described by this section concerning their business.

(h) Chapter 86, Section 401.101, and Subchapters B and D, Chapter 401, apply to a health maintenance organization, except to the extent that the commissioner determines that the nature of the examination of a health maintenance organization renders the applicability of those provisions clearly inappropriate.

(i) Section 38.001, Section 81.003, and Chapter 82 apply to a health maintenance organization.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.043, eff. April 1, 2009.

Sec. 843.157. REHABILITATION, LIQUIDATION, SUPERVISION, OR CONSERVATION OF HEALTH MAINTENANCE ORGANIZATION. (a) The rehabilitation, liquidation, supervision, or conservation of a health maintenance organization shall be treated as the rehabilitation,

liquidation, supervision, or conservation of an insurer and be conducted under the supervision of the commissioner under Chapter 441 or 443, as appropriate.

(b) The commissioner may also order the rehabilitation, liquidation, supervision, or conservation of a health maintenance organization if in the commissioner's opinion the continued operation of the health maintenance organization would be hazardous to the enrollees or to the people of this state.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.044, eff. April 1, 2009.

SUBCHAPTER F. RELATIONS WITH ENROLLEES AND GROUP CONTRACT HOLDERS

Sec. 843.201. DISCLOSURE OF INFORMATION ABOUT HEALTH CARE PLAN TERMS. (a) A health maintenance organization shall provide an accurate written or electronic description of health care plan terms, including restrictions or limitations related to a limited provider network or delegated network within a health care plan, to allow a current or prospective group contract holder or current or prospective enrollee to make comparisons and informed decisions before selecting among health care plans. The written or electronic description must:

(1) be in readable and understandable format prescribed by the commissioner; and

(2) include a current list of physicians and providers, including a delineation of any limited provider network or delegated network.

(b) A health maintenance organization may satisfy the requirement imposed under Subsection (a) through the member handbook provided under Section 843.205 if:

(1) the handbook's contents are substantially similar to and provide the same level of disclosure as the written or electronic description prescribed by the commissioner; and

(2) the current list of physicians and providers is also provided.

(c) If an enrollee designates a primary care physician who practices in a limited provider network or delegated entity, not

later than the 30th day after the date of the enrollee's enrollment, the health maintenance organization shall provide the information required under this section to the enrollee with the enrollee's identification card or in a mailing separate from other information.

(d) A health maintenance organization shall provide to an enrollee on request information on:

(1) whether a physician or other health care provider is a participating provider in the health maintenance organization's network;

(2) whether proposed health care services are covered by the health plan; and

(3) what the enrollee's personal responsibility will be for payment of applicable copayment or deductible amounts.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by Acts 2003, 78th Leg., ch. 261, Sec. 2, eff. Sept. 1, 2003;

Acts 2003, 78th Leg., ch. 1276, Sec. 10A.208(a), eff. Sept. 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 997 (S.B. [1731](#)), Sec. 12, eff. September 1, 2007.

Sec. 843.2015. INFORMATION AVAILABLE THROUGH INTERNET SITE.

(a) A health maintenance organization that maintains an Internet site shall list on the Internet site the physicians and providers, including, if appropriate, mental health providers and substance abuse treatment providers, that may be used by enrollees in accordance with the terms of the enrollee's health care plan. The listing must identify those physicians and providers who continue to be available to provide services to new patients or clients.

(b) The health maintenance organization shall update at least quarterly an Internet site subject to this section.

(c) The commissioner may adopt rules as necessary to implement this section. The rules may govern the form and content of the information required to be provided under Subsection (a).

Acts 2003, 78th Leg., ch. 1177, Sec. 3, eff. Sept. 1, 2003.

Sec. 843.202. DISCLOSURE OF INFORMATION TO MEDICARE RECIPIENTS.

(a) Before a prospective enrollee is enrolled in a health care plan

offered to Medicare recipients by a Medicare-contracting health maintenance organization, the health maintenance organization must provide the prospective enrollee with a disclosure form adopted by the commissioner under Subsection (b).

(b) The commissioner shall adopt a disclosure form informing a prospective enrollee in a Medicare-contracting health maintenance organization of:

(1) the effect of enrollment in the health maintenance organization on the prospective enrollee's opportunity to purchase Medicare supplement insurance; and

(2) any differences in the benefits and costs between the health care plan offered to Medicare recipients and Medicare supplement insurance.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.203. SELECTION OF PRIMARY CARE PHYSICIAN OR PROVIDER.

(a) Each plan application form shall prominently include a space in which the enrollee at the time of application or enrollment shall select a primary care physician or primary care provider.

(b) An enrollee shall at all times have the right to select or change a primary care physician or primary care provider within the health maintenance organization network of available primary care physicians and primary care providers, except that a health maintenance organization may limit an enrollee's request to change physicians or providers to not more than four changes in a 12-month period.

(c) For purposes of this subchapter, an applicant physician, as defined by Chapter 1452, may not be considered to be an available primary care physician or primary care provider within the health maintenance organization delivery network for selection by an enrollee.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 1203 (H.B. 1594), Sec. 2, eff. September 1, 2007.

Sec. 843.204. UNTRUE OR MISLEADING INFORMATION. (a) A health

maintenance organization or a representative of a health maintenance organization may not:

- (1) use or distribute or knowingly permit the use or distribution of prospective enrollee information that is untrue or misleading; or
- (2) use or knowingly permit the use of:
 - (A) advertising that is untrue or misleading;
 - (B) solicitation that is untrue or misleading; or
 - (C) any form of evidence of coverage that is deceptive.

(b) In this chapter, Section 1367.053, Subchapter A, Chapter 1452, Subchapter B, Chapter 1507, Chapters 222, 251, and 258, as applicable to a health maintenance organization, and Chapters 1271 and 1272, a statement or item of information is:

(1) considered to be untrue if the statement or item does not conform to fact in any respect that is or may be significant to an enrollee of, or person considering enrollment in, a health care plan; and

(2) considered to be misleading, whether or not the statement or item is literally untrue, if, in the total context in which the statement is made or the item is communicated, the statement or item may be reasonably understood by a reasonable person who does not possess special knowledge regarding health care coverage as indicating:

(A) the inclusion of a benefit or advantage that does not exist and that is of possible significance to an enrollee of, or person considering enrollment in, a health care plan; or

(B) the absence of an exclusion, limitation, or disadvantage that does exist and that is of possible significance to an enrollee of, or person considering enrollment in, a health care plan.

(c) In this chapter, Section 1367.053, Subchapter A, Chapter 1452, Subchapter B, Chapter 1507, Chapters 222, 251, and 258, as applicable to a health maintenance organization, and Chapters 1271 and 1272, an evidence of coverage is considered to be deceptive if the evidence of coverage, taken as a whole and with consideration given to typography and format as well as language, would cause a reasonable person who does not possess special knowledge regarding health care plans and evidences of coverage for health care plans to expect charges or benefits, services, or other advantages that the evidence of coverage does not provide or that the health care plan

issuing the evidence of coverage does not regularly make available for enrollees covered under the evidence of coverage.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.045, eff. April 1, 2009.

Sec. 843.205. MEMBER'S HANDBOOK; INFORMATION ABOUT COMPLAINTS AND APPEALS. (a) In this section, "major population" means a group constituting 10 percent or more of the enrolled population of the health maintenance organization.

(b) A health maintenance organization shall establish procedures to:

(1) provide to an enrollee a member handbook and materials relating to the complaint and appeals process in the languages of the major populations of the enrolled population; and

(2) provide access to a member handbook and the complaint and appeals process to an enrollee who has a disability that affects the enrollee's ability to communicate or read.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.206. NOTICE OF CHANGE IN PAYMENT ARRANGEMENTS. A health maintenance organization shall notify a group contract holder within 30 days of any substantive change to the payment arrangements between the health maintenance organization and physicians or providers.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.207. NOTICE OF CHANGE IN OPERATIONS. A health maintenance organization shall provide to its enrollees reasonable notice of any material adverse change in the operation of the health maintenance organization that will directly affect the enrollees.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

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

- (1) give to each enrollee under an individual evidence of coverage written notice of the effective date of the increase; and
- (2) provide the enrollee a table that clearly lists:
 - (A) the actual dollar amount of the charge for coverage on the date of the notice;
 - (B) the actual dollar amount of the charge for coverage after the charge increase; and
 - (C) the percentage change between the amounts described by Paragraphs (A) and (B).

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

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

(d) A health maintenance organization may not require an enrollee entitled to notice under this section to respond to the health maintenance organization to renew the coverage or take other action relating to the renewal or extension of the coverage before the 45th day after the date the notice described by Subsection (a) is given.

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

- (1) contact information for the department, including information concerning how to file a complaint with the department;
- (2) contact information for the Texas Consumer Health Assistance Program, including information concerning how to request from the program consumer protection information or assistance with filing a complaint; and
- (3) the addresses of Internet websites that provide consumer information related to rate increase justifications, including the websites of the department and the United States Department of Health and Human Services.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1147 (H.B. [1951](#)), Sec. 3.001, eff. September 1, 2011.

Sec. 843.208. CANCELLATION OR NONRENEWAL OF COVERAGE. A health maintenance organization may cancel or refuse to renew the coverage of an enrollee only for:

- (1) failure to pay the charges for the coverage; or
- (2) another reason prescribed by rules adopted by the commissioner.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.209. IDENTIFICATION CARD. An identification card or other similar document issued by a health maintenance organization to an enrollee must:

- (1) indicate that the health maintenance organization is regulated under this code and subject to the provisions of Subchapter J; and

- (2) display:

(A) the first date on which the enrollee became enrolled; or

(B) a toll-free number a physician or provider may use to obtain that date.

Added by Acts 2003, 78th Leg., ch. 214, Sec. 4, eff. June 17, 2003.

Sec. 843.210. TERMS OF ENROLLEE ELIGIBILITY. (a) A contract between a health maintenance organization and a group contract holder must provide that:

(1) in addition to any other premiums for which the group contract holder is liable, the group contract holder is liable for an enrollee's premiums from the time the enrollee is no longer part of the group eligible for coverage under the contract until the end of the month in which the contract holder notifies the health maintenance organization that the enrollee is no longer part of the group eligible for coverage by the contract; and

(2) the enrollee remains covered by the contract until the end of that period.

(b) Each health maintenance organization that enters into a contract described by Subsection (a) shall notify the group contract holder periodically as provided by this section that the contract holder is liable for premiums on an enrollee who is no longer part of

the group eligible for coverage under the contract until the health maintenance organization receives notification of termination of the enrollee's eligibility for that coverage.

(c) If the health maintenance organization charges the group contract holder on a monthly basis for the coverage premiums, the health maintenance organization shall include the notice required by Subsection (b) in each monthly statement sent to the group contract holder. If the health maintenance organization charges the group contract holder on other than a monthly basis for the premiums, the health maintenance organization shall notify the group contract holder periodically in the manner prescribed by the commissioner by rule.

(d) The notice required by Subsection (b) must include a description of methods preferred by the health maintenance organization for notification by a group contract holder of an enrollee's termination from coverage eligibility.

Added by Acts 2005, 79th Leg., Ch. 669 (S.B. 51), Sec. 2, eff. September 1, 2005.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1217 (S.B. 1143), Sec. 1, eff. September 1, 2009.

Sec. 843.211. APPLICABILITY OF SUBCHAPTER TO ENTITIES CONTRACTING WITH HEALTH MAINTENANCE ORGANIZATION. This subchapter applies to a person to whom a health maintenance organization contracts to:

- (1) process or pay claims;
- (2) obtain the services of physicians or other providers to provide health care services to enrollees; or
- (3) issue verifications or preauthorizations.

Added by Acts 2007, 80th Leg., R.S., Ch. 997 (S.B. 1731), Sec. 13, eff. September 1, 2007.

SUBCHAPTER G. DISPUTE RESOLUTION

Sec. 843.251. COMPLAINT SYSTEM REQUIRED; COMMISSIONER RULES AND EXAMINATION. (a) A health maintenance organization shall implement and maintain a complaint system that provides reasonable

procedures to resolve an oral or written complaint initiated by a complainant concerning health care services. The complaint system must include a process for the notice and appeal of a complaint.

(b) The commissioner may adopt reasonable rules as necessary or proper to implement the provisions of this subchapter relating to the complaint system and administer matters relating to the complaint system.

(c) The commissioner may examine a complaint system for compliance with this subchapter and may require the health maintenance organization to make corrections as the commissioner considers necessary.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.252. COMPLAINT INITIATION AND INITIAL RESPONSE; DEADLINES FOR RESPONSE AND RESOLUTION. (a) If a complainant notifies a health maintenance organization of a complaint, the health maintenance organization, not later than the fifth business day after the date of receiving the complaint, shall send to the complainant a letter acknowledging the date of receipt of the complaint.

(b) The letter required under Subsection (a) must:

(1) include a description of the health maintenance organization's complaint procedures and time frames; and

(2) if the complaint is made orally, be accompanied by a one-page complaint form that prominently and clearly states that the form must be returned to the health maintenance organization for prompt resolution of the complaint.

(c) A health maintenance organization shall acknowledge, investigate, and resolve a complaint not later than the 30th calendar day after the date the health maintenance organization receives the written complaint or one-page complaint form from the complainant.

(d) Subsections (a)-(c) do not apply to a complaint concerning an emergency or a denial of continued hospitalization. A health maintenance organization shall investigate and resolve a complaint concerning an emergency or a denial of continued hospitalization:

(1) in accordance with the medical or dental immediacy of the case; and

(2) not later than one business day after the health maintenance organization receives the complaint.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.253. COMPLAINT INVESTIGATION AND RESOLUTION. (a) A health maintenance organization shall investigate each complaint received in accordance with the health maintenance organization's policies and in compliance with this chapter.

(b) After a health maintenance organization has investigated a complaint, the health maintenance organization shall issue a response letter to the complainant within the time prescribed by Section 843.252(c) that:

(1) explains the health maintenance organization's resolution of the complaint;

(2) states the specific medical and contractual reasons for the resolution;

(3) states the specialization of any physician or other provider consulted; and

(4) contains a complete description of the process for appeal, including the deadlines for the appeals process and the deadlines for the final decision on the appeal.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.254. APPEAL TO COMPLAINT APPEAL PANEL; DEADLINES.

(a) A health maintenance organization shall provide an appeals process for a complainant who is not satisfied with the resolution of the complaint. The appeals process must include the right of the complainant to:

(1) appear in person before a complaint appeal panel at the site at which the enrollee normally receives health care services or at another site agreed to by the complainant; or

(2) address a written appeal to the complaint appeal panel.

(b) The health maintenance organization shall send an acknowledgment letter to the complainant not later than the fifth business day after the date the written request for appeal is received.

(c) The health maintenance organization shall complete the appeals process not later than the 30th calendar day after the date the written request for appeal is received.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.255. COMPOSITION OF COMPLAINT APPEAL PANEL. (a) A health maintenance organization shall appoint members to a complaint appeal panel to advise the health maintenance organization on the resolution of a disputed decision appealed by a complainant.

(b) A complaint appeal panel shall be composed of an equal number of health maintenance organization staff members, physicians or other providers, and enrollees. A member of a complaint appeal panel may not have been previously involved in the disputed decision.

(c) The physicians or other providers on a complaint appeal panel must have experience in the area of care that is in dispute and must be independent of any physician or provider who made any previous determination. If specialty care is in dispute, the complaint appeal panel must include a person who is a specialist in the field of care to which the appeal relates.

(d) The enrollee members of a complaint appeal panel may not be employees of the health maintenance organization.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.256. INFORMATION PROVIDED TO COMPLAINANT RELATING TO COMPLAINT APPEAL PANEL. Not later than the fifth business day before the date a complaint appeal panel is scheduled to meet, unless the complainant agrees otherwise, the health maintenance organization shall provide to the complainant or the complainant's designated representative:

(1) any documentation to be presented to the complaint appeal panel by the health maintenance organization staff;

(2) the specialization of any physicians or providers consulted during the investigation; and

(3) the name and affiliation of each health maintenance organization representative on the complaint appeal panel.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.257. RIGHTS OF COMPLAINANT AT COMPLAINT APPEAL PANEL MEETING. A complainant, or a designated representative if the

enrollee is a minor or is disabled, is entitled to:

- (1) appear in person before the complaint appeal panel;
- (2) present alternative expert testimony; and
- (3) request the presence of and question any person responsible for making the disputed decision that resulted in the appeal.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.258. APPEAL INVOLVING ONGOING EMERGENCY OR CONTINUED HOSPITALIZATION. (a) The investigation and resolution of an appeal of a complaint relating to an ongoing emergency or denial of continued hospitalization shall be concluded:

- (1) in accordance with the medical or dental immediacy of the case; and
- (2) not later than one business day after the complainant's request for appeal is received.

(b) Because of the ongoing emergency or continued hospitalization and at the request of the complainant, the health maintenance organization shall provide, instead of a complaint appeal panel, a review by a physician or provider who:

- (1) has not previously reviewed the case; and
- (2) is of the same or a similar specialty as the physician or provider who would typically manage the medical condition, procedure, or treatment under consideration for review in the appeal.

(c) The physician or provider reviewing the appeal may interview the patient or the patient's designated representative and shall decide the appeal.

(d) The physician or provider may deliver initial notice of the decision on the appeal orally if the physician or provider subsequently provides written notice of the decision not later than the third day after the date of the decision.

(e) The investigation and resolution of an appeal after emergency care has been provided shall be conducted in accordance with the procedures otherwise established under this subchapter, including the right to review by a complaint appeal panel.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.259. NOTICE OF DECISION ON APPEAL. (a) A health maintenance organization shall include in a notice of the final decision on an appeal a statement of the specific medical determination, clinical basis, and contractual criteria used to reach the final decision.

(b) The notice must include the toll-free telephone number and address of the department.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.260. RECORD OF COMPLAINTS. (a) A health maintenance organization shall maintain a complaint and appeal log regarding each complaint. The log must identify those complaints relating to limited provider networks and delegated entities.

(b) A health maintenance organization shall maintain a record of and documentation on each complaint, complaint proceeding, and action taken on each complaint, including a complaint relating to a limited provider network or delegated entity, until the third anniversary of the date the complaint was received.

(c) A complainant is entitled to a copy of the record of the complainant's complaint and any proceeding relating to that complaint.

(d) The department, during any investigation of a health maintenance organization, may review documentation maintained under Subsection (b), including original documentation, regarding a complaint and action taken on the complaint.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.209(a), eff. Sept. 1, 2003.

Sec. 843.261. SPECIAL PROVISIONS FOR APPEALS OF ADVERSE DETERMINATIONS. (a) A health maintenance organization shall implement and maintain an internal appeal system that:

(1) provides reasonable procedures for the resolution of an oral or written appeal concerning dissatisfaction or disagreement with an adverse determination; and

(2) includes procedures for notification, review, and appeal of an adverse determination in accordance with Chapter 4201.

(b) An appeal must be initiated by an enrollee, a person acting on behalf of an enrollee, or an enrollee's provider of record.

(c) When an enrollee, a person acting on behalf of an enrollee, or an enrollee's provider of record expresses orally or in writing any dissatisfaction or disagreement with an adverse determination, the health maintenance organization or utilization review agent shall:

(1) consider the expression of dissatisfaction or disagreement as an appeal of the adverse determination; and

(2) review and resolve the appeal in accordance with Chapter 4201.

(d) A health maintenance organization may integrate its appeal procedures related to adverse determinations with the complaint and appeal procedures established by the health maintenance organization under Section 843.251 and otherwise governed by this subchapter only if the procedures related to adverse determinations comply with this section and Chapter 4201.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.046, eff. April 1, 2009.

Sec. 843.262. CERTAIN DECISIONS BINDING. (a) If an enrollee, a person acting on behalf of an enrollee, or an enrollee's provider of record appeals an adverse determination as provided under Section 843.261 and the health maintenance organization or utilization review agent, as applicable, resolves the claim in favor of the enrollee, the decision is binding on the health maintenance organization.

(b) After a binding decision in favor of an enrollee relating to a proposed health care service, the health maintenance organization shall provide or arrange for the health care service within a time frame that is appropriate for the treatment of the medical condition that was the subject of the appeal.

(c) After a binding decision in favor of an enrollee relating to a health care service already provided, the health maintenance organization shall pay the cost of the service, if not already paid by the health maintenance organization, not later than the 45th day after the date the health maintenance organization receives notice of

the binding decision. A health maintenance organization that fails to pay the cost of service as required by this subsection is subject to penalties provided under Section 843.342.

(d) This section applies only to a health care plan of a political subdivision that is exempt from application of the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.).

Added by Acts 2003, 78th Leg., ch. 348, Sec. 1, eff. Sept. 1, 2003.

SUBCHAPTER H. GENERAL PROVISIONS REGARDING COMPLAINTS

Sec. 843.281. RETALIATORY ACTION PROHIBITED. (a) A health maintenance organization may not engage in retaliatory action, including refusal to renew or cancellation of coverage, against a group contract holder or enrollee because the group or enrollee or a person acting on behalf of the group or enrollee has filed a complaint against the health maintenance organization or appealed a decision of the health maintenance organization.

(b) A health maintenance organization may not engage in retaliatory action, including refusal to renew or termination of a contract, against a physician or provider because the physician or provider has, on behalf of an enrollee, reasonably filed a complaint against the health maintenance organization or appealed a decision of the health maintenance organization.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.282. SUBMITTING COMPLAINTS TO DEPARTMENT. (a) Any person, including a person who has attempted to resolve a complaint through a health maintenance organization's complaint system process and is dissatisfied with the resolution, may submit a complaint to the department alleging a violation of:

- (1) this chapter;
- (2) Section 1367.053;
- (3) Subchapter A, Chapter 1452;
- (4) Subchapter B, Chapter 1507;
- (5) Chapters 222, 251, and 258, as applicable to a health maintenance organization; or
- (6) Chapter 1271 or 1272.

(b) The commissioner shall complete an investigation of a complaint against a health maintenance organization to determine whether a violation has occurred not later than the 60th day after the date the department receives the complaint and all information necessary for the commissioner to make a determination.

(c) The commissioner may extend the time necessary to complete an investigation if:

- (1) additional information is needed;
- (2) an on-site review is necessary;
- (3) the health maintenance organization, the physician or provider, or the complainant does not provide all documentation necessary to complete the investigation; or
- (4) other circumstances beyond the control of the department occur.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.047, eff. April 1, 2009.

Sec. 843.283. POSTING OF INFORMATION ON COMPLAINT PROCESS REQUIRED. A contract between a health maintenance organization and a physician or provider must require the physician or provider to post, in the office of the physician or provider, a notice to enrollees on the process for resolving complaints with the health maintenance organization. The notice must include the department's toll-free telephone number for filing a complaint.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER I. RELATIONS WITH PHYSICIANS AND PROVIDERS

Sec. 843.301. PRACTICE OF MEDICINE NOT AFFECTED. This chapter, Section 1367.053, Subchapter A, Chapter 1452, Subchapter B, Chapter 1507, Chapters 222, 251, and 258, as applicable to a health maintenance organization, and Chapters 1271 and 1272 do not:

- (1) authorize any person, other than a licensed physician or practitioner of the healing arts, acting within the scope of the person's license, to engage directly or indirectly in the practice of medicine or a healing art; or

(2) authorize any person to regulate, interfere with, or intervene in any manner in the practice of medicine or a healing art.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.048, eff. April 1, 2009.

Sec. 843.302. DISCLOSURE OF APPLICATION PROCEDURES AND QUALIFICATION REQUIREMENTS TO PHYSICIAN OR PROVIDER. A health maintenance organization shall, on request, make available and disclose to a physician or provider written application procedures and qualification requirements for contracting with the health maintenance organization.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.303. DENIAL OF INITIAL CONTRACT TO PHYSICIAN OR PROVIDER. (a) A health maintenance organization that denies a contract to a physician or provider who initially applies to contract with the health maintenance organization to provide health care services on behalf of the health maintenance organization shall provide to the applicant written notice of the reasons the initial application was denied.

(b) Unless otherwise limited by Article 21.52B, this section does not prohibit a health maintenance organization from rejecting an initial application from a physician or provider based on the determination that the plan has sufficient qualified physicians or providers.

(c) A health maintenance organization may not deny a contract to a podiatrist described by Section 843.319.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by Acts 2003, 78th Leg., ch. 237, Sec. 3, eff. Sept. 1, 2003.

Sec. 843.304. EXCLUSION OF PROVIDER BASED ON TYPE OF LICENSE PROHIBITED. (a) A provider licensed or otherwise authorized to practice in this state may not be denied the opportunity to

participate in providing health care services that are delivered by a health maintenance organization and that are within the scope of the provider's license or authorization solely because of the type of license or authorization held by the provider.

(b) If a hospital, facility, agency, or supplier is certified by the Medicare program, Title XVIII of the Social Security Act (42 U.S.C. Section 1395 et seq.), or accredited by the Joint Commission on Accreditation of Healthcare Organizations or another national accrediting body, a health maintenance organization shall accept that certification or accreditation.

(c) This section does not require that a health maintenance organization:

- (1) use a particular type of provider in its operation;
- (2) accept each provider of a category or type, except as provided by Article 21.52B; or
- (3) contract directly with providers of a particular category or type.

(d) This section does not limit a health maintenance organization's authority to establish the terms under which health care services are provided by providers.

(e) A provider must comply with the terms established by the health maintenance organization for the provision of health services and for designation as a provider by the health maintenance organization.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.3041. ACUPUNCTURIST SERVICES. (a) A health maintenance organization that includes acupuncture in the services covered by the organization's health care plan may not refuse to provide reimbursement for the performance of a covered acupuncture service solely because the service is performed by an acupuncturist.

(b) This section does not require a health maintenance organization to offer acupuncture as a covered service.

Added by Acts 2005, 79th Leg., Ch. 622 (H.B. [2371](#)), Sec. 1, eff. September 1, 2005.

Sec. 843.3042. CHIROPRACTIC SERVICES. (a) A health

maintenance organization offering a health care plan that covers a service that is within the scope of a chiropractor's license may not refuse to provide reimbursement to an in-network chiropractor for the performance of the covered service solely because the service is provided by a chiropractor.

(b) This section does not require a health maintenance organization to cover a particular health care service.

(c) This section does not affect the right of a health maintenance organization to determine whether a health care service is medically necessary.

(d) A health maintenance organization that violates this section is subject to an administrative penalty as provided by Chapter 84 of not more than \$1,000 for each claim that remains unpaid in violation of this section. Each day the violation continues constitutes a separate violation.

Added by Acts 2019, 86th Leg., R.S., Ch. 116 (S.B. [1739](#)), Sec. 1, eff. September 1, 2019.

Sec. 843.3045. NURSE FIRST ASSISTANT. A health maintenance organization may not refuse to contract with a nurse first assistant, as defined by Section 301.1525, Occupations Code, to be included in the provider's network or refuse to reimburse the nurse first assistant for a covered service that a physician has requested the nurse first assistant to perform.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.210(a), eff. Sept. 1, 2003.

Sec. 843.305. ANNUAL APPLICATION PERIOD FOR PHYSICIANS AND PROVIDERS TO CONTRACT. (a) This section applies only to a health maintenance organization that provides coverage for health care services through:

- (1) one or more physicians or providers who are not partners or employees of the health maintenance organization; or
- (2) one or more physicians or providers who are not owned or operated by the health maintenance organization.

(b) A health maintenance organization shall provide a period of 20 calendar days each calendar year during which any physician or

provider in a service area may, under the terms established by the health maintenance organization for the provision of services and the designation of physicians and providers, apply to participate in providing health care services.

(c) A health maintenance organization that denies the application of a physician or provider shall notify the physician or provider in writing of the reason for the denial.

(d) This section does not require that a health maintenance organization:

(1) use a particular type of physician or provider in its operation;

(2) accept a physician or provider of a category or type that does not meet the practice standards and qualifications established by the health maintenance organization; or

(3) contract directly with physicians or providers of a particular category or type.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.306. TERMINATION OF PARTICIPATION; ADVISORY REVIEW PANEL. (a) Before terminating a contract with a physician or provider, a health maintenance organization shall provide to the physician or provider a written explanation of the reasons for termination.

(b) On request, before the effective date of the termination and within a period not to exceed 60 days, a physician or provider is entitled to a review by an advisory review panel of the health maintenance organization's proposed termination, except in a case involving:

(1) imminent harm to patient health;

(2) an action by a state medical or dental board, another medical or dental licensing board, or another licensing board or government agency that effectively impairs the physician's or provider's ability to practice medicine, dentistry, or another profession; or

(3) fraud or malfeasance.

(c) An advisory review panel must:

(1) be composed of physicians and providers who are appointed to serve on the standing quality assurance committee or

utilization review committee of the health maintenance organization;
and

(2) include, if available, at least one representative of the physician's or provider's specialty or a similar specialty.

(d) The health maintenance organization must consider, but is not bound by, the recommendation of the advisory review panel.

(e) The health maintenance organization on request shall provide to the affected physician or provider a copy of the recommendation of the advisory review panel and the health maintenance organization's determination.

(f) A health maintenance organization may not terminate participation of a physician or provider solely because the physician or provider informs an enrollee of the full range of physicians and providers available to the enrollee, including out-of-network providers.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 275 (H.B. 574), Sec. 2, eff. September 1, 2015.

Sec. 843.307. EXPEDITED REVIEW PROCESS ON TERMINATION OR DESELECTION. On request by the physician or provider, a physician or provider whose participation in a health care plan is being terminated or who is deselected is entitled to an expedited review process by the health maintenance organization.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.308. NOTIFICATION OF PATIENTS OF DESELECTED PHYSICIAN OR PROVIDER. (a) Except as provided by Subsection (b), if a physician or provider is deselected for a reason other than the request of the physician or provider, a health maintenance organization may not notify patients of the deselection until the effective date of the deselection or the advisory review panel makes a formal recommendation.

(b) If the contract of a physician or provider is deselected for a reason related to imminent harm, a health maintenance organization may notify patients immediately.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.309. CONTRACTS WITH PHYSICIANS OR PROVIDERS: NOTICE TO CERTAIN ENROLLEES OF TERMINATION OF PHYSICIAN OR PROVIDER PARTICIPATION IN PLAN. A contract between a health maintenance organization and a physician or provider must provide that reasonable advance notice shall be given to an enrollee of the impending termination from the plan of a physician or provider who is currently treating the enrollee.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.310. CONTRACTS WITH PHYSICIANS OR PROVIDERS: CERTAIN INDEMNITY CLAUSES PROHIBITED. A contract between a health maintenance organization and a physician or provider may not contain a clause purporting to indemnify the health maintenance organization for any liability in tort resulting from an act or omission of the health maintenance organization.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.311. CONTRACTS WITH PODIATRISTS. A contract between a health maintenance organization and a podiatrist licensed by the Texas Department of Licensing and Regulation must provide that:

(1) the podiatrist may request, and the health maintenance organization shall provide not later than the 30th day after the date of the request, a copy of the coding guidelines and payment schedules applicable to the compensation that the podiatrist will receive under the contract for services;

(2) the health maintenance organization may not unilaterally make material retroactive revisions to the coding guidelines and payment schedules; and

(3) the podiatrist may, while practicing within the scope of the law regulating podiatry, provide x-rays and nonprefabricated orthotics covered by the evidence of coverage.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 467 (H.B. 4170), Sec. 19.011, eff. September 1, 2019.

Sec. 843.3115. CONTRACTS WITH DENTISTS. (a) In this section, "covered service" means a dental care service for which reimbursement is available under an enrollee's health care plan contract, or for which reimbursement is available subject to a contractual limitation, including:

- (1) a deductible;
- (2) a copayment;
- (3) coinsurance;
- (4) a waiting period;
- (5) an annual or lifetime maximum limit;
- (6) a frequency limitation; or
- (7) an alternative benefit payment.

(b) A contract between a health maintenance organization and a dentist may not limit the fee the dentist may charge for a service that is not a covered service.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1061 (S.B. 554), Sec. 1, eff. September 1, 2011.

Sec. 843.312. PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE NURSES. (a) A health maintenance organization may not refuse a request by a physician participating in the health maintenance organization delivery network and a physician assistant or advanced practice nurse who is authorized by the physician to provide care under Subchapter B, Chapter 157, Occupations Code, to identify a physician assistant or advanced practice nurse as a provider in the network.

(b) A health maintenance organization may refuse a request under Subsection (a) if the physician assistant or advanced practice nurse does not meet the quality of care standards previously established by the health maintenance organization for participation in the network by physician assistants and advanced practice nurses.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.313. ECONOMIC PROFILING. (a) A health maintenance organization that conducts or uses economic profiling of physicians or providers participating in the health maintenance organization delivery network shall make available to a network physician or provider on request that physician's or provider's economic profile, including the standards by which the physician or provider is measured.

(b) The use of an economic profile must recognize the characteristics of a physician's or provider's practice that may account for variations from expected costs.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.314. INDUCEMENT TO LIMIT MEDICALLY NECESSARY SERVICES PROHIBITED. (a) A health maintenance organization may not use a financial incentive or make a payment to a physician or provider if the incentive or payment acts directly or indirectly as an inducement to limit medically necessary services.

(b) This section does not prohibit the use of capitation as a method of payment.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.315. PAYMENT OF CAPITATION; ASSIGNMENT OF PRIMARY CARE PHYSICIAN OR PROVIDER. (a) This section applies to a health maintenance organization that to any extent uses capitation as a method of compensation.

(b) A health maintenance organization shall begin payment of capitated amounts to an enrollee's primary care physician or primary care provider, computed from the date of enrollment, not later than the 60th day after the date the enrollee selects or is assigned a primary care physician or primary care provider.

(c) If selection or assignment of a primary care physician or primary care provider does not occur at enrollment, capitated amounts that would have been paid to a selected or assigned primary care physician or primary care provider if a selection or assignment had been made shall be reserved as a capitated amount payable until the enrollee makes a selection or the health maintenance organization assigns a primary care physician or primary care provider.

(d) If an enrollee does not select a primary care physician or primary care provider at the time of application or enrollment, a health maintenance organization may assign the enrollee to a primary care physician or primary care provider.

(e) A primary care physician or primary care provider assigned under Subsection (d) must be located within the zip code nearest the enrollee's residence or place of employment.

(f) Subject to Subsection (e), the health maintenance organization shall make the assignment in a manner that results in a fair and equal distribution of enrollees among the health maintenance organization delivery network's primary care physicians or primary care providers.

(g) A health maintenance organization shall inform an enrollee of:

(1) the name, address, and telephone number of a primary care physician or primary care provider to whom the enrollee has been assigned under Subsection (d); and

(2) the enrollee's right to select a different primary care physician or primary care provider.

(h) At any time, an enrollee is entitled to reject the primary care physician or primary care provider assigned and select another physician or provider from the list of primary care physicians or primary care providers for the health maintenance organization delivery network. A rejection by an enrollee of an assigned physician or provider is not a change in provider for purposes of the limitation described by Section 843.203.

(i) A health maintenance organization shall notify a physician or provider of an enrollee's selection of that person as the primary care physician or primary care provider, or of the assignment of the enrollee to that physician or provider by the health maintenance organization, not later than the 30th working day after the date of the selection or assignment.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.316. ALTERNATIVE CAPITATION SYSTEM. As an alternative to the procedures prescribed by Section 843.315, a health maintenance organization may request approval from the department of a capitation payment system that ensures:

(1) immediate availability and accessibility of a primary care physician or primary care provider; and

(2) payment to a primary care physician or primary care provider of a capitated amount certified by a qualified actuary to be actuarially sufficient to compensate the primary care physician or primary care provider for the risk assumed.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.317. EXCLUSION OF PHYSICIAN OR PROVIDER BASED ON AFFILIATION WITH HEALTH MAINTENANCE ORGANIZATION PROHIBITED. A physician, health care provider, group of physicians or health care providers, or health care facility or institution may not exclude a physician or provider from staff privileges or a facility or institution solely because the physician or provider is associated with a health maintenance organization that holds a certificate of authority under this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.318. CERTAIN CONTRACTS OF PARTICIPATING PHYSICIAN OR PROVIDER NOT PROHIBITED. (a) This chapter and this code do not prohibit a physician or provider who is participating in a health maintenance organization delivery network, whether by contracting with a health maintenance organization under Section 843.101 or by subcontracting with a physician or provider in the health maintenance organization delivery network, from entering into a contractual arrangement within a health maintenance organization delivery network described by Subsections (b)-(e).

(b) A physician may contract to provide medical care or arrange to provide medical care through subcontracts with other physicians. A physician may contract to provide through another provider any service that is ancillary to the practice of medicine, other than hospital or other institutional or inpatient provider services.

(c) A provider may contract to provide, or arrange to provide through a subcontract with a similarly licensed provider, any health care service that the providers are licensed to provide, other than medical care.

(d) A provider may contract to provide, or arrange to provide

through a subcontract with another provider, a health care service that the provider is not licensed to provide, other than medical care, if the contracted or subcontracted services constitute less than 15 percent of the total amount of services the provider is to provide or arrange to provide.

(e) A contract or subcontract authorized under this section may provide for compensation under:

- (1) a fee-for-service arrangement;
- (2) a risk-sharing arrangement; or
- (3) a capitation arrangement under which a fixed

predetermined payment is made in exchange for the provision of, or for the arrangement to provide and the guaranty of the provision of, a defined set of covered services to covered persons for a specified period without regard to the quantity of services actually provided.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.025, eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.025, eff. September 1, 2007.

Sec. 843.319. CERTAIN REQUIRED CONTRACTS. Notwithstanding Section 843.304, a health maintenance organization may not deny a contract to a podiatrist licensed by the Texas Department of Licensing and Regulation who joins the professional practice of a contracted physician or provider, satisfies the application procedures of the health maintenance organization, and meets the qualification and credentialing requirements for contracting with the health maintenance organization.

Added by Acts 2003, 78th Leg., ch. 237, Sec. 4, eff. Sept. 1, 2003.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 467 (H.B. 4170), Sec. 19.012, eff. September 1, 2019.

Sec. 843.320. USE OF HOSPITALIST. (a) In this section, "hospitalist" means a physician who:

- (1) serves as physician of record at a hospital for a

hospitalized patient of another physician; and

(2) returns the care of the patient to that other physician at the end of the patient's hospitalization.

(b) A contract between a health maintenance organization and a physician may not require the physician to use a hospitalist for a hospitalized patient.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.211(a), eff. Sept. 1, 2003.

Sec. 843.321. AVAILABILITY OF CODING GUIDELINES. (a) A contract between a health maintenance organization and a physician or provider must provide that:

(1) the physician or 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 physician or provider will receive under the contract;

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

(3) the health maintenance organization or the health maintenance organization's agent will provide notice of changes to the coding guidelines and fee schedules that will result in a change of payment to the physician or 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) the contract may be terminated by the physician or provider on or before the 30th day after the date the physician or provider receives information requested under this subsection without penalty or discrimination in participation in other health care products or plans.

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

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

(2) disclose the information to a governmental agency

involved in the regulation of health care or insurance.

(c) The health maintenance organization shall, on request of the physician or provider, provide the name, edition, and model version of the software that the health maintenance organization uses to determine bundling and unbundling of claims.

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

Added by Acts 2003, 78th Leg., ch. 214, Sec. 5, eff. June 17, 2003. Renumbered from Insurance Code, Section 843.319 by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 23.001(60), eff. September 1, 2005.

Sec. 843.323. CONTRACT PROVISIONS PROHIBITING REJECTION OF BATCHED CLAIMS. (a) If requested by a participating physician or provider, a health maintenance organization shall include a provision in the physician's or provider's contract providing that the health maintenance organization or the health maintenance organization's clearinghouse may not refuse to process or pay an electronically submitted clean claim, as defined by Subchapter J, because the claim is submitted together with or in a batch submission with a claim that is not a clean claim.

(b) In accordance with Chapters 82 and 84, the commissioner may issue a cease and desist order against or impose sanctions on a health maintenance organization that violates this section or a contract provision adopted under this section.

Added by Acts 2005, 79th Leg., Ch. 668 (S.B. 50), Sec. 1, eff. September 1, 2005.

SUBCHAPTER J. PAYMENT OF CLAIMS TO PHYSICIANS AND PROVIDERS

Sec. 843.336. DEFINITION. (a) In this subchapter, "clean claim" means a claim that complies with this section.

(b) A nonelectronic claim by a physician or provider, other than an institutional provider, is a clean claim if the claim is submitted using the Centers for Medicare and Medicaid Services Form 1500 or, if adopted by the commissioner by rule, a successor to that form developed by the National Uniform Claim Committee or its successor. An electronic claim by a physician or provider, other than an institutional provider, is a clean claim if the claim is

submitted using the Professional 837 (ASC X12N 837) format or, if adopted by the commissioner by rule, a successor to that format adopted by the Centers for Medicare and Medicaid Services or its successor.

(c) A nonelectronic claim by an institutional provider is a clean claim if the claim is submitted using the Centers for Medicare and Medicaid Services Form UB-92 or, if adopted by the commissioner by rule, a successor to that form developed by the National Uniform Billing Committee or its successor. An electronic claim by an institutional provider is a clean claim if the claim is submitted using the Institutional 837 (ASC X12N 837) format or, if adopted by the commissioner by rule, a successor to that format adopted by the Centers for Medicare and Medicaid Services or its successor.

(d) The commissioner may adopt rules that specify the information that must be entered into the appropriate fields on the applicable claim form for a claim to be a clean claim.

(e) The commissioner may not require any data element for an electronic claim that is not required in an electronic transaction set needed to comply with federal law.

(f) A health maintenance organization and a physician or provider may agree by contract to use fewer data elements than are required in an electronic transaction set needed to comply with federal law.

(g) An otherwise clean claim submitted by a physician or provider that includes additional fields, data elements, attachments, or other information not required under this section is considered to be a clean claim for the purposes of this section.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 214, Sec. 6, eff. June 17, 2003.

Sec. 843.337. TIME FOR SUBMISSION OF CLAIM; DUPLICATE CLAIMS; ACKNOWLEDGMENT OF RECEIPT OF CLAIM. (a) A physician or provider must submit a claim to a health maintenance organization not later than the 95th day after the date the physician or provider provides the health care services for which the claim is made. A health maintenance organization shall accept as proof of timely filing a claim filed in compliance with Subsection (e) or information from another health maintenance organization or insurer showing that the

physician or provider submitted the claim to the health maintenance organization or insurer in compliance with Subsection (e).

(b) If a physician or provider fails to submit a claim in compliance with this section, the physician or provider forfeits the right to payment.

(c) The period for submitting a claim under this section may be extended by:

(1) contract;

(2) notice published by the commissioner allowing an extension of prompt payment deadlines to a later date chosen by the commissioner due to a catastrophic event; or

(3) the department's approval of a physician's or provider's request for an extension due to a catastrophic event that substantially interferes with the normal business operations of the physician or provider.

(c-1) The commissioner may adopt rules to implement Subsection (c), including rules establishing requirements for a request made under Subsection (c)(3).

(d) A physician or provider may not submit a duplicate claim for payment before the 46th day after the date the original claim was submitted. The commissioner shall adopt rules under which a health maintenance organization may determine whether a claim is a duplicate claim.

(e) Except as provided by Chapter 1213, a physician or provider may, as appropriate:

(1) mail a claim by United States mail, first class, or by overnight delivery service;

(2) submit the claim electronically;

(3) fax the claim; or

(4) hand deliver the claim.

(f) If a claim for health care services provided to a patient is mailed, the claim is presumed to have been received by the health maintenance organization on the fifth day after the date the claim is mailed or, if the claim is mailed using overnight service or return receipt requested, on the date the delivery receipt is signed. If the claim is submitted electronically, the claim is presumed to have been received on the date of the electronic verification of receipt by the health maintenance organization or the health maintenance organization's clearinghouse. If the health maintenance organization or the health maintenance organization's clearinghouse does not

provide a confirmation within 24 hours of submission by the physician or provider, the physician's or provider's clearinghouse shall provide the confirmation. The physician's or provider's clearinghouse must be able to verify that the filing contained the correct payor identification of the entity to receive the filing. If the claim is faxed, the claim is presumed to have been received on the date of the transmission acknowledgment. If the claim is hand delivered, the claim is presumed to have been received on the date the delivery receipt is signed.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 214, Sec. 7, eff. June 17, 2003.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.049, eff. April 1, 2009.

Acts 2023, 88th Leg., R.S., Ch. 90 (S.B. 1286), Sec. 1, eff. September 1, 2023.

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

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

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

(3) if the health maintenance organization determines that the claim is not payable, notify the physician or provider in writing why the claim will not be paid.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by Acts 2003, 78th Leg., ch. 214, Sec. 8, eff. June 17, 2003.
Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 798 (H.B. 2292), Sec. 2, eff.
September 1, 2011.

Sec. 843.3385. ADDITIONAL INFORMATION. (a) If a health maintenance organization needs additional information from a treating participating physician or provider to determine payment, the health maintenance organization, not later than the 30th calendar day after the date the health maintenance organization receives a clean claim, shall request in writing that the physician or provider provide an attachment to the claim that is relevant and necessary for clarification of the claim.

(b) The request must describe with specificity the clinical information requested and relate only to information the health maintenance organization can demonstrate is specific to the claim or the claim's related episode of care. The participating physician or provider is not required to provide an attachment that is not contained in, or is not in the process of being incorporated into, the patient's medical or billing record maintained by a participating physician or provider.

(c) A health maintenance organization that requests an attachment under this section shall determine whether the claim is payable on or before the later of the 15th day after the date the health maintenance organization receives the requested attachment or the latest date for determining whether the claim is payable under Section 843.338 or 843.339.

(d) A health maintenance organization may not make more than one request under this section in connection with a claim. Sections 843.337(e) and (f) apply to a request for and submission of an attachment under Subsection (a).

(e) If a health maintenance organization requests an attachment or other information from a person other than the participating physician or provider who submitted the claim, the health maintenance organization shall provide notice containing the name of the physician or provider from whom the health maintenance organization is requesting information to the physician or provider who submitted the claim. The health maintenance organization may not withhold payment pending receipt of an attachment or information requested

under this subsection. If on receiving an attachment or information requested under this subsection the health maintenance organization determines that there was an error in payment of the claim, the health maintenance organization may recover any overpayment under Section 843.350.

(f) The commissioner shall adopt rules under which a health maintenance organization can easily identify an attachment or other information submitted by a physician or provider under this section.

Added by Acts 2003, 78th Leg., ch. 214, Sec. 9, eff. June 17, 2003.

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

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

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 214, Sec. 10, eff. June 17, 2003.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 798 (H.B. [2292](#)), Sec. 3, eff. September 1, 2011.

Sec. 843.340. AUDITED CLAIMS. (a) Except as provided by Section 843.3385, if a health maintenance organization intends to audit a claim submitted by a participating physician or provider, the health maintenance organization shall pay the charges submitted at 100 percent of the contracted rate on the claim not later than the 30th day after the date the health maintenance organization receives the clean claim from the participating physician or provider if

submitted electronically or if submitted nonelectronically not later than the 45th day after the date on which the health maintenance organization receives the clean claim from a participating physician or provider. The health maintenance organization shall clearly indicate on the explanation of payment statement in the manner prescribed by the commissioner by rule that the clean claim is being paid at 100 percent of the contracted rate, subject to completion of the audit.

(b) If the health maintenance organization requests additional information to complete the audit, the request must describe with specificity the clinical information requested and relate only to information the health maintenance organization in good faith can demonstrate is specific to the claim or episode of care. The health maintenance organization may not request as a part of the audit information that is not contained in, or is not in the process of being incorporated into, the patient's medical or billing record maintained by a participating physician or provider.

(c) If the participating physician or provider does not supply information reasonably requested by the health maintenance organization in connection with the audit, the health maintenance organization may:

(1) notify the physician or provider in writing that the physician or provider must provide the information not later than the 45th day after the date of the notice or forfeit the amount of the claim; and

(2) if the physician or provider does not provide the information required by this section, recover the amount of the claim.

(d) The health maintenance organization must complete the audit on or before the 180th day after the date the clean claim is received by the health maintenance organization, and any additional payment due a participating physician or provider or any refund due the health maintenance organization shall be made not later than the 30th day after the completion of the audit.

(e) If a participating physician or provider disagrees with a refund request made by a health maintenance organization based on the audit, the health maintenance organization shall provide the physician or provider with an opportunity to appeal, and the health maintenance organization may not attempt to recover the payment until all appeal rights are exhausted.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 214, Sec. 11, eff. June 17, 2003.

Sec. 843.3405. INVESTIGATION AND DETERMINATION OF PAYMENT. The investigation and determination of payment, including any coordination of other payments, does not extend the period for determining whether a claim is payable under Section 843.338 or 843.339 or for auditing a claim under Section 843.340.

Added by Acts 2003, 78th Leg., ch. 214, Sec. 12, eff. June 17, 2003.

Sec. 843.341. CLAIMS PROCESSING PROCEDURES. (a) A health maintenance organization shall provide a participating physician or provider with copies of all applicable utilization review policies and claim processing policies or procedures.

(b) A health maintenance organization's claims payment processes shall:

(1) use nationally recognized, generally accepted Current Procedural Terminology codes, notes, and guidelines, including all relevant modifiers; and

(2) be consistent with nationally recognized, generally accepted bundling edits and logic.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 214, Sec. 13, eff. June 17, 2003.

Sec. 843.342. VIOLATION OF CERTAIN CLAIMS PAYMENT PROVISIONS; PENALTIES. (a) Except as provided by this section, if a clean claim submitted to a health maintenance organization is payable and the health maintenance organization does not determine under this subchapter that the claim is payable and pay the claim on or before the date the health maintenance organization is required to make a determination or adjudication of the claim, the health maintenance organization shall pay the physician or provider making the claim the contracted rate owed on the claim plus a penalty in the amount of the lesser of:

(1) 50 percent of the difference between the billed charges, as submitted on the claim, and the contracted rate; or
(2) \$100,000.

(b) If the claim is paid on or after the 46th day and before the 91st day after the date the health maintenance organization is required to make a determination or adjudication of the claim, the health maintenance organization shall pay a penalty in the amount of the lesser of:

(1) 100 percent of the difference between the billed charges, as submitted on the claim, and the contracted rate; or
(2) \$200,000.

(c) If the claim is paid on or after the 91st day after the date the health maintenance organization is required to make a determination or adjudication of the claim, the health maintenance organization shall pay a penalty computed under Subsection (b) plus 18 percent annual interest on that amount. Interest under this subsection accrues beginning on the date the health maintenance organization was required to pay the claim and ending on the date the claim and the penalty are paid in full.

(d) Except as provided by this section, a health maintenance organization that determines under this subchapter that a claim is payable, pays only a portion of the amount of the claim on or before the date the health maintenance organization is required to make a determination or adjudication of the claim, and pays the balance of the contracted rate owed for the claim after that date shall pay to the physician or provider, in addition to the contracted amount owed, a penalty on the amount not timely paid in the amount of the lesser of:

(1) 50 percent of the underpaid amount; or
(2) \$100,000.

(e) If the balance of the claim is paid on or after the 46th day and before the 91st day after the date the health maintenance organization is required to make a determination or adjudication of the claim, the health maintenance organization shall pay a penalty on the balance of the claim in the amount of the lesser of:

(1) 100 percent of the underpaid amount; or
(2) \$200,000.

(f) If the balance of the claim is paid on or after the 91st day after the date the health maintenance organization is required to make a determination or adjudication of the claim, the health

maintenance organization shall pay a penalty on the balance of the claim computed under Subsection (e) plus 18 percent annual interest on that amount. Interest under this subsection accrues beginning on the date the health maintenance organization was required to pay the claim and ending on the date the claim and the penalty are paid in full.

(g) For the purposes of Subsections (d) and (e), the underpaid amount is calculated on the ratio of the amount underpaid on the contracted rate to the contracted rate as applied to an amount equal to the billed charges as submitted on the claim minus the contracted rate.

(h) A health maintenance organization is not liable for a penalty under this section:

(1) if the failure to pay the claim in accordance with this subchapter is a result of a catastrophic event and:

(A) the commissioner published a notice allowing an extension of the applicable prompt payment deadlines due to the catastrophic event; or

(B) the department approved the health maintenance organization's request for an extension due to the substantial interference of the catastrophic event with the normal business operations of the health maintenance organization; or

(2) if the claim was paid in accordance with this subchapter, but for less than the contracted rate, and:

(A) the physician or provider notifies the health maintenance organization of the underpayment after the 270th day after the date the underpayment was received; and

(B) the health maintenance organization pays the balance of the claim on or before the 30th day after the date the health maintenance organization receives the notice.

(i) Subsection (h) does not relieve the health maintenance organization of the obligation to pay the remaining unpaid contracted rate owed the physician or provider.

(j) A health maintenance organization that pays a penalty under this section shall clearly indicate on the explanation of payment statement in the manner prescribed by the commissioner by rule the amount of the contracted rate paid and the amount paid as a penalty.

(k) In addition to any other penalty or remedy authorized by this code or another insurance law of this state, a health maintenance organization that violates Section 843.338, 843.339, or

843.340 in processing more than two percent of clean claims submitted to the health maintenance organization is subject to an administrative penalty under Chapter 84. For each day an administrative penalty is imposed under this subsection, the penalty may not exceed \$1,000 for each claim that remains unpaid in violation of Section 843.338, 843.339, or 843.340.

(l) In determining whether a health maintenance organization has processed physician and provider claims in compliance with Section 843.338, 843.339, or 843.340, the commissioner shall consider paid claims, other than claims that have been paid under Section 843.340, and shall compute a compliance percentage for physician and provider claims, other than institutional provider claims, and a compliance percentage for institutional provider claims.

(m) Notwithstanding any other provision of this section, this subsection governs the payment of a penalty under this section. For a penalty under this section relating to a clean claim submitted by a physician or provider other than an institutional provider, the health maintenance organization shall pay the entire penalty to the physician or provider, except for any interest computed under Subsection (c), which shall be paid to the Texas Health Insurance Risk Pool. For a penalty under this section relating to a clean claim submitted by an institutional provider, the health maintenance organization shall pay 50 percent of the total penalty amount computed under this section, including interest, to the institutional provider and the remaining 50 percent of that amount to the Texas Health Insurance Risk Pool.

(n) In this section, "institutional provider" means a hospital or other medical or health-related service facility that provides care for the sick or injured or other care that may be covered in an evidence of coverage.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 214, Sec. 14, eff. June 17, 2003; Acts 2003, 78th Leg., ch. 1276, Sec. 10A.212, eff. Sept. 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 435 (S.B. 1884), Sec. 1, eff. September 1, 2007.

Acts 2009, 81st Leg., R.S., Ch. 265 (H.B. 2064), Sec. 1, eff. January 1, 2010.

Acts 2023, 88th Leg., R.S., Ch. 90 (S.B. [1286](#)), Sec. 2, eff. September 1, 2023.

Sec. 843.343. ATTORNEY'S FEES. A physician or provider may recover reasonable attorney's fees and court costs in an action to recover payment under this subchapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 214, Sec. 15, eff. June 17, 2003.

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

- (1) process or pay claims;
- (2) obtain the services of physicians and providers to provide health care services to enrollees; or
- (3) issue verifications or preauthorizations.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 214, Sec. 16, eff. June 17, 2003.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 798 (H.B. [2292](#)), Sec. 5, eff. September 1, 2011.

Sec. 843.345. EXCEPTION. This subchapter does not apply to a capitated payment required to be made to a physician or provider under an agreement to provide health care services.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 214, Sec. 17, eff. June 17, 2003.

Sec. 843.346. PAYMENT OF CLAIMS. Except as provided by this subchapter, a health maintenance organization shall pay a physician

or provider for health care services and benefits provided to an enrollee not later than:

(1) the 45th day after the date on which a claim for payment is received with the documentation reasonably necessary to process the claim; or

(2) if applicable, within the number of calendar days specified by written agreement between the physician or provider and the health maintenance organization.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 214, Sec. 18, eff. June 17, 2003.

Sec. 843.347. VERIFICATION. (a) In this section, "verification" means a reliable representation by a health maintenance organization to a physician or provider that the health maintenance organization will pay the physician or provider for proposed health care services if the physician or provider renders those services to the patient for whom the services are proposed. The term includes precertification, certification, recertification, and any other term that would be a reliable representation by a health maintenance organization to a physician or provider and includes preauthorization only when preauthorization is a condition for the verification.

(b) On the request of a physician or provider for verification of a particular health care service the participating physician or provider proposes to provide to a particular patient, the health maintenance organization shall inform the physician or provider without delay whether the service, if provided to that patient, will be paid by the health maintenance organization and shall specify any deductibles, copayments, or coinsurance for which the enrollee is responsible.

(c) A health maintenance organization shall have appropriate personnel reasonably available at a toll-free telephone number to provide a verification under this section between 6 a.m. and 6 p.m. central time Monday through Friday on each day that is not a legal holiday and between 9 a.m. and noon central time on Saturday, Sunday, and legal holidays. A health maintenance organization must have a telephone system capable of accepting or recording incoming phone

calls for verifications after 6 p.m. central time Monday through Friday and after noon central time on Saturday, Sunday, and legal holidays and responding to each of those calls on or before the second calendar day after the date the call is received.

(d) A health maintenance organization may decline to determine eligibility for payment if the insurer notifies the physician or preferred provider who requested the verification of the specific reason the determination was not made.

(e) A health maintenance organization may establish a specific period during which the verification is valid of not less than 30 days.

(f) A health maintenance organization that declines to provide a verification shall notify the physician or provider who requested the verification of the specific reason the verification was not provided.

(g) If a health maintenance organization has provided a verification for proposed health care services, the health maintenance organization may not deny or reduce payment to the physician or provider for those health care services if provided to the enrollee on or before the 30th day after the date the verification was provided unless the physician or provider has materially misrepresented the proposed health care services or has substantially failed to perform the proposed health care services.

(h) A health maintenance organization providing routine vision services as a single health care service plan or providing dental health care services as a single health care service plan is not required to comply with Subsection (c) with respect to those services. For purposes of this subsection, "routine vision services" means a routine annual or biennial eye examination to determine ocular health and refractive conditions that may include provision of glasses or contact lenses.

(i) A health maintenance organization described by Subsection (h) shall:

(1) have appropriate personnel reasonably available at a toll-free telephone number to provide a verification under this section between 8 a.m. and 5 p.m. central time Monday through Friday on each day that is not a legal holiday;

(2) have a telephone system capable of accepting or recording incoming phone calls for verifications after 5 p.m. Monday through Friday and all day on Saturday, Sunday, and legal holidays;

and

(3) respond to calls accepted or recorded on the telephone system described by Subdivision (2) not later than the next business day after the date the call is received.

Added by Acts 2003, 78th Leg., ch. 214, Sec. 19, eff. June 17, 2003.
Amended by:

Acts 2005, 79th Leg., Ch. 669 (S.B. 51), Sec. 3, eff. September 1, 2005.

Sec. 843.348. PREAUTHORIZATION OF HEALTH CARE SERVICES. (a) In this section, "preauthorization" means a determination by a health maintenance organization that health care services proposed to be provided to a patient are medically necessary and appropriate.

(b) A health maintenance organization that uses a preauthorization process for health care services shall provide each participating physician or provider, not later than the fifth business day after the date a request is made, a list of health care services that require preauthorization and information concerning the preauthorization process.

(c) If proposed health care services require preauthorization as a condition of the health maintenance organization's payment to a participating physician or provider, the health maintenance organization shall determine whether the health care services proposed to be provided to the enrollee are medically necessary and appropriate.

(d) On receipt of a request from a participating physician or provider for preauthorization, the health maintenance organization shall review and issue a determination indicating whether the health care services are preauthorized. The determination must be issued and transmitted not later than the third calendar day after the date the request is received by the health maintenance organization.

(e) If the proposed health care services involve inpatient care and the health maintenance organization requires preauthorization as a condition of payment, the health maintenance organization shall review the request and issue a length of stay for the admission into a health care facility based on the recommendation of the patient's physician or provider and the health maintenance organization's written medically accepted screening criteria and review procedures.

If the proposed health care services are to be provided to a patient who is an inpatient in a health care facility at the time the services are proposed, the health maintenance organization shall review the request and issue a determination indicating whether proposed services are preauthorized within 24 hours of the request by the physician or provider.

(f) A health maintenance organization shall have appropriate personnel reasonably available at a toll-free telephone number to respond to requests for a preauthorization between 6 a.m. and 6 p.m. central time Monday through Friday on each day that is not a legal holiday and between 9 a.m. and noon central time on Saturday, Sunday, and legal holidays. A health maintenance organization must have a telephone system capable of accepting or recording incoming phone calls for preauthorizations after 6 p.m. central time Monday through Friday and after noon central time on Saturday, Sunday, and legal holidays and responding to each of those calls not later than 24 hours after the call is received.

(g) If the health maintenance organization has preauthorized health care services, the health maintenance organization may not deny or reduce payment to the physician or provider for those services based on medical necessity or appropriateness of care unless the physician or provider has materially misrepresented the proposed health care services or has substantially failed to perform the proposed health care services.

(h) This section applies to an agent or other person with whom a health maintenance organization contracts to perform, or to whom the health maintenance organization delegates the performance of, preauthorization of proposed health care services.

(i) A health maintenance organization providing routine vision services as a single health care service plan or providing dental health care services as a single health care service plan is not required to comply with Subsection (f) with respect to those services. For purposes of this subsection, "routine vision services" means a routine annual or biennial eye examination to determine ocular health and refractive conditions that may include provision of glasses or contact lenses.

(j) A health maintenance organization described by Subsection (i) shall:

(1) have appropriate personnel reasonably available at a toll-free telephone number to respond to requests for

preauthorization under this section between 8 a.m. and 5 p.m. central time Monday through Friday on each day that is not a legal holiday;

(2) have a telephone system capable of accepting or recording incoming phone calls for preauthorizations after 5 p.m. Monday through Friday and all day on Saturday, Sunday, and legal holidays; and

(3) respond to calls accepted or recorded on the telephone system described by Subdivision (2) not later than the next business day after the date the call is received.

Added by Acts 2003, 78th Leg., ch. 214, Sec. 19, eff. June 17, 2003.

Amended by:

Acts 2005, 79th Leg., Ch. 669 (S.B. 51), Sec. 4, eff. September 1, 2005.

Acts 2019, 86th Leg., R.S., Ch. 1218 (S.B. 1742), Sec. 2.01, eff. September 1, 2019.

Sec. 843.3481. POSTING OF PREAUTHORIZATION REQUIREMENTS. (a) A health maintenance organization that uses a preauthorization process for health care services shall make the requirements and information about the preauthorization process readily accessible to enrollees, physicians, providers, and the general public by posting the requirements and information on the health maintenance organization's Internet website.

(b) The preauthorization requirements and information described by Subsection (a) must:

(1) be posted:

(A) except as provided by Subsection (c) or (d), conspicuously in a location on the Internet website that does not require the use of a log-in or other input of personal information to view the information; and

(B) in a format that is easily searchable and accessible;

(2) except for the screening criteria under Subdivision (4)(C), be written in plain language that is easily understandable by enrollees, physicians, providers, and the general public;

(3) include a detailed description of the preauthorization process and procedure; and

(4) include an accurate and current list of the health care

services for which the health maintenance organization requires preauthorization that includes the following information specific to each service:

(A) the effective date of the preauthorization requirement;

(B) a list or description of any supporting documentation that the health maintenance organization requires from the physician or provider ordering or requesting the service to approve a request for that service;

(C) the applicable screening criteria, which may include Current Procedural Terminology codes and International Classification of Diseases codes; and

(D) statistics regarding preauthorization approval and denial rates for the service in the preceding calendar year, including statistics in the following categories:

(i) physician or provider type and specialty, if any;

(ii) indication offered;

(iii) reasons for request denial;

(iv) denials overturned on internal appeal;

(v) denials overturned by an independent review organization; and

(vi) total annual preauthorization requests, approvals, and denials for the service.

(c) This section may not be construed to require a health maintenance organization to provide specific information that would violate any applicable copyright law or licensing agreement. To comply with a posting requirement described by Subsection (b), a health maintenance organization may, instead of making that information publicly available on the health maintenance organization's Internet website, supply a summary of the withheld information sufficient to allow a licensed physician or provider, as applicable for the specific service, who has sufficient training and experience related to the service to understand the basis for the health maintenance organization's medical necessity or appropriateness determinations.

(d) If a requirement or information described by Subsection (a) is licensed, proprietary, or copyrighted material that the health maintenance organization has received from a third party with which the health maintenance organization has contracted, to comply with a

posting requirement described by Subsection (b), the health maintenance organization may, instead of making that information publicly available on the health maintenance organization's Internet website, provide the material to a physician or provider who submits a preauthorization request using a nonpublic secured Internet website link or other protected, nonpublic electronic means.

Added by Acts 2019, 86th Leg., R.S., Ch. 1218 (S.B. 1742), Sec. 2.02, eff. September 1, 2019.

Sec. 843.3482. CHANGES TO PREAUTHORIZATION REQUIREMENTS. (a) Except as provided by Subsection (b), not later than the 60th day before the date a new or amended preauthorization requirement takes effect, a health maintenance organization that uses a preauthorization process for health care services shall provide notice of the new or amended preauthorization requirement and disclose the new or amended requirement in the health maintenance organization's newsletter or network bulletin, if any, and on the health maintenance organization's Internet website.

(b) For a change in a preauthorization requirement or process that removes a service from the list of health care services requiring preauthorization or amends a preauthorization requirement in a way that is less burdensome to enrollees or participating physicians or providers, a health maintenance organization shall provide notice of the change in the preauthorization requirement and disclose the change in the health maintenance organization's newsletter or network bulletin, if any, and on the health maintenance organization's Internet website not later than the fifth day before the date the change takes effect.

(c) Not later than the fifth day before the date a new or amended preauthorization requirement takes effect, a health maintenance organization shall update its Internet website to disclose the change to the health maintenance organization's preauthorization requirements or process and the date and time the change is effective.

Added by Acts 2019, 86th Leg., R.S., Ch. 1218 (S.B. 1742), Sec. 2.02, eff. September 1, 2019.

Sec. 843.3483. REMEDY FOR NONCOMPLIANCE. In addition to any other penalty or remedy provided by law, a health maintenance organization that uses a preauthorization process for health care services that violates this subchapter with respect to a required publication, notice, or response regarding its preauthorization requirements, including by failing to comply with any applicable deadline for the publication, notice, or response, must provide an expedited appeal under Section 4201.357 for any health care service affected by the violation.

Added by Acts 2019, 86th Leg., R.S., Ch. 1218 (S.B. 1742), Sec. 2.02, eff. September 1, 2019.

Sec. 843.349. COORDINATION OF PAYMENT. (a) A health maintenance organization may require a physician or provider to retain in the physician's or provider's records updated information concerning other health benefit plan coverage and to provide the information to the health maintenance organization on the applicable form described by Section 843.336. Except as provided by this section, a health maintenance organization may not require a physician or provider to investigate coordination of other health benefit plan coverage.

(b) Coordination of other payment under this section does not extend the period for determining whether a service is eligible for payment under Section 843.338 or 843.339 or for auditing a claim under Section 843.340.

(c) A participating physician or provider who submits a claim for particular health care services to more than one health maintenance organization or insurer shall provide written notice on the claim submitted to each health maintenance organization or insurer of the identity of each other health maintenance organization or insurer with which the same claim is being filed.

(d) On receipt of notice under Subsection (c), a health maintenance organization shall coordinate and determine the appropriate payment for each health maintenance organization or insurer to make to the physician or provider.

(e) Except as provided by Subsection (f), if a health maintenance organization is a secondary payor and pays a portion of a claim that should have been paid by the health maintenance

organization or insurer that is the primary payor, the overpayment may only be recovered from the health maintenance organization or insurer that is primarily responsible for that amount.

(f) If the portion of the claim overpaid by the secondary health maintenance organization was also paid by the primary health maintenance organization or insurer, the secondary health maintenance organization may recover the amount of the overpayment under Section 843.350 from the physician or provider who received the payment. A health maintenance organization processing an electronic claim as a secondary payor shall rely on the primary payor information submitted on the claim by the physician or provider. Primary payor information may be submitted electronically by the primary payor to the secondary payor.

(g) A health maintenance organization may share information with another health maintenance organization or an insurer to the extent necessary to coordinate appropriate payment obligations on a specific claim.

Added by Acts 2003, 78th Leg., ch. 214, Sec. 19, eff. June 17, 2003.

Sec. 843.350. OVERPAYMENT. (a) A health maintenance organization may recover an overpayment to a physician or provider if:

(1) not later than the 180th day after the date the physician or provider receives the payment, the health maintenance organization provides written notice of the overpayment to the physician or provider that includes the basis and specific reasons for the request for recovery of funds; and

(2) the physician or provider does not make arrangements for repayment of the requested funds on or before the 45th day after the date the physician or provider receives the notice.

(b) If a physician or provider disagrees with a request for recovery of an overpayment, the health maintenance organization shall provide the physician or provider with an opportunity to appeal, and the health maintenance organization may not recover the overpayment until all appeal rights are exhausted.

Added by Acts 2003, 78th Leg., ch. 214, Sec. 19, eff. June 17, 2003.

Sec. 843.351. SERVICES PROVIDED BY CERTAIN PHYSICIANS AND PROVIDERS. The provisions of this subchapter relating to prompt payment by a health maintenance organization of a physician or provider and to verification of health care services apply to a physician or provider who:

(1) is not included in the health maintenance organization delivery network; and

(2) provides to an enrollee:

(A) care related to an emergency or its attendant episode of care as required by state or federal law; or

(B) specialty or other health care services at the request of the health maintenance organization or a physician or provider who is included in the health maintenance organization delivery network because the services are not reasonably available within the network.

Added by Acts 2003, 78th Leg., ch. 214, Sec. 19, eff. June 17, 2003.

Sec. 843.352. CONFLICT WITH OTHER LAW. To the extent of any conflict between this subchapter and Subchapter C, Chapter 1204, this subchapter controls.

Added by Acts 2003, 78th Leg., ch. 214, Sec. 19, eff. June 17, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 2E.050, eff. April 1, 2009.

Sec. 843.353. WAIVER PROHIBITED. Except as provided by Sections 843.336(f) and 843.337(c), the provisions of this subchapter may not be waived, voided, or nullified by contract.

Added by Acts 2003, 78th Leg., ch. 214, Sec. 19, eff. June 17, 2003.

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

Added by Acts 2011, 82nd Leg., R.S., Ch. 798 (H.B. 2292), Sec. 6, eff. September 1, 2011.

SUBCHAPTER K. RELATIONS BETWEEN ENROLLEE AND PHYSICIAN OR PROVIDER

Sec. 843.361. ENROLLEES HELD HARMLESS. A contract or other agreement between a health maintenance organization and a physician or provider must specify that the physician or provider will hold an enrollee harmless for payment of the cost of covered health care services if the health maintenance organization does not pay the physician or provider for those services.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.362. CONTINUITY OF CARE; OBLIGATION OF HEALTH MAINTENANCE ORGANIZATION. (a) In this section, "special circumstance" means a condition regarding which a treating physician or provider reasonably believes that discontinuing care by that physician or provider could cause harm to an enrollee who is a patient. Examples of an enrollee who has a special circumstance include an enrollee with a disability, acute condition, life-threatening illness, or who is past the 24th week of pregnancy.

(b) Each contract between a health maintenance organization and a physician and provider must provide that termination of the contract, except for reason of medical competence or professional behavior, does not release the health maintenance organization from the obligation of continuing to reimburse a physician or provider providing medically necessary treatment at the time of termination to an enrollee who has a special circumstance in accordance with the dictates of medical prudence. Subject to Subsections (d) and (e), the health maintenance organization must provide continued reimbursement at not less than the contract rate in exchange for the enrollee's continued receipt of ongoing treatment from the physician or provider.

(c) The treating physician or provider shall identify a special circumstance. The treating physician or provider must:

- (1) request that an enrollee be permitted to continue treatment under the physician's or provider's care; and
- (2) agree not to seek payment from the enrollee of any

amount for which the enrollee would not be responsible if the physician or provider continued to be included in the health maintenance organization delivery network.

(d) Except as provided by Subsection (e), this section does not extend the obligation of a health maintenance organization to reimburse a terminated physician or provider for ongoing treatment of an enrollee after:

(1) the 90th day after the effective date of the termination; or

(2) if the enrollee has been diagnosed with a terminal illness at the time of termination, the expiration of the nine-month period after the effective date of the termination.

(e) If an enrollee is past the 24th week of pregnancy at the time of termination, a health maintenance organization's obligation to reimburse a terminated physician or provider or, if applicable, an enrollee extends through delivery of the child and applies to immediate postpartum care and a follow-up checkup within the six-week period after delivery.

(f) A contract between a health maintenance organization and a physician or provider must provide procedures for resolving disputes regarding the necessity for continued treatment by a physician or provider.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.363. PROTECTED PHYSICIAN OR PROVIDER COMMUNICATIONS WITH PATIENTS. (a) A health maintenance organization may not, as a condition of a contract with a physician, dentist, or provider, or in any other manner, prohibit, attempt to prohibit, or discourage a physician, dentist, or provider from discussing with or communicating in good faith with a current, prospective, or former patient, or a person designated by a patient, with respect to:

(1) information or opinions regarding the patient's health care, including the patient's medical condition or treatment options;

(2) information or opinions regarding the terms, requirements, or services of the health care plan as they relate to the medical needs of the patient;

(3) the termination of the physician's, dentist's, or provider's contract with the health care plan or the fact that the

physician, dentist, or provider will otherwise no longer be providing medical care, dental care, or health care services under the health care plan; or

(4) information regarding the availability of facilities, both in-network and out-of-network, for the treatment of the patient's medical condition.

(a-1) A health maintenance organization may not, as a condition of payment with a physician, dentist, or provider, or in any other manner, require a physician, dentist, or provider to provide a notification form stating that the physician, dentist, or provider is an out-of-network provider to a current, prospective, or former patient, or a person designated by the patient, if the form contains additional information that is intended, or is otherwise required to be presented in a manner that is intended, to intimidate the patient.

(b) A health maintenance organization may not in any manner penalize, terminate, or refuse to compensate for covered services a physician, dentist, or provider for communicating in a manner protected by this section with a current, prospective, or former patient, or a person designated by a patient.

(c) A contract provision that violates this section is void.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 275 (H.B. 574), Sec. 3, eff. September 1, 2015.

SUBCHAPTER L. FINANCIAL REGULATION OF HEALTH MAINTENANCE ORGANIZATIONS

Sec. 843.401. FIDUCIARY RESPONSIBILITY. A director, officer, member, employee, or partner of a health maintenance organization who receives, collects, disburses, or invests funds in connection with the activities of the health maintenance organization is responsible for the funds in a fiduciary relationship to the enrollees.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.402. OFFICERS' AND EMPLOYEES' BOND. (a) A health maintenance organization shall maintain in force in its own name a fidelity bond on its officers and employees in an amount of at least

\$100,000 or another amount prescribed by the commissioner.

(b) The fidelity bond must be issued by an insurer that holds a certificate of authority in this state. If, after notice and hearing, the commissioner determines that a fidelity bond is not available from an insurer that holds a certificate of authority in this state, the health maintenance organization may obtain a fidelity bond procured by a surplus lines agent resident in this state in compliance with Chapter 981.

(c) The fidelity bond must obligate the surety to pay any loss of money or other property the health maintenance organization sustains because of an act of fraud or dishonesty by an employee or officer of the health maintenance organization, acting alone or in concert with others, while employed or serving as an officer of the health maintenance organization.

(d) Instead of a fidelity bond, a health maintenance organization may deposit cash with the comptroller. The deposit must be maintained in the amount and is subject to the same conditions required for a fidelity bond under this section.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.403. MINIMUM NET WORTH. (a) A health maintenance organization authorized to provide basic health care services shall maintain a minimum net worth of \$1.5 million.

(b) A health maintenance organization authorized to provide limited health care services shall maintain a minimum net worth of \$1 million.

(c) A health maintenance organization authorized to offer only a single health care service plan shall maintain a minimum net worth of \$500,000.

(d) The minimum net worth required by this section may consist only of:

- (1) money of the United States;
- (2) bonds of this state;
- (3) bonds or other evidences of indebtedness of the United States that are guaranteed as to principal and interest by the United States; or
- (4) bonds or other interest-bearing evidences of indebtedness of a county or municipality of this state.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.404. ADDITIONAL NET WORTH REQUIREMENTS. (a) The commissioner may adopt rules or by rule establish guidelines requiring a health maintenance organization to maintain a specified net worth based on:

- (1) the nature and kind of risks the health maintenance organization underwrites or reinsures;
- (2) the premium volume of risks the health maintenance organization underwrites or reinsures;
- (3) the composition, quality, duration, or liquidity of the health maintenance organization's investment portfolio;
- (4) fluctuations in the market value of securities the health maintenance organization holds;
- (5) the adequacy of the health maintenance organization's reserves;
- (6) the number of individuals enrolled by the health maintenance organization; or
- (7) other business risks.

(b) Rules adopted or guidelines established under this section must be designed to ensure the financial solvency of health maintenance organizations for the protection of enrollees. The rules or guidelines may provide for a health maintenance organization to comply with a risk-based net worth requirement established under this section in stages over a two-year period.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.405. DEPOSIT WITH COMPTROLLER. (a) Unless otherwise provided by this section, a health maintenance organization shall deposit with the comptroller cash or securities, or any combination of cash, securities, and other guarantees that are acceptable to the commissioner, in the amount prescribed by this section.

(b) The amount of a health maintenance organization's initial deposit or other guarantee must be \$100,000 for a health maintenance organization offering basic health care services, \$75,000 for a health maintenance organization offering limited health care services, and \$50,000 for a health maintenance organization offering

a single health care service plan.

(c) On or before March 15 of the year following the year in which the health maintenance organization receives a certificate of authority, it shall deposit with the comptroller an amount equal to the difference between the initial deposit and 100 percent of its estimated uncovered health care expenses for the first 12 months of operation.

(d) On or before March 15 of each subsequent year, a health maintenance organization shall deposit the amount of the difference between its total uncovered health care expenses, based on its annual statement from the previous year, and the total amount previously deposited and not withdrawn from the state treasury. For any subsequent year in which the amount of the difference specified by this subsection is zero or less, the commissioner may not require the health maintenance organization to make any additional deposit under this subsection.

(e) If, on application made not more than once in each calendar year by a health maintenance organization, the commissioner determines that the amount previously deposited by the health maintenance organization has exceeded the amount required to be on deposit by more than \$50,000 for a continuous 12-month period, the commissioner shall allow the health maintenance organization to withdraw the portion of the deposit that exceeds by more than \$50,000 the amount required to be on deposit, unless the commissioner determines that the release of a portion of the deposit could be hazardous to enrollees, creditors, or the public.

(f) If, on application, the commissioner determines that the amount previously deposited by a health maintenance organization continues to exceed the amount required to be on deposit, the commissioner shall allow the health maintenance organization to withdraw the portion of the deposit that exceeds the amount required to be on deposit, unless the commissioner determines that the release of that portion of the deposit could be hazardous to enrollees, creditors, or the public.

(g) On application by a health maintenance organization operating for more than one year under a certificate of authority, the commissioner may waive some or all of the requirements imposed by Subsection (b), (c), or (d) for any period if the commissioner determines that the waiver is justified because:

- (1) the total amount of the deposit or other guarantee is

equal to at least 25 percent of the health maintenance organization's estimated uncovered expenses for the next calendar year;

(2) the health maintenance organization's net worth is equal to at least 25 percent of its estimated uncovered expenses for the next calendar year;

(3) the health maintenance organization has a net worth of at least \$5 million; or

(4) the health maintenance organization's sponsoring organization has a net worth of at least \$5 million for each health maintenance organization whose uncovered expenses the sponsoring organization guarantees.

(h) If one or more of the requirements imposed by Subsection (b), (c), or (d) is waived, any amount previously deposited shall remain on deposit until released in whole or in part by the comptroller on order of the commissioner under Subsection (g).

(i) A health maintenance organization that has made a deposit with the comptroller may, at its option, withdraw the deposit or any part of the deposit after substituting a deposit of cash or securities of equal amount and value to the withdrawn deposit or portion of deposit. The commissioner must first approve any securities being substituted.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.406. HAZARDOUS FINANCIAL CONDITION. (a) If the financial condition of a health maintenance organization indicates that the continued operation of the health maintenance organization could be hazardous to its enrollees or creditors or the public, the commissioner may, after notice and opportunity for hearing:

(1) suspend or revoke the health maintenance organization's certificate of authority; or

(2) order the health maintenance organization to take action reasonably necessary to correct the condition, including by:

(A) reducing by reinsurance the total amount of present and potential liability for benefits;

(B) reducing the volume of new business being accepted;

(C) reducing expenses by specified methods;

(D) suspending or limiting for a period the writing of new business; or

(E) increasing the health maintenance organization's capital and surplus by contribution.

(b) In a manner consistent with the purposes of this section, the commissioner by rule may establish:

(1) uniform standards and criteria for early warning that the continued operation of a health maintenance organization could be hazardous to the health maintenance organization's enrollees or creditors or the public; and

(2) standards for evaluating the financial condition of a health maintenance organization.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.407. RECEIVERSHIP AND DELINQUENCY PROCEEDINGS. (a) In addition to all other remedies available by law, if the commissioner believes that a health maintenance organization or another person is insolvent or does not maintain the net worth required under Sections 843.403, 843.4031, and 843.404, the commissioner may bring an action in a Travis County district court to be named receiver in accordance with Section 843.157 and Chapter 443.

(b) The court may:

(1) find that a receiver should take charge of the assets of the health maintenance organization; and

(2) name the commissioner as the receiver of the health maintenance organization in accordance with Section 843.157 and Chapter 443.

(c) The operations and business of a health maintenance organization represent the business of insurance for purposes of Section 843.157 and Chapters 441 and 443.

(d) Exclusive venue of receivership and delinquency proceedings for a health maintenance organization is in Travis County.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.051, eff. April 1, 2009.

Sec. 843.408. INSOLVENCY AND ALLOCATION TO OTHER HEALTH MAINTENANCE ORGANIZATIONS. (a) If a health maintenance organization

becomes insolvent, the commissioner shall equitably allocate the insolvent health maintenance organization's group contracts and nongroup enrollees among all health maintenance organizations that operate within a portion of the insolvent health maintenance organization's service area. The commissioner shall allocate the group contracts by order. In making allocations, the commissioner shall consider the resources of each health maintenance organization.

(b) A successor health maintenance organization to which one or more groups are allocated shall offer each group the successor health maintenance organization's coverage at rates determined in accordance with the successor health maintenance organization's existing methodology or in accordance with that methodology as adjusted by the commissioner.

(c) A successor health maintenance organization to which nongroup enrollees are allocated shall offer each nongroup enrollee the successor health maintenance organization's existing coverage for individual or conversion coverage, as determined by the nongroup enrollee's type of coverage from the insolvent health maintenance organization, at rates determined in accordance with the successor health maintenance organization's existing methodology or in accordance with that methodology as adjusted by the commissioner. A successor health maintenance organization that does not offer direct nongroup enrollment shall provide coverage at rates that reflect the average group rate of the successor health maintenance organization.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.409. EXAMINATION EXPENSES. (a) A credit against the amount of premium taxes to be paid by a health maintenance organization in a taxable year may not be allowed on:

(1) an examination fee or expense paid to another state;

or

(2) an examination expense:

(A) directly attributable to an examination of the books, records, accounts, or principal offices of a health maintenance organization located outside this state; or

(B) paid in a different taxable year.

(b) The limitations provided by Subsections (a)(1) and (a)(2)(B) apply to foreign health maintenance organizations.

Added by Acts 2003, 78th Leg., ch. 209, Sec. 9A, eff. Jan. 1, 2004;
Acts 2003, 78th Leg., ch. 1276, Sec. 10A.207, eff. Sept. 1, 2003.

Sec. 843.410. ASSESSMENTS. (a) To provide funds for the administrative expenses of the commissioner regarding rehabilitation, liquidation, supervision, conservatorship, or seizure of a health maintenance organization in this state that is placed under supervision or in conservatorship under Chapter 441 or against which a delinquency proceeding is commenced under Chapter 443 and that is found by the commissioner to have insufficient funds to pay the total amount of health care claims and the administrative expenses incurred by the commissioner regarding the rehabilitation, liquidation, supervision, conservatorship, or seizure, the commissioner shall assess each health maintenance organization in the proportion that the gross premiums of the health maintenance organization that were written in this state during the preceding calendar year bear to the aggregate gross premiums that were written in this state by all health maintenance organizations, as found after review of annual statements and other reports the commissioner considers necessary.

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

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

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

Transferred, redesignated and amended from Insurance Code, Section

843.441 by Acts 2011, 82nd Leg., R.S., Ch. 1147 (H.B. 1951), Sec. 2.002, eff. September 1, 2011.

SUBCHAPTER N. ENFORCEMENT

Sec. 843.461. ENFORCEMENT ACTIONS. (a) After notice and opportunity for a hearing, the commissioner may:

- (1) suspend or revoke a certificate of authority issued to a health maintenance organization under this chapter;
- (2) impose sanctions under Chapter 82;
- (3) issue a cease and desist order under Chapter 83; or
- (4) impose administrative penalties under Chapter 84.

(b) The commissioner may take an enforcement action listed in Subsection (a) against a health maintenance organization if the commissioner finds that the health maintenance organization:

- (1) is operating in a manner that is:
 - (A) significantly contrary to its basic organizational documents or health care plan; or
 - (B) contrary to the manner described in and reasonably inferred from other information submitted under Section 843.078, 843.079, or 843.080;
- (2) issues an evidence of coverage or uses a schedule of charges for health care services that does not comply with the requirements of Sections 843.346, 1271.001-1271.005, 1271.007, 1271.151, 1271.152, and 1271.156, and Subchapters B, C, E, F, and G, Chapter 1271;
- (3) does not meet the requirements of Section 843.082(1);
- (4) provides a health care plan that does not provide or arrange for basic health care services, provides a limited health care service plan that does not provide or arrange for the plan's limited health care services, or provides a single health care service plan that does not provide or arrange for a single health care service;
- (5) cannot fulfill its obligation to provide:
 - (A) health care services as required under its health care plan;
 - (B) limited health care services as required under its limited health care service plan; or
 - (C) a single health care service as required under its single health care service plan;

(6) is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees;

(7) has not implemented the complaint system required by Section 843.251 in a manner to resolve reasonably valid complaints;

(8) has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive, or unfair manner or a person on behalf of the health maintenance organization has advertised or merchandised the health maintenance organization's services in an untrue, misrepresentative, misleading, deceptive, or unfair manner;

(9) would be hazardous to its enrollees if it continued in operation;

(10) has not complied substantially with:

(A) this chapter or a rule adopted under this chapter; or

(B) Section 1367.053, Subchapter A, Chapter 1452, Subchapter B, Chapter 1507, Chapter 222, 251, or 258, as applicable to a health maintenance organization, or Chapter 1271 or 1272 or a rule adopted under one of those provisions; or

(11) has not taken corrective action the commissioner considers necessary to correct a failure to comply with this chapter, any applicable provision of this code, or any applicable rule or order of the commissioner not later than the 30th day after the date of notice of the failure or within any longer period specified in the notice and determined by the commissioner to be reasonable.

(c) The commissioner may suspend or revoke a certificate of authority only after complying with this section.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.052, eff. April 1, 2009.

Acts 2013, 83rd Leg., R.S., Ch. 161 (S.B. 1093), Sec. 11.001, eff. September 1, 2013.

Sec. 843.462. OPERATIONS DURING SUSPENSION OR AFTER REVOCATION OF CERTIFICATE OF AUTHORITY. (a) During the period a certificate of authority of a health maintenance organization is suspended, the

health maintenance organization may not:

(1) enroll additional enrollees except newborn children or other newly acquired dependents of existing enrollees; or

(2) advertise or solicit in any way.

(b) After a certificate of authority of a health maintenance organization is revoked, the health maintenance organization:

(1) shall proceed, immediately following the effective date of the order of revocation, to conclude its affairs;

(2) may not conduct further business except as essential to the orderly conclusion of its affairs; and

(3) may not advertise or solicit in any way.

(c) Notwithstanding Subsection (b), the commissioner may, by written order, permit the further operation of the health maintenance organization to the extent that the commissioner finds necessary to serve the best interest of enrollees and to provide enrollees with the greatest practical opportunity to obtain continuing health care coverage.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.463. INJUNCTIONS. If the commissioner believes that a health maintenance organization or another person is violating or has violated this chapter or a rule adopted under this chapter or Section 1367.053, Subchapter A, Chapter 1452, Subchapter B, Chapter 1507, Chapter 222, 251, or 258, as applicable to a health maintenance organization, or Chapter 1271 or 1272 or a rule adopted under one of those provisions, the commissioner may bring an action in a Travis County district court to enjoin the violation and obtain other relief the court considers appropriate.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.053, eff. April 1, 2009.

Sec. 843.464. CRIMINAL PENALTY. (a) A person, including an agent or officer of a health maintenance organization, commits an offense if the person:

(1) wilfully violates this chapter or a rule adopted under

this chapter or Section 1367.053, Subchapter A, Chapter 1452, Subchapter B, Chapter 1507, Chapter 222, 251, or 258, as applicable to a health maintenance organization, or Chapter 1271 or 1272 or a rule adopted under one of those provisions; or

(2) knowingly makes a false statement with respect to a report or statement required under this chapter or Section 1367.053, Subchapter A, Chapter 1452, Subchapter B, Chapter 1507, Chapter 222, 251, or 258, as applicable to a health maintenance organization, or Chapter 1271 or 1272.

(b) An offense under this section is a Class B misdemeanor.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.054, eff. April 1, 2009.

CHAPTER 844. CERTIFICATION OF CERTAIN NONPROFIT HEALTH CORPORATIONS
SUBCHAPTER A. GENERAL PROVISIONS

Sec. 844.001. DEFINITIONS. In this chapter:

(1) "Approved nonprofit health corporation" means a nonprofit health corporation certified under Section 162.001, Occupations Code.

(2) "Certificate holder" means an approved nonprofit health corporation that holds a certificate of authority issued under this chapter.

(3) "Health care plan" has the meaning assigned by Section 843.002.

(4) "Health maintenance organization" means a health maintenance organization licensed under Chapter 843.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 844.002. EXCEPTIONS. This chapter does not apply to:

(1) an approved nonprofit health corporation that contracts to arrange for or provide health care services on a fee-for-service basis;

(2) a contract entered into by a certificate holder to arrange for or provide health care services on a fee-for-service basis; or

(3) an activity exempt from regulation under Section 843.053 or 843.073.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 844.003. EXCEPTIONS TO TEXAS HEALTH MAINTENANCE ORGANIZATION ACT. This chapter may not be construed to alter the exceptions stated in Sections 843.053 and 843.073.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 844.004. RULES. Except as provided by Section 844.101(b), the commissioner shall adopt rules to implement this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 844.005. PROVISION OF CERTAIN SERVICES ON BEHALF OF HEALTH MAINTENANCE ORGANIZATIONS. (a) An approved nonprofit health corporation may arrange for or provide health care services on a risk-sharing or capitated risk arrangement on behalf of a health maintenance organization.

(b) An approved nonprofit health corporation is not required to obtain a certificate of authority under this chapter or under Chapter 843 to arrange for or provide health care services as provided by Subsection (a).

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER B. AUTHORITY TO ENGAGE IN BUSINESS

Sec. 844.051. CERTIFICATE OF AUTHORITY REQUIRED. An approved nonprofit health corporation may not arrange for or provide a health care plan to enrollees on a prepaid basis unless the corporation holds a certificate of authority issued under this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 844.052. CERTIFICATE APPLICATION; ELIGIBILITY REQUIREMENTS. (a) An approved nonprofit health corporation may apply to the department for a certificate of authority under this chapter.

(b) The commissioner may issue a certificate of authority only to an applicant that:

(1) meets the same requirements for the issuance of a certificate of authority that a health maintenance organization is required to meet under Chapter 843; and

(2) establishes accreditation by:

(A) the National Committee on Quality Assurance;

(B) the Joint Commission on Accreditation of Healthcare Organization's accreditation for health care networks; or

(C) an accrediting organization recognized by rule of the commissioner.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 844.053. PROVISIONAL CERTIFICATE OF AUTHORITY. The commissioner shall grant a provisional certificate of authority to an applicant if:

(1) the applicant has applied for accreditation from an accrediting organization described by Section 844.052(b)(2);

(2) the applicant is diligently pursuing accreditation;

(3) the accrediting organization has not denied the application for accreditation; and

(4) the applicant satisfies each other requirement of this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 844.054. POWERS AND DUTIES OF CERTIFICATE HOLDER. (a) A certificate holder has all the powers granted to and duties imposed on a health maintenance organization under the insurance laws of this state, including Chapter 843, and is subject to regulation and regulatory enforcement under those laws in the same manner as a health maintenance organization.

(b) A certificate holder shall maintain accreditation as described by Section 844.052(b)(2).

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER C. PROHIBITED CONDUCT

Sec. 844.101. UNFAIR COMPETITION. (a) A certificate holder may not engage in unfair and disruptive provider hiring or contracting practices for the purpose of limiting competition from traditional community providers.

(b) The Texas State Board of Medical Examiners shall adopt rules to implement this section.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

CHAPTER 845. STATEWIDE RURAL HEALTH CARE SYSTEM

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 845.001. SHORT TITLE. This chapter may be cited as the Statewide Rural Health Care System Act.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 845.002. DEFINITIONS. In this chapter:

(1) "Board" means the board of directors of the system.

(2) "Enrollee" means an individual who:

(A) resides in a rural area; and

(B) is entitled to receive health care services through a health care plan sponsored by, arranged for, or provided by the system.

(3) "Health care services" has the meaning assigned by Section 843.002.

(4) "Health care provider" means a physician, facility, practitioner, or other person or organization who, under a license or grant of authority issued by this state, provides care or supplies to individuals under a health benefit plan. The term does not include a hospital provider.

(5) "Hospital provider" means a county hospital, county hospital authority, hospital district, municipal hospital, or municipal hospital authority.

(6) "Local health care provider" means:

(A) a person licensed, registered, or certified as a

health care practitioner in this state who resides or practices in a rural area in which the person provides health care services; or

(B) a general or specialty hospital that is not a hospital provider under this chapter.

(7) "Participating hospital provider" means a hospital provider that participates in the system.

(8) "Person" means an individual, professional association, professional corporation, partnership, limited liability corporation, limited liability partnership, or nonprofit corporation, including a nonprofit corporation certified under Section 162.001, Occupations Code.

(9) "Rural area" means:

(A) a county with a population of 50,000 or less;

(B) an area that is not delineated as an urbanized area by the United States Bureau of the Census; or

(C) any other area designated as rural by a rule adopted by the commissioner, subject to Section 845.003.

(10) "System" means the statewide rural health care system established under this chapter.

(11) "Territorial jurisdiction" means the geographical area in which a participating hospital provider is obligated by law to provide health care services.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.213(a), eff. Sept. 1, 2003.

Sec. 845.003. RURAL AREA DESIGNATION. In determining whether to designate an area as a rural area under this chapter, the commissioner shall consider any area that is delineated as an urbanized area by the United States Bureau of the Census and:

(1) is contiguous with and not more than 10 miles away from a rural area described by Section 845.002(9)(A) or (B);

(2) is sparsely populated, compared to areas within a 10-mile radius that are delineated as urbanized areas by the United States Bureau of the Census;

(3) has not increased in population in any single calendar year in the seven years before the commissioner makes the designation; and

(4) in which emergency or primary care services:

(A) are limited or unavailable in accordance with network access standards imposed by the commissioner; and

(B) would be made materially more accessible by allowing access to care in a contiguous area that is otherwise eligible to participate in the system.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.213(b), eff. Sept. 1, 2003.

Sec. 845.004. RULES. The commissioner shall adopt rules as necessary to implement this subchapter and Subchapters B, C, and D.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.218(b), eff. Sept. 1, 2003.

SUBCHAPTER B. SYSTEM

Sec. 845.051. STATEWIDE RURAL HEALTH CARE SYSTEM. The commissioner shall designate a single organization as the statewide rural health care system. The system is authorized to sponsor, arrange for the provision of, or provide health care services to enrollees in programs in rural areas. The programs are not subject to:

(1) a law requiring the coverage or the offer of coverage for services by a particular health care provider under:

(A) Chapter 62, Health and Safety Code;

(B) Chapter 32, Human Resources Code;

(C) a state-, county-, or local government-sponsored indigent care initiative; or

(D) a federal Medicare Plus Choice program; or

(2) Subchapters A-I, Chapter 1251, Subchapter A, Chapter 1364, Subchapter A, Chapter 1366, or Section 1551.064 under a state-, county-, or local government-sponsored uninsured or indigent care initiative.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.214(a), eff.

Sept. 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.055, eff. April 1, 2009.

Sec. 845.052. ORGANIZATION REQUIREMENTS. The system must:

(1) be a corporation organized under the Texas Non-Profit Corporation Act (Article 1396-1.01 et seq., Vernon's Texas Civil Statutes); and

(2) consist of a combination of two or more hospital providers, each of which:

(A) is a member of the corporation; and

(B) is located in a rural area.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 845.053. REQUIREMENTS APPLICABLE TO CERTAIN PLANS. (a) Except as provided by Subsection (b), if the system seeks to sponsor, arrange for the provision of, or provide health care services to enrollees in exchange for a predetermined payment per enrollee on a prepaid basis, the system must comply with:

(1) all requirements under this code imposed on health plans, including health maintenance organizations; and

(2) any additional requirements the commissioner determines are necessary to ensure enrollee access to health care providers and health care services.

(b) The system is not required to comply with requirements described by Subdivision (a)(1) that relate to mileage, distance, network adequacy, and scope of coverage that the commissioner determines are not applicable to the system.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.214(a), eff. Sept. 1, 2003.

Sec. 845.054. LOCAL GOVERNMENT. (a) The system is:

(1) a unit of local government that is a governmental unit for purposes of Chapter 101, Civil Practice and Remedies Code; and

(2) a local government for purposes of Chapter 102, Civil Practice and Remedies Code.

(b) The system may enter into interlocal cooperation contracts under Chapter 791, Government Code, and is a local government for purposes of that chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 845.055. PROVISION OF ADMINISTRATIVE AND HEALTH CARE SERVICES. (a) The system shall contract with or otherwise arrange for local health care provider networks composed of not more than 19 counties to deliver health care services to enrollees residing in the rural areas of the territorial jurisdiction of the participating hospital providers.

(b) If the local health care provider networks under contract or arrangement with the system as provided by Subsection (a) are unable to provide the type and quality of health care services required by the enrollees, the system may contract with health care practitioners who are not local health care providers.

(c) The system may:

(1) enter into a contract or joint venture to provide administrative services under this chapter;

(2) enter into an intergovernmental or interlocal agreement; or

(3) provide technical assistance and management services to local health care providers as necessary to deliver health care services.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 845.056. GIFTS AND GRANTS. The system may accept gifts or grants of money or property to provide programs and services.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 845.057. LIMITATION ON AUTHORITY OF PARTICIPATING HOSPITAL PROVIDERS. The participating hospital providers may exercise only the authority provided by Sections 845.058, 845.101, and 845.103.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 845.058. SALE OR DISSOLUTION OF SYSTEM. (a) The participating hospital providers may authorize, by a two-thirds vote, the sale of the system or substantially all of the assets of the system.

(b) Except as otherwise provided by law, on the sale or dissolution of the system or the sale of substantially all of the assets of the system, the net revenue shall be distributed equally to the participating hospital providers after payment of any outstanding liabilities incurred by the system.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER C. BOARD OF DIRECTORS

Sec. 845.101. APPOINTMENT OF BOARD. (a) The system is governed by a board of directors that consists of 17 members. Notwithstanding the Texas Non-Profit Corporation Act (Article 1396-1.01 et seq., Vernon's Texas Civil Statutes), appointments to the board shall be made as provided by this section.

(b) The participating hospital providers shall elect, by a majority vote of the governing bodies of the participating hospital providers, five members who represent the participating hospital providers.

(c) Twelve members shall be appointed according to the system's bylaws, including:

(1) six members who reside in the territorial jurisdictions of the participating hospital providers, including:

(A) two members who represent employers;

(B) two members who represent local government officials; and

(C) two members who represent consumers of health care services; and

(2) six members who are licensed physicians who reside and practice in the territorial jurisdictions of the participating hospital providers, including at least three members who perform the general practice of medicine as their professional practice.

(d) Appointments to the board under Subsection (c) shall be

made in a manner that provides representation for the territorial jurisdictions of all participating hospital providers.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1170, Sec. 41.01, eff. Sept. 1, 2003; Acts 2003, 78th Leg., ch. 1276, Sec. 10A.215(a), eff. Sept. 1, 2003.

Sec. 845.102. TERMS; VACANCY. (a) Members of the board serve staggered six-year terms. The terms of five or six members expire December 1 of each even-numbered year.

(b) A person may not be appointed to serve consecutive terms.

(c) A person may be appointed to serve a nonconsecutive term if the person left the board at the expiration of the person's previous term.

(d) If a vacancy occurs during a member's term, the same entity that appointed the member shall appoint a replacement to fill the unexpired term.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1170, Sec. 41.02, eff. Sept. 1, 2003.

Sec. 845.103. REMOVAL OF CERTAIN BOARD MEMBERS. The participating hospital providers may remove, by a two-thirds vote, any member of the board elected by the participating hospital providers under Section 845.101(b).

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 845.104. BOARD DUTIES. The board shall:

(1) administer the system;

(2) adopt policies and procedures for the system that are consistent with the purposes of this subchapter and Subchapters A, B, and D; and

(3) adopt rules for the holding of regular and special meetings.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.218(b), eff.
Sept. 1, 2003.

Sec. 845.105. RULES RELATING TO ADMINISTRATIVE AND HEALTH CARE SERVICES. The board may adopt rules to regulate the provision of administrative services and health care services by the system.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 845.106. OFFICERS. The board may elect officers as it considers appropriate.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 845.107. EXECUTIVE COMMITTEE. (a) The board may appoint an executive committee as determined by the board to be useful in conducting the business of the board.

(b) The board may delegate to the executive committee any responsibility considered reasonable by the board.

(c) An executive committee appointed under this section must consist of:

(1) two members who represent the participating hospital providers;

(2) two members who are community representatives, including employers, local government officials, or consumers of health care services; and

(3) two members who meet the requirements of Section 845.101(c)(2).

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 845.108. ADMINISTRATIVE SERVICES; PERSONNEL. (a) The board may, by majority vote:

(1) contract for administrative, management, or support services;

(2) hire an executive director;

(3) contract with a consultant, an attorney, or other professional; or

(4) retain other staff as necessary to perform the duties of the system.

(b) If the board hires an executive director for the system, the board shall delegate to the executive director the authority to hire staff for the system and may delegate to the executive director other duties determined by the board to be appropriate.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.216(a), eff. Sept. 1, 2003.

Sec. 845.109. ADVISORY COMMITTEES. (a) The board may appoint a health care services advisory committee. The advisory committee must include members who represent rural, urban, and educational groups and organizations. The advisory committee, as directed by the board, shall meet and advise the board on any matter.

(b) The board may appoint other advisory committees as determined by the board to be appropriate.

(c) A member of an advisory committee appointed under this section is not entitled to compensation for service on the committee.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 845.110. OPEN MEETINGS AND RECORDS REQUIREMENTS. (a) Meetings of the board are open to the public in accordance with Chapter 551, Government Code. This subsection does not require the board to conduct an open meeting to deliberate:

(1) pricing or financial planning information relating to a bid or negotiation for arranging or providing services or product lines to another person if disclosure of the information would give the advantage to competitors;

(2) information relating to a proposed new service, product line, or marketing strategy;

(3) patient information made confidential under Chapter 159, Occupations Code, or Subchapter G, Chapter 241, Health and Safety Code; or

(4) information that relates to the credentialing of

physicians or to peer review and that is made confidential under Subchapter A, Chapter 160, Occupations Code, or Subchapter G, Chapter 241, Health and Safety Code.

(b) The board shall keep a record of its proceedings in accordance with Chapter 551, Government Code.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER D. STATE MANAGED CARE CONTRACTS

Sec. 845.151. CONTRACT AWARD. To the extent consistent with federal law, the state shall award to the system at least one of the state managed care contracts that are awarded to provide health care services to beneficiaries of the medical assistance program under Chapter 32, Human Resources Code, in the rural areas of the territorial jurisdiction of the participating hospital providers.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 845.152. PARTICIPATION REQUIREMENT. As a requirement of participation in a state contract awarded under Section 845.151, the system must satisfactorily address the qualifications for arranging to provide health care services to beneficiaries of certain governmental health care programs as delineated in the contractor's request for proposal, including:

(1) readiness reviews and adequacy of credentialing, medical management, quality assurance, claims payment, information management, provider and patient education, and complaint and grievance procedures; and

(2) adequacy of physician and provider networks, including factors such as diversity, geographic accessibility, inclusion of physicians and other providers that have furnished a significant amount of Medicaid or charity care to beneficiaries, and tertiary and subspecialty services.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 845.153. REIMBURSEMENT AT STATE-DEFINED CAPITATION RATE.

(a) To the extent the system operates under a certificate of

authority issued under Chapter 843, the Medicaid contracting agency shall reimburse the system at the state-defined capitation rate for each service area in which the system operates.

(b) The system is not required as a condition of participation in a state contract awarded under Section 845.151 to accept from the Medicaid contracting agency a capitation rate that is lower than the state-defined capitation rate for each service area in which the system operates.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 845.154. RIGHT OF STATE TO CANCEL CONTRACT ON SALE OR DISSOLUTION. The state may cancel a contract awarded under this subchapter if the system is sold or dissolved.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 845.155. USE OF SYSTEM AS PILOT PROGRAM, DEMONSTRATION PROJECT, OR STUDY. The commissioner of health and human services may use the system for:

- (1) a voluntary pilot or demonstration program that:
 - (A) evaluates the use of an insured model for beneficiaries of a medical assistance program in a rural area not currently included in an existing Medicaid managed care pilot program area; and
 - (B) incorporates the principles of prevention and disease management; and
- (2) a study of the use of promotoras as defined by Section 48.001, Health and Safety Code.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.217(a), eff. Sept. 1, 2003.

SUBCHAPTER E. GOALS OF SYSTEM

Sec. 845.201. RURAL HEALTH CARE DELIVERY SYSTEM. (a) The system is designed to protect and enhance the rural health care delivery system by:

- (1) establishing a statewide rural health care network;

(2) supporting funding to rural communities;
 (3) enabling administrative simplification for the benefit of rural providers that participate in various health care plans;
 and

(4) ensuring the inclusion of consumer-oriented attributes considered important to a successful health care organization.

(b) The attributes described by Subsection (a)(4) include:

- (1) consideration of patient rights;
- (2) preservation of patient rights;
- (3) preservation of the provider-patient relationship;
- (4) emphasis on prevention and wellness;
- (5) an appropriate credentialing and peer review program;

and

- (6) emphasis on quality improvement and disease management.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.218(a), eff. Sept. 1, 2003.

Sec. 845.202. PATIENT RIGHTS POLICIES. It is intended that the system incorporate patient-focused considerations that include:

- (1) open communication;
- (2) informed consent;
- (3) protection of confidentiality and privacy;
- (4) full disclosure of program policies and procedures to patients and providers;
- (5) coverage of emergency care;
- (6) disclosure of compensation arrangements with providers;

and

- (7) efficient appeal of coverage decisions.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.218(a), eff. Sept. 1, 2003.

Sec. 845.203. PATIENT-PHYSICIAN RELATIONSHIP. It is intended that the system preserve significant traditional and ethical relationships between a patient and the patient's health care provider by ensuring that:

- (1) medical management does not intrude on the delivery of quality patient care;

- (2) the process of making health care decisions remains a matter between a patient and the patient's health care provider; and
- (3) nothing in the system will place a health care provider in an adverse relationship with a patient.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.218(a), eff. Sept. 1, 2003.

Sec. 845.204. PUBLIC HEALTH AND PREVENTION. It is intended that the system use incentives to promote healthy communities and individuals by using a public health model that focuses on health promotion, illness prevention, patient self-care education, and incentives that encourage positive health behavior.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.218(a), eff. Sept. 1, 2003.

Sec. 845.205. CREDENTIALS AND PEER REVIEW. To ensure that enrollees will receive quality health care, it is intended that the system focus on processes for obtaining credentials and performing peer review that take into consideration the unique nature of rural communities and that track processes required under federal and state law. It is intended that local physicians and hospitals retain responsibility for these processes. These processes are not intended to exclude otherwise qualified practitioners from participating in the system.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.218(a), eff. Sept. 1, 2003.

Sec. 845.206. QUALITY IMPROVEMENT AND MANAGEMENT. It is intended that the system use standard guidelines established by the National Committee on Quality Assurance and other recognized accrediting organizations to:

- (1) ensure that the program achieves the objectives of providing quality patient care; and
- (2) emphasize establishing benchmarks to measure program outcomes that will be made available to the public through proper

reporting procedures.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.218(a), eff. Sept. 1, 2003.

CHAPTER 846. MULTIPLE EMPLOYER WELFARE ARRANGEMENTS
SUBCHAPTER A. GENERAL PROVISIONS

Sec. 846.001. DEFINITIONS. In this chapter:

(1) "Board" means the board of trustees or directors, as applicable, of a multiple employer welfare arrangement.

(2) "Employee welfare benefit plan" has the meaning assigned by Section 3(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1002(1)).

(3) "Health benefit plan" includes any plan that provides benefits for health care services. The term does not include:

(A) accident-only or disability income insurance coverage, or a combination of accident-only and disability income insurance coverage;

(B) credit-only insurance coverage;

(C) disability insurance;

(D) coverage for a specified disease or illness;

(E) Medicare services under a federal contract;

(F) Medicare supplement and Medicare Select policies regulated in accordance with federal law;

(G) long-term care coverage or benefits, nursing home care coverage or benefits, home health care coverage or benefits, community-based care coverage or benefits, or any combination of those coverages or benefits;

(H) coverage that provides limited-scope dental or vision benefits;

(I) coverage provided by a single service health maintenance organization;

(J) workers' compensation insurance coverage or similar insurance coverage;

(K) coverage provided through a jointly managed trust authorized under 29 U.S.C. Section 141 et seq. that contains a plan of benefits for employees that is negotiated in a collective bargaining agreement governing wages, hours, and working conditions of the employees that is authorized under 29 U. S.C. Section 157;

(L) hospital indemnity or other fixed indemnity insurance coverage;

(M) reinsurance contracts issued on a stop-loss, quota-share, or similar basis;

(N) short-term major medical contracts;

(O) liability insurance coverage, including general liability insurance coverage and automobile liability insurance coverage;

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

(Q) automobile medical payment insurance coverage;

(R) coverage for on-site medical clinics;

(S) coverage that provides other limited benefits specified by federal regulations; or

(T) other coverage that is:

(i) similar to the coverage described by this subdivision under which benefits for medical care are secondary or incidental to other coverage benefits; and

(ii) specified in federal regulations.

(4) "Health status related factor" means:

(A) health status;

(B) medical condition, including both physical and mental illness;

(C) claims experience;

(D) receipt of health care;

(E) medical history;

(F) genetic information;

(G) evidence of insurability, including conditions arising out of acts of family violence; and

(H) disability.

(5) "Multiple employer welfare arrangement" has the meaning assigned by Section 3(40) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1002(40)).

(6) "Organizational document" means the articles, bylaws, agreements, trusts, or other documents or instruments describing the rights and obligations of employers, employees, and beneficiaries with respect to a multiple employer welfare arrangement.

(7) "Participation criteria" means any criteria or rules established by an employer to determine the employees who are eligible for enrollment or continued enrollment under the terms of a

health benefit plan.

(8) "Preexisting condition provision" means a provision that excludes or limits coverage for a disease or condition for a specified period after the effective date of coverage.

(9) "Waiting period" means a period established by a multiple employer welfare arrangement that must elapse before an individual who is a potential participating employee in a health benefit plan is eligible to be covered for benefits.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 846.002. APPLICABILITY OF CHAPTER. (a) In this section, "fully insured multiple employer welfare arrangement" means an arrangement that provides to its participating employees and beneficiaries benefits for which 100 percent of the liability has been assumed by an insurance company authorized to do business in this state.

(b) This chapter applies only to a multiple employer welfare arrangement that meets either or both of the following criteria:

(1) one or more of the employer members in the arrangement:

(A) is domiciled in this state; or

(B) has its principal headquarters or principal administrative office in this state; or

(2) the arrangement solicits an employer that:

(A) is domiciled in this state; or

(B) has its principal headquarters or principal administrative office in this state.

(c) This chapter does not apply to a fully insured multiple employer welfare arrangement during the period in which the arrangement is fully insured. The commissioner periodically may require proof that the arrangement is fully insured.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 846.003. LIMITED EXEMPTION FROM INSURANCE LAWS; APPLICABILITY OF CERTAIN LAWS. (a) A multiple employer welfare arrangement is exempt from the operation of all insurance laws of this state, except laws that are made applicable by their specific terms or as specified in this section or chapter.

(b) A multiple employer welfare arrangement is subject to the following laws:

- (1) Subchapters C and D, Chapter 36;
- (2) Section 38.001;
- (3) Section 81.002;
- (4) Chapter 82;
- (5) Chapter 83;
- (6) Chapter 86;
- (7) Section 201.003;
- (8) Sections 401.051, 401.052, 401.054-401.062, 401.151, 401.152, 401.155, and 401.156;
- (9) Chapter 441;
- (10) Chapter 443;
- (11) Chapter 461;
- (12) Section 521.005;
- (13) Chapter 541;
- (14) Chapter 701;
- (15) Chapter 801;
- (16) Chapter 803;
- (17) Chapter 804;
- (18) Subchapter A, Chapter 805; and
- (19) Sections 841.259, 841.701-841.702, and 841.704-841.705.

(c) A multiple employer welfare arrangement is only considered an insurer for purposes of the laws described by this section.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 2E.056, eff. April 1, 2009.

Sec. 846.0035. APPLICABILITY OF CERTAIN LAWS TO ASSOCIATION PROVIDING HEALTH BENEFITS. (a) This section applies only to a multiple employer welfare arrangement:

- (1) that was issued an initial certificate of authority under Section 846.054 on or after January 1, 2024; or
- (2) that elects to be bound by this section in the manner prescribed by the commissioner.

(b) A multiple employer welfare arrangement that provides a

comprehensive health benefit plan, as determined by the commissioner, is subject to the following laws as if the arrangement were an insurer, individuals entitled to coverage under the plan were insureds, and the health benefits were provided through an insurance policy:

- (1) Chapter 421;
- (2) Chapter 422;
- (3) Subchapters C, F, and K, Chapter 1451; and
- (4) Chapter 4201.

(c) A multiple employer welfare arrangement that provides a comprehensive health benefit plan, as determined by the commissioner, that is determined by the commissioner to be structured in the manner of a preferred provider benefit plan or an exclusive provider benefit plan as defined in Section 1301.001 is subject to the following laws as if the arrangement were an insurer, individuals entitled to coverage under the plan were insureds, and the health benefits were provided through an insurance policy:

- (1) Chapter 1301; and
- (2) Chapter 1467.

Added by Acts 2023, 88th Leg., R.S., Ch. 117 (H.B. [290](#)), Sec. 1, eff. September 1, 2023.

Sec. 846.004. LATE-PARTICIPATING EMPLOYEE OR DEPENDENT. (a) For purposes of this chapter, an employee or dependent eligible for enrollment in a participating employer's health benefit plan is a late-participating employee or dependent if the individual requests enrollment after the expiration of:

- (1) the initial enrollment period established under the terms of the first health benefit plan for which that employee or dependent was eligible through the participating employer; or
- (2) an open enrollment period under Section 846.257.

(b) An employee or dependent is not a late-participating employee or dependent if the individual:

- (1) was covered under another health benefit plan or self-funded employer health benefit plan at the time the individual was eligible to enroll;
- (2) declined enrollment in writing, at the time of the initial eligibility for enrollment, stating that coverage under

another health benefit plan or self-funded employer health benefit plan was the reason for declining enrollment;

(3) has lost coverage under the other health benefit plan or self-funded employer health benefit plan as a result of:

(A) the termination of employment;

(B) a reduction in the number of hours of employment;

(C) the termination of the other plan's coverage;

(D) the termination of contributions toward the premium made by the employer; or

(E) the death of a spouse or divorce; and

(4) requests enrollment not later than the 31st day after the date coverage under the other health benefit plan or self-funded employer health benefit plan terminates.

(c) An employee or dependent is also not a late-participating employee or dependent if the individual is:

(1) employed by an employer that offers multiple health benefit plans and the individual elects a different health benefit plan during an open enrollment period under Section 846.257;

(2) a spouse for whom a court has ordered coverage under a covered employee's plan and the request for enrollment of the spouse is made not later than the 31st day after the date the court order is issued; or

(3) a child for whom a court has ordered coverage under a covered employee's plan and the request for enrollment is made not later than the 31st day after the date the employer receives the court order.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 846.005. RULES; ORDERS. (a) The commissioner may, on notice and opportunity for all interested persons to be heard, adopt rules and issue orders reasonably necessary to augment and implement this chapter.

(b) The commissioner shall adopt rules necessary to meet the minimum requirements of federal law and regulations.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 846.006. APPEAL OF ORDERS. A person affected by an order

of the commissioner issued under this chapter may appeal that order by filing suit in a district court in Travis County under Subchapter D, Chapter 36.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 846.007. PREMIUM RATES; ADJUSTMENTS. (a) A multiple employer welfare arrangement may charge premiums in accordance with this section to the group of employees or dependents who meet the participation criteria and who do not decline coverage.

(b) A multiple employer welfare arrangement may not charge an adjustment to premium rates for individual employees or dependents for health status related factors or duration of coverage. Any adjustment must be applied uniformly to the rates charged for all participating employees and dependents of participating employees of the employer.

(c) Subsection (b) does not restrict the amount that an employer may be charged for coverage.

(d) A multiple employer welfare arrangement may establish premium discounts, rebates, or a reduction in otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention. A discount, rebate, or reduction established under this subsection does not violate Section 541.056(a).

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 2E.057, eff. April 1, 2009.

SUBCHAPTER B. FORMATION AND STRUCTURE OF MULTIPLE EMPLOYER WELFARE ARRANGEMENTS

Sec. 846.051. CERTIFICATE OF AUTHORITY REQUIRED. A person may not establish or maintain an employee welfare benefit plan that is a multiple employer welfare arrangement in this state unless the arrangement obtains and maintains a certificate of authority issued under this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 846.052. APPLICATION FOR INITIAL CERTIFICATE OF AUTHORITY.

(a) A person who wants to establish an employee welfare benefit plan that is a multiple employer welfare arrangement must apply for an initial certificate of authority on an application form prescribed by the commissioner.

(b) The application form must be completed and submitted along with all information required by the commissioner, including:

- (1) a copy of each organizational document;
- (2) current financial statements of the arrangement;
- (3) a fully detailed statement indicating the plan under which the arrangement proposes to transact business;
- (4) an initial actuarial opinion in compliance with the requirements of Section 846.153(a)(2) and subject to Section 846.157(b); and

(5) demonstration by the applicant that the arrangement is in compliance with all applicable federal and state laws, as determined by the commissioner.

(c) The application must be accompanied by proof of a fidelity bond that:

- (1) protects against acts of fraud or dishonesty in servicing the multiple employer welfare arrangement;
- (2) covers each person responsible for servicing the employee welfare benefit plan; and
- (3) is in an amount equal to the greater of 10 percent of the premiums and contributions received by the arrangement or 10 percent of the benefits paid, during the preceding calendar year, with a minimum of \$10,000 and a maximum of \$500,000.

(d) A third-party administrator licensed to engage in business in this state is not required to submit a fidelity bond under Subsection (c).

(e) The commissioner shall promptly examine the application and documents submitted by the applicant and may:

- (1) conduct any investigation that the commissioner considers necessary; and
- (2) examine under oath any person interested in or connected with the multiple employer welfare arrangement.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 117 (H.B. 290), Sec. 2, eff. September 1, 2023.

Sec. 846.053. ELIGIBILITY REQUIREMENTS FOR INITIAL CERTIFICATE OF AUTHORITY. (a) An applicant for an initial certificate of authority as a multiple employer welfare arrangement must meet the requirements of this section.

(b) The employers in the multiple employer welfare arrangement must:

(1) be members of an association or group of five or more businesses that are in the same trade or industry, including closely related businesses that provide support, services, or supplies primarily to that trade or industry; or

(2) for a multiple employer welfare arrangement to which Section 846.0035 applies, each have a principal place of business in the same region that does not exceed the boundaries of this state or the boundaries of a metropolitan statistical area designated by the United States Office of Management and Budget.

(c) If the employers in the multiple employer welfare arrangement are members of an association, the association must:

(1) be engaged in substantial activity for its members other than sponsorship of an employee welfare benefit plan; and

(2) if Section 846.0035 does not apply to the multiple employer welfare arrangement, have been in existence for at least two years before engaging in any activities relating to providing employee health benefits to its members.

(d) The employee welfare plan of the association or group in the multiple employer welfare arrangement must be controlled and sponsored directly by participating employers, participating employees, or both.

(d-1) For purposes of a multiple employer welfare arrangement to which Section 846.0035 applies, a working owner of a trade or business without employees may qualify as both an employer and as an employee of the trade or industry for the purposes of this section. In this subsection, "working owner" means an individual who:

(1) has an ownership right of any nature in a trade or business, whether incorporated or unincorporated, including a partner and other self-employed individual;

(2) earns wages or self-employment income from the trade or business for providing personal services to the trade or business; and

(3) either:

(A) works on average at least 20 hours per week or at least 80 hours per month providing personal services to the working owner's trade or business; or

(B) has wages or self-employment income from the individual's trade or business that at least equals the individual's cost of coverage for participation by the individual and any covered beneficiaries in the group health plan sponsored by the group or association in which the individual is participating.

(e) The association or group of employers in the multiple employer welfare arrangement must be a not-for-profit organization.

(f) The multiple employer welfare arrangement must:

(1) have within its own organization adequate facilities and competent personnel, as determined by the commissioner, to administer the employee benefit plan; or

(2) have contracted with a third-party administrator licensed to engage in business in this state.

(g) The multiple employer welfare arrangement:

(1) must have applications from not fewer than five employers and must provide similar benefits for not fewer than 200 separate participating employees; and

(2) will have annual gross premiums of or contributions to the plan of not less than:

(A) \$20,000 for a plan that provides only vision benefits;

(B) \$75,000 for a plan that provides only dental benefits; and

(C) \$200,000 for all other plans.

(h) The multiple employer welfare arrangement must possess a written commitment, binder, or policy for stop-loss insurance issued by an insurer authorized to do business in this state that provides:

(1) at least 30 days' notice to the commissioner of any cancellation or nonrenewal of coverage; and

(2) both specific and aggregate coverage with an aggregate retention of not more than 125 percent of the amount of expected claims for the next plan year and a specific retention amount annually determined by the actuarial opinion required by Section

846.153(a)(2).

(i) Both the specific and aggregate coverage required by Subsection (h)(2) must require all claims to be submitted within 90 days after the claim is incurred and provide a 12-month claims incurred period and a 15-month paid claims period for each policy year.

(j) The contributions must be established to fund at least 100 percent of the aggregate retention plus all other costs of the multiple employer welfare arrangements.

(k) The multiple employer welfare arrangement must establish a procedure for handling claims for benefits on dissolution of the arrangement.

(l) The multiple employer welfare arrangement must obtain the required bond.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by:

Acts 2023, 88th Leg., R.S., Ch. 117 (H.B. 290), Sec. 3, eff. September 1, 2023.

Sec. 846.054. ISSUANCE OF INITIAL CERTIFICATE OF AUTHORITY.

(a) The commissioner shall approve, deny, or disapprove an application for an initial certificate of authority that meets the requirements of Section 846.053 not later than the 60th day after the date on which the application is filed.

(a-1) On the applicant's request, the commissioner shall hold a hearing on a denial. Not later than the 30th day after the date of the applicant's request for a hearing, the commissioner shall request a hearing date.

(b) An initial certificate of authority is a temporary certificate issued for a one-year term.

(c) On receipt of the initial certificate of authority, the multiple employer welfare arrangement shall begin business.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1022 (H.B. 4291), Sec. 11, eff. June 19, 2009.

Sec. 846.055. EXTENSION OF TERM OF INITIAL CERTIFICATE OF AUTHORITY. The commissioner may extend the term of an initial certificate of authority for a period not to exceed one year if the commissioner determines that the multiple employer welfare arrangement is likely to meet the requirements of this chapter for a final certificate of authority within that period. The commissioner may not grant more than one extension of the initial certificate of authority regardless of the length of time for which an extension was granted.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 846.056. FINAL CERTIFICATE OF AUTHORITY. (a) A multiple employer welfare arrangement that holds an initial certificate of authority must apply for a final certificate of authority not later than the first anniversary of the date of issuance of the initial certificate.

(b) The multiple employer welfare arrangement must file an application for a final certificate of authority on a form prescribed by the commissioner and furnish the information required by the commissioner. The application for a final certificate of authority must include only:

- (1) the names and addresses of:
 - (A) the association or group of employers sponsoring the arrangement;
 - (B) the board members of the arrangement; and
 - (C) if the employers in the arrangement are not an association, at least five employers;
- (2) proof of compliance with the bonding requirements;
- (3) a copy of each plan document and each agreement with service providers; and
- (4) a funding report containing:
 - (A) a statement certified by the board and an actuarial opinion that all applicable requirements of Section 846.153 have been met;
 - (B) an actuarial opinion describing the extent to which contributions or premium rates:
 - (i) are not excessive;
 - (ii) are not unfairly discriminatory; and

(iii) are adequate to provide for the payment of all obligations and the maintenance of required cash reserves and surplus by the arrangement;

(C) a statement of the current value of the assets and liabilities accumulated by the arrangement and a projection of the assets, liabilities, income, and expenses of the arrangement for the next 12-month period; and

(D) a statement of the costs to be charged for coverage, including an itemization of amounts for:

(i) administrative expenses;

(ii) reserves; and

(iii) other expenses associated with operation of the arrangement.

(c) The reserves described in Section 846.154(a) must have been established or be established before the final certificate of authority is issued.

(d) If, after examination and investigation, the commissioner is satisfied that the multiple employer welfare arrangement meets the requirements of this chapter, the commissioner shall issue a final certificate of authority to the arrangement.

(e) The commissioner shall maintain the information required under Subsection (b)(1)(C) and Subsection (b)(3) as confidential information.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 846.057. DENIAL OF FINAL CERTIFICATE OF AUTHORITY. (a) The commissioner shall deny a final certificate of authority to an applicant that does not comply with this chapter.

(b) If the commissioner denies a final certificate of authority, the commissioner shall issue a written notice of refusal to the applicant. The notice of refusal must state the basis for the denial. The notice of refusal constitutes 30 days' advance notice of the revocation of the initial certificate of authority.

(c) If the applicant submits a written request for a hearing not later than the 30th day after the date of mailing of the notice of refusal, revocation of the initial certificate of authority is temporarily stayed, and the commissioner shall promptly conduct a hearing at which the applicant is given an opportunity to show

compliance with this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 846.058. DISQUALIFICATION. (a) A multiple employer welfare arrangement, each board member and officer of the arrangement, and any agent or other person associated with the arrangement shall be subject to disqualification for eligibility for a certificate of authority if the person:

- (1) makes a material misstatement or omission in an application for a certificate of authority under this chapter;
 - (2) obtains or attempts to obtain at any time a certificate of authority or license for an insurance entity through intentional misrepresentation or fraud;
 - (3) misappropriates or converts to the person's own use or improperly withholds money under an employee welfare benefit plan or multiple employer welfare arrangement;
 - (4) is prohibited from serving in any capacity with the arrangement under Section 411, Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1111);
 - (5) without reasonable cause or excuse, fails to appear in response to a subpoena, examination, warrant, or any other order lawfully issued by the commissioner; or
 - (6) has previously been subject to a determination by the commissioner resulting in:
 - (A) suspension or revocation of a certificate of authority or license; or
 - (B) denial of a certificate of authority or license on grounds that would be sufficient for suspension or revocation.
- (b) This section does not apply to a participating employer in its capacity as a participating employer and the employer's participating employees.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 846.059. FEES; SERVICE OF PROCESS. (a) Each multiple employer welfare arrangement shall pay to the department in the amount set by the commissioner:

- (1) an application fee for an initial certificate of

authority;

(2) an application fee for a final certificate of authority; and

(3) a filing fee for submission of the arrangement's annual statement.

(b) The commissioner shall set the fees described by Subsection (a) in amounts reasonable and necessary to defray the costs of administering this chapter.

(c) Each multiple employer welfare arrangement shall appoint the commissioner as its resident agent for purposes of service of process. The fee for that service is \$50, payable at the time of appointment.

(d) Fees paid under this section shall be deposited to the credit of the Texas Department of Insurance operating fund.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 846.060. SUSPENSION, REVOCATION, OR LIMITATION OF CERTIFICATE OF AUTHORITY. In addition to any requirement or remedy under a law cited under Section 846.003, the commissioner may suspend, revoke, or limit the certificate of authority of a multiple employer welfare arrangement if the commissioner determines, after notice and hearing, that the agreement does not comply with this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 846.061. ACTION BY ATTORNEY GENERAL. (a) The commissioner may notify the attorney general of a violation of this chapter, and the attorney general may apply to a district court in Travis County for leave to file suit in the nature of quo warranto or for injunctive relief or both.

(b) The attorney general may seek and the court may order:

- (1) restitution for victims of an act declared to be unlawful under this chapter;
- (2) assessment of a fine under this code; and
- (3) recovery of reasonable attorney's fees.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER C. BOARD MEMBERS; OTHER OFFICERS AND PERSONNEL

Sec. 846.101. BOARD MEMBERS; NOTICE OF ELECTIONS. (a) Except as otherwise provided, the powers of a multiple employer welfare arrangement shall be exercised by a board elected to carry out the purposes established by the organizational documents of the arrangement.

(b) The member employers shall elect at least 75 percent of the board members. At least 75 percent of the board members must be individuals who are covered under the arrangement.

(c) An owner, officer, or employee of a third-party administrator who provides services to the multiple employer welfare arrangement or any other person who has received compensation from the arrangement may not serve as a board member.

(d) Each board member shall be elected for a term of at least two years.

(e) Each member employer of a multiple employer welfare arrangement shall be given notice of each election of board members and is entitled to an equal vote, either in person or by a written proxy signed by the member employer. An owner, officer, or employee of a third-party administrator who provides services to the arrangement or any other person who has received compensation from the arrangement may not serve as proxy.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 846.102. DUTIES OF BOARD MEMBERS. (a) The board members of a multiple employer welfare arrangement are responsible for all operations of the arrangement and shall take all necessary precautions to safeguard the assets of the arrangement.

(b) A board member shall give the attention and exercise the vigilance, diligence, care, and skill that a prudent person would use in like or similar circumstances.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 846.103. LIMITATION ON ACTION AGAINST BOARD MEMBER. A board member may not be held liable in a private cause of action for

any delinquency under Section 846.102 after the expiration of the earlier of:

- (1) six years from the date of delinquency; or
- (2) two years from the time when the delinquency is discovered by a person complaining of the delinquency.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 846.104. COMPENSATION OF BOARD MEMBERS. A board member serves without compensation from the multiple employer welfare arrangement except for actual and necessary expenses.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 846.105. OFFICERS; AGENTS. (a) The board shall select officers for the multiple employer welfare arrangement as designated in the organizational documents and may appoint agents as necessary for the arrangement to engage in business. Each officer and agent may exercise the authority and perform the duties required in the management of the property and affairs of the arrangement as delegated by the board.

(b) The board may remove an officer or agent if the board determines that the business interests of the multiple employer welfare arrangement are served by the removal.

(c) The board shall secure the fidelity of any or all of the officers or agents who handle the funds of the multiple employer welfare arrangement by bond or otherwise.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 846.106. COMPENSATION OF OFFICERS, AGENTS, AND EMPLOYEES. (a) A multiple employer welfare arrangement may pay the officers and agents of the arrangement suitable compensation. An officer, employee, or agent of an arrangement may not be compensated unreasonably.

(b) The compensation of any officer or employee of a multiple employer welfare arrangement may not be computed directly or indirectly as a percentage of money or premium collected.

(c) The compensation of an agent may not exceed five percent of the money or premium collected.

(d) A multiple employer welfare arrangement may pay compensation or make an emolument to an officer of the arrangement only if the compensation or emolument is first authorized by a majority vote of the board of the arrangement.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 846.107. RECEIPT OF THING OF VALUE; CRIMINAL PENALTY.

(a) A board member, officer, or employee of a multiple employer welfare arrangement may not, knowingly and intentionally, directly or indirectly:

(1) receive money or another valuable thing for negotiating, procuring, recommending, or aiding in:

(A) a purchase by or sale to the arrangement of property; or

(B) a loan from the arrangement; or

(2) be pecuniarily interested as a principal, coprincipal, agent, or beneficiary in a purchase, sale, or loan described by Subdivision (1).

(b) A person commits an offense if the person violates this section. An offense under this subsection is a felony of the third degree.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER D. POWERS AND DUTIES OF MULTIPLE EMPLOYER WELFARE ARRANGEMENTS

Sec. 846.151. GENERAL POWERS. (a) Unless otherwise provided by or inconsistent with this chapter, each multiple employer welfare arrangement may exercise the powers provided by this section.

(b) A multiple employer welfare arrangement may have succession, by its name, for the term stated in its trust agreement.

(c) A multiple employer welfare arrangement may sue and be sued. An arrangement may:

(1) complain and defend in any court;

(2) be a party to any proceedings before a public body of this state or of any other state or government; and

(3) sue a participating employer, an employee, or a beneficiary for any cause relating to the business of the arrangement.

(d) A multiple employer welfare arrangement may have a seal that may be used by having the seal or a facsimile of the seal impressed, affixed, or otherwise reproduced. The arrangement may alter the seal at will.

(e) A multiple employer welfare arrangement may appoint officers and agents as the business of the arrangement requires.

(f) A multiple employer welfare arrangement may adopt, amend, and repeal bylaws as necessary for the government of its affairs.

(g) A multiple employer welfare arrangement may conduct its business in this state, other states, and foreign countries and their territories and colonies.

(h) A multiple employer welfare arrangement may have offices outside this state.

(i) A multiple employer welfare arrangement may acquire, hold, mortgage, pledge, assign, and transfer real and personal property subject to this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 846.152. FILING OF ORGANIZATIONAL DOCUMENTS. A multiple employer welfare arrangement shall file with the commissioner its organizational documents and all appurtenant amendments before those documents take effect.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 846.153. REQUIRED FILINGS. (a) A multiple employer welfare arrangement engaging in business in this state shall file the following with the commissioner on forms approved by the commissioner:

(1) a financial statement audited by a certified public accountant;

(2) an actuarial opinion prepared and certified by an actuary who is:

(A) not an employee of the arrangement; and

(B) a fellow of the Society of Actuaries, a member of

the American Academy of Actuaries, or an enrolled actuary under the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.); and

(3) any modified terms of a plan document together with a certification from the trustees that the changes are in compliance with the minimum requirements of this chapter.

(b) A multiple employer welfare arrangement shall file the financial statement and the actuarial opinion required by Subsection (a) within 90 days of the end of the fiscal year.

(c) The actuarial opinion required under Subsection (a) must include:

(1) a description of the actuarial soundness of the multiple employer welfare arrangement, including any actions recommended to improve the actuarial soundness of the arrangement;

(2) the amount of cash reserves recommended to be maintained by the arrangement; and

(3) the level of specific and aggregate stop-loss insurance recommended to be maintained by the arrangement.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 846.154. CASH RESERVE REQUIREMENTS. (a) The amount of cash reserves recommended under Section 846.153(c)(2) may not be less than the greater of:

(1) 20 percent of the total contributions in the preceding plan year; or

(2) 20 percent of the total estimated contributions for the current plan year.

(b) Cash reserves required by this section must be:

(1) computed with proper actuarial regard for:

(A) known claims, paid and outstanding;

(B) a history of incurred but not reported claims;

(C) claims handling expenses;

(D) unearned premium;

(E) an estimate for bad debts;

(F) a trend factor; and

(G) a margin for error; and

(2) maintained in cash or federally guaranteed obligations of less than five-year maturity that have a fixed or recoverable

principal amount or in other investments as the commissioner may authorize by rule.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 846.155. ADJUSTMENT OF CONTRIBUTIONS. If the recommended cash reserves required by Section 846.154(a) exceed the greater of 40 percent of the total contributions for the preceding plan year or 40 percent of the total contributions expected for the current plan year, the contributions may be reduced to fund less than 100 percent of the aggregate retention plus all other costs of the multiple employer welfare arrangement, but not less than the level of contributions necessary to fund the minimum reserves required under Section 846.154(a).

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 846.156. WAIVER OR REDUCTION OF REQUIRED STOP-LOSS INSURANCE OR CASH RESERVES. On the application of a multiple employer welfare arrangement, the commissioner may waive or reduce the requirement for aggregate stop-loss insurance coverage and the amount of recommended cash reserves required by Section 846.154(a) on a determination that the interests of the participating employers and employees are adequately protected.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 846.157. RENEWAL OF CERTIFICATE; ADDITIONAL ACTUARIAL REVIEW. (a) The commissioner shall review the forms required by Section 846.153 and shall renew a multiple employer welfare arrangement's certificate of authority unless the commissioner determines that the arrangement does not comply with this chapter.

(b) On a finding of good cause, the commissioner may order an actuarial review of a multiple employer welfare arrangement in addition to the actuarial opinion required by Section 846.153(a). The arrangement shall pay the cost of the additional actuarial review.

(c) If the commissioner determines that a multiple employer

welfare arrangement does not comply with this chapter, the commissioner may order the arrangement to correct the deficiencies. The commissioner may take any action against the multiple employer welfare arrangement authorized by this code if the arrangement does not initiate immediate corrective action.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 846.158. EXAMINATION OF MULTIPLE EMPLOYER WELFARE ARRANGEMENTS. (a) The commissioner or the commissioner's appointee may examine the affairs of any multiple employer welfare arrangement.

(b) For the purposes of this section the commissioner:

(1) shall have free access to all the books, records, and documents that relate to the business of the plan; and

(2) may examine under oath a board member, officer, agent, or employee of the multiple employer welfare arrangement in relation to the affairs, transactions, and conditions of the arrangement.

(c) Each multiple employer welfare arrangement shall pay the expenses of the examination as provided by Sections 401.151, 401.152, 401.155, and 401.156.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.058, eff. April 1, 2009.

Sec. 846.159. NAME OF MULTIPLE EMPLOYER WELFARE ARRANGEMENT.

(a) A multiple employer welfare arrangement shall transact business under the arrangement's own name and may not adopt any assumed name. An arrangement may not use a name that is the same as or closely resembles the name of any other arrangement that:

(1) possesses a certificate of authority; and

(2) is engaged in business in this state.

(b) A multiple employer welfare arrangement may change its name by:

(1) amending the articles of the arrangement; or

(2) taking a new name with the approval of the commissioner.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 846.160. EVIDENCE OF EXISTENCE. A certified copy of the multiple employer welfare arrangement's certificate of authority is prima facie evidence of the existence of the arrangement in a legal proceeding.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER E. PROVISION OF COVERAGE

Sec. 846.201. BENEFITS ALLOWED. (a) A multiple employer welfare arrangement may only provide one or more of the following:

- (1) medical, dental, vision, surgical, or hospital care;
- (2) benefits in the event of sickness, accident, disability, or death;
- (3) another benefit authorized to be provided by health insurers in this state; and
- (4) prepaid legal services.

(b) Except as otherwise limited by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a multiple employer welfare arrangement may only provide benefits to:

- (1) active or retired owners, officers, directors, or employees of or partners in participating employers; and
- (2) the beneficiaries of a person described by Subdivision (1).

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 846.202. PREEXISTING CONDITION PROVISION. (a) In this section, "creditable coverage" has the meaning assigned by Section 1205.004.

(b) A preexisting condition provision in a multiple employer welfare arrangement's plan document may apply only to coverage for a disease or condition for which medical advice, diagnosis, care, or treatment was recommended or received during the six months before the earlier of:

- (1) the effective date of coverage; or
- (2) the first day of the waiting period.

(c) A preexisting condition provision in a multiple employer welfare arrangement's plan document may not apply to expenses incurred on or after the expiration of the 12 months following the initial effective date of coverage of the participating employee, dependent, or late-participating employee or dependent.

(d) A preexisting condition provision in a multiple employer welfare arrangement's plan document may not apply to an individual who was continuously covered for an aggregate period of 12 months under creditable coverage that was in effect until a date not more than 63 days before the effective date of coverage under the health benefit plan, excluding any waiting period.

(e) In determining whether a preexisting condition provision applies to an individual covered by a multiple employer welfare arrangement's plan document, the arrangement shall credit the time the individual was covered under previous creditable coverage if the previous coverage was in effect at any time during the 12 months preceding the effective date of coverage under the arrangement. If the previous coverage was issued under a health benefit plan, any waiting period that applied before that coverage became effective must also be credited against the preexisting condition provision period.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 2E.059, eff. April 1, 2009.

Sec. 846.203. TREATMENT OF CERTAIN CONDITIONS AS PREEXISTING PROHIBITED. (a) A multiple employer welfare arrangement may not treat genetic information as a preexisting condition described by Section 846.202 in the absence of a diagnosis of the condition related to the information.

(b) A multiple employer welfare arrangement may not treat pregnancy as a preexisting condition described by Section 846.202.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 846.204. WAITING PERIOD PERMITTED. Sections 846.202 and 846.203 do not preclude application of a waiting period that applies

to all new participating employees under the health benefit plan in accordance with the terms of the multiple employer welfare arrangement's plan document.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 846.205. CERTAIN LIMITATIONS OR EXCLUSIONS OF COVERAGE PROHIBITED. (a) A multiple employer welfare arrangement's plan document may not limit or exclude, by use of a rider or amendment applicable to a specific individual, coverage by type of illness, treatment, medical condition, or accident.

(b) This section does not preclude a multiple employer welfare arrangement from limiting or excluding coverage for a preexisting condition in accordance with Section 846.202.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 846.206. RENEWABILITY OF COVERAGE; CANCELLATION. (a) Except as provided by Section 846.207, a multiple employer welfare arrangement shall renew the health benefit plan, at the employer's option, unless:

- (1) a contribution has not been paid as required by the terms of the plan;
- (2) the employer has committed fraud or has intentionally misrepresented a material fact;
- (3) the employer has not complied with the terms of the health benefit plan document;
- (4) the health benefit plan is ceasing to offer any coverage in a geographic area; or
- (5) there has been a failure to meet the terms of an applicable collective bargaining agreement or other agreement requiring or authorizing contributions to the health benefit plan, including a failure to renew the agreement or to employ employees covered by the agreement.

(b) A multiple employer welfare arrangement may refuse to renew the coverage of a participating employee or dependent for fraud or intentional misrepresentation of a material fact by that person.

(c) A multiple employer welfare arrangement may not cancel a health benefit plan except for a reason specified for refusal to

renew under Subsection (a). An arrangement may not cancel the coverage of a participating employee or dependent except for a reason specified for refusal to renew under Subsection (b).

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 846.207. REFUSAL TO RENEW. (a) A multiple employer welfare arrangement may elect to refuse to renew all health benefit plans delivered or issued for delivery by the arrangement in this state. The arrangement shall notify:

(1) the commissioner of the election not later than the 180th day before the date coverage under the first health benefit plan terminates under this subsection; and

(2) each affected employer not later than the 180th day before the date on which coverage terminates for that employer.

(b) A multiple employer welfare arrangement that elects under this section to refuse to renew all health benefit plans may not write a health benefit plan in this state before the fifth anniversary of the date notice is delivered to the commissioner under Subsection (a).

(c) A multiple employer welfare arrangement may elect to discontinue a health benefit plan only if the arrangement:

(1) provides notice to each employer of the discontinuation before the 90th day preceding the date of the discontinuation of the plan;

(2) offers to each employer the option to purchase coverage under another health benefit plan offered by the arrangement; and

(3) acts uniformly without regard to the claims experience of the employer or any health status related factor of participating employees or dependents or new employees or dependents who may become eligible for the coverage.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 846.208. NOTICE TO COVERED PERSONS. (a) A multiple employer welfare arrangement that cancels or refuses to renew coverage under a health benefit plan under Section 846.206 or Section 846.207 shall notify the employer of the cancellation of or refusal to renew coverage not later than the 30th day before the date

termination of coverage is effective. The employer is responsible for notifying participating employees of the cancellation of or refusal to renew coverage.

(b) The notice provided under this section is in addition to any other notice required by Section 846.206 or Section 846.207.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 846.209. WRITTEN STATEMENT OF DENIAL, CANCELLATION, OR REFUSAL TO RENEW. Denial by a multiple employer welfare arrangement of an application for coverage from an employer or cancellation of or refusal to renew must:

- (1) be in writing; and
- (2) state the reason or reasons for the denial, cancellation, or refusal to renew.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER F. PARTICIPATION IN COVERAGE

Sec. 846.251. PARTICIPATION CRITERIA. Participation criteria may not be based on health status related factors.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 846.252. COVERAGE REQUIREMENTS. (a) A multiple employer welfare arrangement:

- (1) may refuse to provide coverage to an employer in accordance with the arrangement's underwriting standards and criteria;
- (2) shall accept or reject the entire group of individuals who meet the participation criteria and who choose coverage; and
- (3) may exclude only those employees or dependents who have declined coverage.

(b) On issuance of coverage to an employer, each multiple employer welfare arrangement shall provide coverage to the employees who meet the participation criteria without regard to an individual's health status related factors.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 846.253. PROHIBITION ON EXCLUSION OF ELIGIBLE EMPLOYEE OR DEPENDENT. A multiple employer welfare arrangement may not exclude an employee who meets the participation criteria or an eligible dependent, including a late-participating employee or dependent, who would otherwise be covered.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 846.254. WRITTEN NOTICE TO EMPLOYEES COVERED. A multiple employer welfare arrangement, in connection with an employee welfare benefit plan, shall provide to each participating employee covered by the plan a written notice at the time the employee's coverage becomes effective that states that:

(1) individuals covered by the plan are only partially insured; and

(2) if the plan or the arrangement does not ultimately pay medical expenses that are eligible for payment under the plan for any reason, the participating employer or its participating employee covered by the plan may be liable for those expenses.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 846.255. DECLINING COVERAGE. (a) A multiple employer welfare arrangement shall obtain a written waiver from each employee who meets the participation criteria and declines coverage under a health plan offered to an employer. The waiver must ensure that the employee was not induced or pressured to decline coverage because of the employee's health status related factors.

(b) A multiple employer welfare arrangement may not provide coverage to an employer or the employees of an employer if the arrangement or an agent for the arrangement knows that the employer has induced or pressured an employee who meets the participation criteria or a dependent of the employee to decline coverage because of that individual's health status related factors.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 846.256. MINIMUM CONTRIBUTION OR PARTICIPATION REQUIREMENTS. (a) A multiple employer welfare arrangement may require an employer to meet minimum contribution or participation requirements as a condition of issuance and renewal of coverage in accordance with the terms of the arrangement's plan document.

(b) The minimum contribution and participation requirements must be stated in the plan document and must be applied uniformly to each employer offered or issued coverage by the multiple employer welfare arrangement in this state.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 846.257. ENROLLMENT; WAITING PERIOD. (a) The initial enrollment period for employees meeting the participation criteria must be at least 31 days, with a 31-day annual open enrollment period. The enrollment period must consist of an entire calendar month, beginning on the first day of the month and ending on the last day of the month. If the month is February, the period must last through March 2.

(b) A multiple employer welfare arrangement may establish a waiting period.

(c) A new employee who meets the participation criteria may not be denied coverage if the application for coverage is received by the multiple employer welfare arrangement not later than the 31st day after the later of:

(1) the date on which the employment begins; or

(2) the date on which the waiting period established under Subsection (b) expires.

(d) If dependent coverage is offered to participating employees under the terms of a multiple employer welfare arrangement's plan document:

(1) the initial enrollment period for the dependents must be at least 31 days, with a 31-day annual open enrollment period; and

(2) a dependent of a new employee meeting the participation criteria established by the arrangement may not be denied coverage if the application for coverage is received by the arrangement not later

than the 31st day after the later of:

- (A) the date on which the employment begins;
- (B) the date on which the waiting period established under Subsection (b) expires; or
- (C) the date on which the dependent becomes eligible for enrollment.

(e) A late-participating employee or dependent may be excluded from coverage until the next annual open enrollment period and may be subject to a one-year preexisting condition provision as described by Section 846.202. The period during which a preexisting condition provision applies may not exceed 18 months after the date of the initial application.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 846.258. COVERAGE FOR NEWBORN CHILDREN. (a) A multiple employer welfare arrangement's plan document may not limit or exclude initial coverage of a newborn child of a participating employee.

(b) Coverage of a newborn child of a participating employee under this section ends on the 32nd day after the date of the child's birth unless:

- (1) children are eligible for coverage under the multiple employer welfare arrangement's plan document; and
- (2) not later than the 31st day after the date of birth, the arrangement receives:
 - (A) notice of the birth; and
 - (B) any required additional premium.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.219(a), eff. Sept. 1, 2003.

Sec. 846.259. COVERAGE FOR ADOPTED CHILDREN. (a) This section applies only if children are eligible for coverage under the terms of a multiple employer welfare arrangement's plan document.

(b) A multiple employer welfare arrangement plan document may not limit or exclude initial coverage of an adopted child of a participating employee. A child is considered to be the child of a participating employee if the participating employee is a party to a

suit in which the employee seeks to adopt the child.

(c) An adopted child of a participating employee may be enrolled, at the employee's option, not later than the 31st day after:

(1) the date the employee becomes a party to a suit in which the employee seeks to adopt the child; or

(2) the date the adoption becomes final.

(d) Coverage of an adopted child of a participating employee under this section ends unless the multiple employer welfare arrangement receives notice of the adoption and any required additional premiums not later than the 31st day after:

(1) the date the participating employee becomes a party to a suit in which the employee seeks to adopt the child; or

(2) the date the adoption becomes final.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.219(b), eff. Sept. 1, 2003.

Sec. 846.260. LIMITING AGE APPLICABLE TO UNMARRIED CHILD. If children are eligible for coverage under the terms of a multiple employer welfare arrangement's plan document, any limiting age applicable to an unmarried child of an enrollee is 25 years of age.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.219(c), eff. Sept. 1, 2003.

SUBCHAPTER G. MARKETING

Sec. 846.301. MARKETING REQUIREMENTS. On request, each employer purchasing a health benefit plan shall be given a summary of the plans for which the employer is eligible.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 846.302. ADDITIONAL REPORTING REQUIREMENTS. The department may require periodic reports by multiple employer welfare arrangements and agents regarding the health benefit plans issued by the arrangements. The reporting requirements must comply with

federal law and regulations.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 846.303. APPLICABILITY TO THIRD-PARTY ADMINISTRATOR. If a multiple employer welfare arrangement enters into an agreement with a third-party administrator to provide administrative, marketing, or other services related to offering health benefit plans to employers in this state, the third-party administrator is subject to this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

CHAPTER 847. HEALTH CARE QUALITY ASSURANCE

Sec. 847.001. SHORT TITLE. This chapter may be cited as the Health Care Quality Assurance Act.

Added by Acts 2005, 79th Leg., Ch. 789 (S.B. 155), Sec. 1, eff. June 17, 2005.

Sec. 847.002. LEGISLATIVE FINDINGS; PURPOSES. The legislature finds that to ensure enrollees high quality care, many health benefit plan issuers voluntarily undergo a rigorous accreditation process conducted by nationally recognized accreditation organizations. To maintain accreditation, these health benefit plan issuers are subject to continuing review of their processes and standards. The legislature recognizes that many of these processes and standards are also reviewed by state agencies, resulting in increased agency costs and increased health benefit plan administrative costs. The purpose of this chapter is to allow appropriate recognition of accreditation by nationally recognized accreditation organizations and to foster coordination among state agencies in order to:

- (1) help make health benefit plan coverage more affordable for consumers; and
- (2) eliminate duplication of effort by both health benefit plan issuers and state agencies.

Added by Acts 2005, 79th Leg., Ch. 789 (S.B. 155), Sec. 1, eff. June

17, 2005.

Sec. 847.003. DEFINITIONS. In this chapter:

(1) "Commission" means the Health and Human Services Commission.

(2) "Health benefit plan" means an individual, group, blanket, or franchise insurance policy, a certificate issued under a group policy, a group hospital service contract, or an individual or group subscriber contract or evidence of coverage issued by a health maintenance organization that provides benefits for health care services. The term does not include:

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

(B) credit-only insurance coverage;

(C) disability insurance coverage;

(D) Medicare services under a federal contract;

(E) Medicare supplement and Medicare Select benefit plans regulated in accordance with federal law;

(F) long-term care coverage or benefits, nursing home care coverage or benefits, home health care coverage or benefits, community-based care coverage or benefits, or any combination of those coverages or benefits;

(G) workers' compensation insurance coverage or similar insurance coverage;

(H) coverage provided through a jointly managed trust authorized under 29 U.S.C. Section 141 et seq. that contains a plan of benefits for employees that is negotiated in a collective bargaining agreement governing wages, hours, and working conditions of the employees that is authorized under 29 U.S.C. Section 157;

(I) hospital indemnity or other fixed indemnity insurance coverage;

(J) reinsurance contracts issued on a stop-loss, quota-share, or similar basis;

(K) short-term major medical contracts;

(L) liability insurance coverage, including general liability insurance coverage and automobile liability insurance coverage, and coverage issued as a supplement to liability insurance coverage, including automobile medical payment insurance coverage;

- (M) coverage for on-site medical clinics;
 - (N) coverage that provides other limited benefits specified by federal regulations;
 - (O) coverage that provides limited scope dental or vision benefits; or
 - (P) other coverage that:
 - (i) is similar to the coverage described by this subdivision under which benefits for medical care are secondary or incidental to other coverage benefits; and
 - (ii) is specified by federal regulations.
- (3) "National accreditation organization" means:
- (A) the Accreditation Association for Ambulatory Health Care;
 - (B) the Joint Commission on Accreditation of Healthcare Organizations;
 - (C) the National Committee for Quality Assurance;
 - (D) the American Accreditation HealthCare Commission ("URAC"); or
 - (E) any other national accreditation entity recognized by rules jointly adopted by the commissioner of insurance and the executive commissioner of the commission.

Added by Acts 2005, 79th Leg., Ch. 789 (S.B. [155](#)), Sec. 1, eff. June 17, 2005.

Sec. 847.004. APPLICABILITY OF CHAPTER. This chapter applies only to an entity that issues a health benefit plan and that holds a license or certificate of authority issued by the commissioner and provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

- (1) an insurance company;
- (2) a group hospital service corporation operating under Chapter 842;
- (3) a health maintenance organization operating under Chapter 843;
- (4) an approved nonprofit health corporation that holds a certificate of authority issued by the commissioner under Chapter 844;
- (5) a multiple employer welfare arrangement that holds a

certificate of authority under Chapter 846;

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

(7) a fraternal benefit society operating under Chapter 885; or

(8) a reciprocal exchange operating under Chapter 942.

Added by Acts 2005, 79th Leg., Ch. 789 (S.B. 155), Sec. 1, eff. June 17, 2005.

Sec. 847.005. PRESUMED COMPLIANCE WITH CERTAIN STATUTORY AND REGULATORY REQUIREMENTS. (a) A health benefit plan issuer is presumed to be in compliance with state statutory and regulatory requirements if:

(1) the health benefit plan issuer has received nonconditional accreditation by a national accreditation organization; and

(2) the national accreditation organization's accreditation requirements are the same, substantially similar to, or more stringent than the department's statutory or regulatory requirements.

(b) A health benefit plan issuer that offers a Medicare Advantage coordinated care plan under a contract with the federal Centers for Medicare and Medicaid Services is presumed to be in compliance with any state statutory and regulatory requirements that are the same, substantially similar to, or more stringent than the requirements for Medicare Advantage coordinated care plans, as determined by the commissioner.

(c) If the department determines that a health benefit plan issuer is in compliance with a state statutory or regulatory requirement, the commission may presume that a Medicaid or state child health plan program managed care plan offered by a health benefit plan issuer under contract with the commission is in compliance with any contractual Medicaid or state child health plan program managed care plan requirement that is the same as, substantially similar to, or more stringent than the state statutory or regulatory requirement, as determined by the commission.

(d) The commissioner may take appropriate action, including imposition of sanctions under Chapter 82, against a health benefit plan issuer who is presumed under Subsection (a), (b), or (c) to be

in compliance with state statutory and regulatory requirements but does not maintain compliance with the same, substantially similar, or more stringent requirements applicable to the issuer under Subsection (a), (b), or (c).

(e) The department shall monitor and analyze periodically as prescribed by rule by the commissioner updates and amendments made to national accreditation standards as necessary to ensure that those standards remain the same, substantially similar to, or more stringent than the department's statutory or regulatory requirements.

Added by Acts 2005, 79th Leg., Ch. 789 (S.B. 155), Sec. 1, eff. June 17, 2005.

Sec. 847.006. FILING OF ACCREDITATION REPORT; CONFIDENTIALITY REQUIREMENTS. (a) The commissioner may require a health benefit plan issuer to submit to the commissioner the accreditation report issued by the national accreditation organization.

(b) An accreditation report submitted under Subsection (a) is proprietary and confidential information under Chapter 552, Government Code, and is not subject to subpoena. The commissioner shall limit the disclosure of the accreditation report to those department employees who need the accreditation report to perform the duties of their job. A department employee may not further disclose the accreditation report.

(c) The national accreditation organization recommendations summary results are not proprietary information and are subject to public disclosure under Chapter 552, Government Code.

Added by Acts 2005, 79th Leg., Ch. 789 (S.B. 155), Sec. 1, eff. June 17, 2005.

Sec. 847.007. DUTIES OF COMMISSIONER OF INSURANCE. (a) In conducting an examination of a health benefit plan issuer, the commissioner:

(1) shall accept the accreditation report submitted by the health benefit plan issuer as a prima facie demonstration of the issuer's compliance with the processes and standards for which the issuer has received accreditation; and

(2) may adopt relevant findings in a health benefit plan

issuer's accreditation report in the examination report if the accreditation report complies with applicable state and federal requirements regarding the nondisclosure of proprietary and confidential information and personal health information.

(b) Subsection (a) does not apply to any process or standard of a health benefit plan issuer that is not covered as part of the issuer's accreditation. This section does not set minimum quality standards but operates only as a replacement of duplicate requirements.

(c) The commissioner may by rule determine the application of compliance with national accreditation requirements by a delegated entity, delegated third party, or utilization review agent to compliance by the health benefit plan issuer that contracts with the delegated entity, delegated third party, or agent.

Added by Acts 2005, 79th Leg., Ch. 789 (S.B. 155), Sec. 1, eff. June 17, 2005.

Sec. 847.008. COMMISSION DUTIES. (a) The commission may require the commissioner to submit to the commission the documents reviewed by the department that substantiate the compliance of the health benefit plan issuer with applicable state statutory and regulatory requirements.

(b) Documents submitted under Subsection (a) are proprietary and confidential information under Chapter 552, Government Code, and are not subject to subpoena. The commission shall limit disclosure of the documents to commission employees who need the documentation to perform the duties of their job. A commission employee may not further disclose the compliance documents.

Added by Acts 2005, 79th Leg., Ch. 789 (S.B. 155), Sec. 1, eff. June 17, 2005.

Sec. 847.009. MEMORANDUM OF UNDERSTANDING. The commissioner and the commission must enter into a memorandum of understanding to specify the responsibilities of the department and the commission under this chapter.

Added by Acts 2005, 79th Leg., Ch. 789 (S.B. 155), Sec. 1, eff. June

17, 2005.

Sec. 847.010. ENFORCEMENT. This chapter may not be construed to prohibit the commissioner or the commission from enforcing laws or rules relating to:

- (1) the operation of a health benefit plan; or
- (2) violation of a contract.

Added by Acts 2005, 79th Leg., Ch. 789 (S.B. 155), Sec. 1, eff. June 17, 2005.

CHAPTER 848. HEALTH CARE COLLABORATIVES

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 848.001. DEFINITIONS. In this chapter:

(1) "Affiliate" means a person who controls, is controlled by, or is under common control with one or more other persons.

(2) "Health care collaborative" means an entity:

(A) that undertakes to arrange for medical and health care services for insurers, health maintenance organizations, and other payors in exchange for payments in cash or in kind;

(B) that accepts and distributes payments for medical and health care services;

(C) that consists of:

(i) physicians;

(ii) rural hospitals;

(iii) physicians and other health care providers;

(iv) physicians and insurers or health maintenance organizations; or

(v) physicians, other health care providers, and insurers or health maintenance organizations; and

(D) that is certified by the commissioner under this chapter to lawfully accept and distribute payments to physicians and other health care providers using the reimbursement methodologies authorized by this chapter.

(3) "Health care services" means services provided by a physician or health care provider to prevent, alleviate, cure, or heal human illness or injury. The term includes:

(A) pharmaceutical services;

- (B) medical, chiropractic, or dental care; and
- (C) hospitalization.

(4) "Health care provider" means any person, partnership, professional association, corporation, facility, or institution licensed, certified, registered, or chartered by this state to provide health care services. The term includes a hospital but does not include a physician.

(5) "Health maintenance organization" means an organization operating under Chapter 843.

(6) "Hospital" means a general or special hospital, including a public or private institution licensed under Chapter 241 or 577, Health and Safety Code.

(7) Repealed by Acts 2015, 84th Leg., R.S., Ch. 946 , Sec. 1.14(e)(2), eff. September 1, 2015, and Ch. 837 , Sec. 3.40(d), eff. January 1, 2016.

(8) "Physician" means:

(A) an individual licensed to practice medicine in this state;

(B) a professional association organized under the Texas Professional Association Act (Article 1528f, Vernon's Texas Civil Statutes) or the Texas Professional Association Law by an individual or group of individuals licensed to practice medicine in this state;

(C) a partnership or limited liability partnership formed by a group of individuals licensed to practice medicine in this state;

(D) a nonprofit health corporation certified under Section 162.001, Occupations Code;

(E) a company formed by a group of individuals licensed to practice medicine in this state under the Texas Limited Liability Company Act (Article 1528n, Vernon's Texas Civil Statutes) or the Texas Professional Limited Liability Company Law; or

(F) an organization wholly owned and controlled by individuals licensed to practice medicine in this state.

(9) "Potentially preventable event" has the meaning assigned by Section 1002.001, Health and Safety Code.

(10) "Rural hospital" means a licensed hospital with 75 beds or fewer that:

(A) is located in a county with a population of 50,000 or less; or

(B) has been designated by the Centers for Medicare and Medicaid Services as a critical access hospital, rural referral center, or sole community hospital.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 4.01, eff. September 28, 2011.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 3.40(d), eff. January 1, 2016.

Acts 2015, 84th Leg., R.S., Ch. 946 (S.B. 277), Sec. 1.14(e)(2), eff. September 1, 2015.

Acts 2019, 86th Leg., R.S., Ch. 915 (H.B. 3934), Sec. 1, eff. June 10, 2019.

Sec. 848.002. EXCEPTION: DELEGATED ENTITIES. (a) This section applies only to an entity, other than a health maintenance organization, that:

(1) by itself or through a subcontract with another entity, undertakes to arrange for or provide medical care or health care services to enrollees in exchange for predetermined payments on a prospective basis; and

(2) accepts responsibility for performing functions that are required by:

(A) Chapter 222, 251, 258, or 1272, as applicable, to a health maintenance organization; or

(B) Chapter 843, Chapter 1271, Section 1367.053, Subchapter A, Chapter 1452, or Subchapter B, Chapter 1507, as applicable, solely on behalf of health maintenance organizations.

(b) An entity described by Subsection (a) is subject to Chapter 1272 and is not required to obtain a certificate of authority or determination of approval under this chapter.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 4.01, eff. September 28, 2011.

Sec. 848.003. USE OF INSURANCE-RELATED TERMS BY HEALTH CARE COLLABORATIVE. A health care collaborative that is not an insurer or health maintenance organization may not use in its name, contracts, or literature:

(1) the following words or initials:

- (A) "insurance";
- (B) "casualty";
- (C) "surety";
- (D) "mutual";
- (E) "health maintenance organization"; or
- (F) "HMO"; or

(2) any other words or initials that are:

- (A) descriptive of the insurance, casualty, surety, or health maintenance organization business; or
- (B) deceptively similar to the name or description of an insurer, surety corporation, or health maintenance organization engaging in business in this state.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 4.01, eff. September 28, 2011.

Sec. 848.004. APPLICABILITY OF INSURANCE LAWS. (a) An organization may not arrange for or provide health care services to enrollees on a prepaid or indemnity basis through health insurance or a health benefit plan, including a health care plan, as defined by Section 843.002, unless the organization as an insurer or health maintenance organization holds the appropriate certificate of authority issued under another chapter of this code.

(b) Except as provided by Subsection (c), the following provisions of this code apply to a health care collaborative in the same manner and to the same extent as they apply to an individual or entity otherwise subject to the provision:

- (1) Section 38.001;
- (2) Subchapter A, Chapter 542;
- (3) Chapter 541;
- (4) Chapter 543;
- (5) Chapter 602;
- (6) Chapter 701;
- (7) Chapter 803; and
- (8) Chapter 804.

(c) The remedies available under this chapter in the manner provided by Chapter 541 do not include:

- (1) a private cause of action under Subchapter D, Chapter

541; or

- (2) a class action under Subchapter F, Chapter 541.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 4.01, eff. September 28, 2011.

Sec. 848.005. CERTAIN INFORMATION CONFIDENTIAL. (a) Except as provided by Subsection (b), an application, filing, or report required under this chapter is public information subject to disclosure under Chapter 552, Government Code.

(b) The following information is confidential and is not subject to disclosure under Chapter 552, Government Code:

(1) a contract, agreement, or document that establishes another arrangement:

(A) between a health care collaborative and a governmental or private entity for all or part of health care services provided or arranged for by the health care collaborative; or

(B) between a health care collaborative and participating physicians and health care providers;

(2) a written description of a contract, agreement, or other arrangement described by Subdivision (1);

(3) information relating to bidding, pricing, or other trade secrets submitted to:

(A) the department under Sections 848.057(a)(5) and (6); or

(B) the attorney general under Section 848.059;

(4) information relating to the diagnosis, treatment, or health of a patient who receives health care services from a health care collaborative under a contract for services; and

(5) information relating to quality improvement or peer review activities of a health care collaborative.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 4.01, eff. September 28, 2011.

Sec. 848.006. COVERAGE BY HEALTH CARE COLLABORATIVE NOT REQUIRED. (a) Except as provided by Subsection (b) and subject to Chapter 843 and Section 1301.0625, an individual may not be required

to obtain or maintain coverage under:

(1) an individual health insurance policy written through a health care collaborative; or

(2) any plan or program for health care services provided on an individual basis through a health care collaborative.

(b) This chapter does not require an individual to obtain or maintain health insurance coverage.

(c) Subsection (a) does not apply to an individual:

(1) who is required to obtain or maintain health benefit plan coverage:

(A) written by an institution of higher education at which the individual is or will be enrolled as a student; or

(B) under an order requiring medical support or dental support for a child; or

(2) who voluntarily applies for benefits under a state administered program under Title XIX of the Social Security Act (42 U.S.C. Section 1396 et seq.), or Title XXI of the Social Security Act (42 U.S.C. Section 1397aa et seq.).

(d) Except as provided by Subsection (e), a fine or penalty may not be imposed on an individual if the individual chooses not to obtain or maintain coverage described by Subsection (a).

(e) Subsection (d) does not apply to a fine or penalty imposed on an individual described in Subsection (c) for the individual's failure to obtain or maintain health benefit plan coverage.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 4.01, eff. September 28, 2011.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1150 (S.B. 550), Sec. 55, eff. September 1, 2018.

SUBCHAPTER B. AUTHORITY TO ENGAGE IN BUSINESS

Sec. 848.051. OPERATION OF HEALTH CARE COLLABORATIVE. A health care collaborative that is certified by the department under this chapter may provide or arrange to provide health care services under contract with a governmental or private entity.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 4.01, eff. September 28, 2011.

Sec. 848.052. FORMATION AND GOVERNANCE OF HEALTH CARE COLLABORATIVE. (a) A health care collaborative is governed by a board of directors.

(b) The person who establishes a health care collaborative shall appoint an initial board of directors. Each member of the initial board serves a term of not more than 18 months. Subsequent members of the board shall be elected to serve two-year terms by physicians and health care providers who participate in the health care collaborative as provided by this section. The board shall elect a chair from among its members.

(c) If the participants in a health care collaborative are all physicians, each member of the board of directors must be an individual physician who is a participant in the health care collaborative.

(c-1) If the participants in a health care collaborative are all rural hospitals, each member of the board of directors must be a representative of a participant.

(d) If the participants in a health care collaborative are both physicians and other health care providers, the board of directors must consist of:

(1) an even number of members who are individual physicians, selected by physicians who participate in the health care collaborative;

(2) a number of members equal to the number of members under Subdivision (1) who represent health care providers, one of whom is an individual physician, selected by health care providers who participate in the health care collaborative; and

(3) one individual member with business expertise, selected by unanimous vote of the members described by Subdivisions (1) and (2).

(d-1) If a health care collaborative includes hospital-based physicians, one member of the board of directors must be a hospital-based physician.

(e) The board of directors must include at least three nonvoting ex officio members who represent the community in which the health care collaborative operates.

(f) An individual may not serve on the board of directors of a health care collaborative if the individual has an ownership interest in, serves on the board of directors of, or maintains an officer position with:

(1) another health care collaborative that provides health care services in the same service area as the health care collaborative; or

(2) a physician or health care provider that:

(A) does not participate in the health care collaborative; and

(B) provides health care services in the same service area as the health care collaborative.

(g) In addition to the requirements of Subsection (f), the board of directors of a health care collaborative shall adopt a conflict of interest policy to be followed by members.

(h) The board of directors may remove a member for cause. A member may not be removed from the board without cause.

(i) The organizational documents of a health care collaborative may not conflict with any provision of this chapter, including this section.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 4.01, eff. September 28, 2011.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 915 (H.B. 3934), Sec. 2, eff. June 10, 2019.

Sec. 848.053. COMPENSATION ADVISORY COMMITTEE; SHARING OF CERTAIN DATA. (a) The board of directors of a health care collaborative shall establish a compensation advisory committee to develop and make recommendations to the board regarding charges, fees, payments, distributions, or other compensation assessed for health care services provided by physicians or health care providers who participate in the health care collaborative. The committee must include:

(1) two members of the board of directors, of which one member is the hospital-based physician member, if the health care collaborative includes hospital-based physicians; and

(2) if the health care collaborative consists of physicians and other health care providers:

(A) a physician who is not a participant in the health care collaborative, selected by the physicians who are participants in the collaborative; and

(B) a member selected by the other health care providers who participate in the collaborative.

(b) A health care collaborative shall establish and enforce policies to prevent the sharing of charge, fee, and payment data among nonparticipating physicians and health care providers.

(c) The compensation advisory committee shall make recommendations to the board of directors regarding all charges, fees, payments, distributions, or other compensation assessed for health care services provided by a physician or health care provider who participates in the health care collaborative.

(d) Except as provided by Subsections (e) and (f), the board of directors and the compensation advisory committee may not use or consider a government payor's payment rates in setting the charges or fees for health care services provided by a physician or health care provider who participates in the health care collaborative.

(e) The board of directors or the compensation advisory committee may use or consider a government payor's payment rates when setting the charges or fees for health care services paid by a government payor.

(f) This section does not prohibit a reference to a government payor's payment rates in agreements with health maintenance organizations, insurers, or other payors.

(g) After the compensation advisory committee submits a recommendation to the board of directors, the board shall formally approve or refuse the recommendation.

(h) For purposes of this section, "government payor" includes:

- (1) Medicare;
- (2) Medicaid;
- (3) the state child health plan program; and
- (4) the TRICARE Military Health System.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 4.01, eff. September 28, 2011.

Sec. 848.054. CERTIFICATE OF AUTHORITY AND DETERMINATION OF APPROVAL REQUIRED. (a) An organization may not organize or operate a health care collaborative in this state unless the organization holds a certificate of authority issued under this chapter.

(b) The commissioner shall adopt rules governing the

application for a certificate of authority under this subchapter.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 4.01, eff. September 28, 2011.

Sec. 848.055. EXCEPTIONS. (a) An organization is not required to obtain a certificate of authority under this chapter if the organization holds an appropriate certificate of authority issued under another chapter of this code.

(b) A person is not required to obtain a certificate of authority under this chapter to the extent that the person is:

- (1) a physician engaged in the delivery of medical care; or
- (2) a health care provider engaged in the delivery of health care services other than medical care as part of a health maintenance organization delivery network.

(c) A medical school, medical and dental unit, or health science center as described by Section 61.003, 61.501, or 74.601, Education Code, is not required to obtain a certificate of authority under this chapter to the extent that the medical school, medical and dental unit, or health science center contracts to deliver medical care services within a health care collaborative. This chapter is otherwise applicable to a medical school, medical and dental unit, or health science center.

(d) An entity licensed under the Health and Safety Code that employs a physician under a specific statutory authority is not required to obtain a certificate of authority under this chapter to the extent that the entity contracts to deliver medical care services and health care services within a health care collaborative. This chapter is otherwise applicable to the entity.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 4.01, eff. September 28, 2011.

Sec. 848.056. APPLICATION FOR CERTIFICATE OF AUTHORITY. (a) An organization may apply to the commissioner for and obtain a certificate of authority to organize and operate a health care collaborative.

(b) An application for a certificate of authority must:

- (1) comply with all rules adopted by the commissioner;

(2) be verified under oath by the applicant or an officer or other authorized representative of the applicant;

(3) be reviewed by the division within the office of attorney general that is primarily responsible for enforcing the antitrust laws of this state and of the United States under Section 848.059;

(4) demonstrate that the health care collaborative contracts with a sufficient number of primary care physicians in the health care collaborative's service area;

(5) state that enrollees may obtain care from any physician or health care provider in the health care collaborative; and

(6) identify a service area within which medical services are available and accessible to enrollees.

(c) Not later than the 190th day after the date an applicant submits an application to the commissioner under this section, the commissioner shall approve or deny the application.

(d) The commissioner by rule may:

(1) extend the date by which an application is due under this section; and

(2) require the disclosure of any additional information necessary to implement and administer this chapter, including information necessary to antitrust review and oversight.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 4.01, eff. September 28, 2011.

Sec. 848.057. REQUIREMENTS FOR APPROVAL OF APPLICATION. (a) The commissioner shall issue a certificate of authority on payment of the application fee prescribed by Section 848.152 if the commissioner is satisfied that:

(1) the applicant meets the requirements of Section 848.056;

(2) with respect to health care services to be provided, the applicant:

(A) has demonstrated the willingness and potential ability to ensure that the health care services will be provided in a manner that:

(i) increases collaboration among health care providers and integrates health care services;

(ii) promotes improvement in quality-based health care outcomes, patient safety, patient engagement, and coordination of services; and

(iii) reduces the occurrence of potentially preventable events;

(B) has processes that contain health care costs without jeopardizing the quality of patient care;

(C) has processes to develop, compile, evaluate, and report statistics on performance measures relating to the quality and cost of health care services, the pattern of utilization of services, and the availability and accessibility of services; and

(D) has processes to address complaints made by patients receiving services provided through the organization;

(3) the applicant is in compliance with all rules adopted by the commissioner under Section 848.151;

(4) the applicant has working capital and reserves sufficient to operate and maintain the health care collaborative and to arrange for services and expenses incurred by the health care collaborative;

(5) the applicant's proposed health care collaborative is not likely to reduce competition in any market for physician, hospital, or ancillary health care services due to:

(A) the size of the health care collaborative; or

(B) the composition of the collaborative, including the distribution of physicians by specialty within the collaborative in relation to the number of competing health care providers in the health care collaborative's geographic market; and

(6) the pro-competitive benefits of the applicant's proposed health care collaborative are likely to substantially outweigh the anticompetitive effects of any increase in market power.

(b) A certificate of authority is effective for a period of one year, subject to Section 848.060(d).

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 4.01, eff. September 28, 2011.

Sec. 848.058. DENIAL OF CERTIFICATE OF AUTHORITY. (a) The commissioner may not issue a certificate of authority if the commissioner determines that the applicant's proposed plan of

operation does not meet the requirements of Section 848.057.

(b) If the commissioner denies an application for a certificate of authority under Subsection (a), the commissioner shall notify the applicant that the plan is deficient and specify the deficiencies.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 4.01, eff. September 28, 2011.

Sec. 848.059. CONCURRENCE OF ATTORNEY GENERAL. (a) If the commissioner determines that an application for a certificate of authority filed under Section 848.056 complies with the requirements of Section 848.057, the commissioner shall forward the application, and all data, documents, and analysis considered by the commissioner in making the determination, to the attorney general. The attorney general shall review the application and the data, documents, and analysis and, if the attorney general concurs with the commissioner's determination under Sections 848.057(a)(5) and (6), the attorney general shall notify the commissioner.

(b) If the attorney general does not concur with the commissioner's determination under Sections 848.057(a)(5) and (6), the attorney general shall notify the commissioner.

(c) A determination under this section shall be made not later than the 60th day after the date the attorney general receives the application and the data, documents, and analysis from the commissioner.

(d) If the attorney general lacks sufficient information to make a determination under Sections 848.057(a)(5) and (6), within 60 days of the attorney general's receipt of the application and the data, documents, and analysis the attorney general shall inform the commissioner that the attorney general lacks sufficient information as well as what information the attorney general requires. The commissioner shall then either provide the additional information to the attorney general or request the additional information from the applicant. The commissioner shall promptly deliver any such additional information to the attorney general. The attorney general shall then have 30 days from receipt of the additional information to make a determination under Subsection (a) or (b).

(e) If the attorney general notifies the commissioner that the attorney general does not concur with the commissioner's

determination under Sections 848.057(a)(5) and (6), then, notwithstanding any other provision of this subchapter, the commissioner shall deny the application.

(f) In reviewing the commissioner's determination, the attorney general shall consider the findings, conclusions, or analyses contained in any other governmental entity's evaluation of the health care collaborative.

(g) The attorney general at any time may request from the commissioner additional time to consider an application under this section. The commissioner shall grant the request and notify the applicant of the request. A request by the attorney general or an order by the commissioner granting a request under this section is not subject to administrative or judicial review.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 4.01, eff. September 28, 2011.

Sec. 848.060. RENEWAL OF CERTIFICATE OF AUTHORITY AND DETERMINATION OF APPROVAL. (a) Not later than the 180th day before the one-year anniversary of the date on which a health care collaborative's certificate of authority was issued or most recently renewed, the health care collaborative shall file with the commissioner an application to renew the certificate.

(b) An application for renewal must:

(1) be verified by at least two principal officers of the health care collaborative; and

(2) include:

(A) a financial statement of the health care collaborative, including a balance sheet and receipts and disbursements for the preceding calendar year, certified by an independent certified public accountant;

(B) a description of the service area of the health care collaborative;

(C) a description of the number and types of physicians and health care providers participating in the health care collaborative;

(D) an evaluation of the quality and cost of health care services provided by the health care collaborative;

(E) an evaluation of the health care collaborative's

processes to promote evidence-based medicine, patient engagement, and coordination of health care services provided by the health care collaborative;

(F) the number, nature, and disposition of any complaints filed with the health care collaborative under Section 848.107; and

(G) any other information required by the commissioner.

(c) If a completed application for renewal is filed under this section:

(1) the commissioner shall conduct a review under Section 848.057 as if the application for renewal were a new application, and, on approval by the commissioner, the attorney general shall review the application under Section 848.059 as if the application for renewal were a new application; and

(2) the commissioner shall renew or deny the renewal of a certificate of authority at least 20 days before the one-year anniversary of the date on which a health care collaborative's certificate of authority was issued.

(d) If the commissioner does not act on a renewal application before the one-year anniversary of the date on which a health care collaborative's certificate of authority was issued or renewed, the health care collaborative's certificate of authority expires on the 90th day after the date of the one-year anniversary unless the renewal of the certificate of authority or determination of approval, as applicable, is approved before that date.

(e) A health care collaborative shall report to the department a material change in the size or composition of the collaborative. On receipt of a report under this subsection, the department may require the collaborative to file an application for renewal before the date required by Subsection (a).

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 4.01, eff. September 28, 2011.

SUBCHAPTER C. GENERAL POWERS AND DUTIES OF HEALTH CARE COLLABORATIVE

Sec. 848.101. PROVIDING OR ARRANGING FOR SERVICES. (a) A health care collaborative may provide or arrange for health care services through contracts with physicians and health care providers or with entities contracting on behalf of participating physicians

and health care providers.

(b) A health care collaborative may not prohibit a physician or other health care provider, as a condition of participating in the health care collaborative, from participating in another health care collaborative.

(c) A health care collaborative may not use a covenant not to compete to prohibit a physician from providing medical services or participating in another health care collaborative in the same service area.

(d) Except as provided by Subsection (f), on written consent of a patient who was treated by a physician participating in a health care collaborative, the health care collaborative shall provide the physician with the medical records of the patient, regardless of whether the physician is participating in the health care collaborative at the time the request for the records is made.

(e) Records provided under Subsection (d) shall be made available to the physician in the format in which the records are maintained by the health care collaborative. The health care collaborative may charge the physician a fee for copies of the records, as established by the Texas Medical Board.

(f) If a physician requests a patient's records from a health care collaborative under Subsection (d) for the purpose of providing emergency treatment to the patient:

(1) the health care collaborative may not charge a fee to the physician under Subsection (e); and

(2) the health care collaborative shall provide the records to the physician regardless of whether the patient has provided written consent.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 4.01, eff. September 28, 2011.

Sec. 848.102. INSURANCE, REINSURANCE, INDEMNITY, AND REIMBURSEMENT. A health care collaborative may contract with an insurer authorized to engage in business in this state to provide insurance, reinsurance, indemnification, or reimbursement against the cost of health care and medical care services provided by the health care collaborative. This section does not affect the requirement that the health care collaborative maintain sufficient working

capital and reserves.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 4.01, eff. September 28, 2011.

Sec. 848.103. PAYMENT BY GOVERNMENTAL OR PRIVATE ENTITY. (a) A health care collaborative may:

(1) contract for and accept payments from a governmental or private entity for all or part of the cost of services provided or arranged for by the health care collaborative; and

(2) distribute payments to participating physicians and health care providers.

(b) Notwithstanding any other law, a health care collaborative that is in compliance with this code, including Chapters 841, 842, and 843, as applicable, may contract for, accept, and distribute payments from governmental or private payors based on fee-for-service or alternative payment mechanisms, including:

(1) episode-based or condition-based bundled payments;

(2) capitation or global payments; or

(3) pay-for-performance or quality-based payments.

(c) Except as provided by Subsection (d), a health care collaborative may not contract for and accept payment from a governmental or private entity on a prepaid, capitation, or indemnity basis unless the health care collaborative is licensed as a health maintenance organization or insurer. The department shall review a health care collaborative's proposed payment methodology in contracts with governmental or private entities to ensure compliance with this section.

(d) A health care collaborative may contract for and accept compensation on a prepaid or capitation basis from a health maintenance organization or insurer.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 4.01, eff. September 28, 2011.

Sec. 848.104. CONTRACTS FOR ADMINISTRATIVE OR MANAGEMENT SERVICES. A health care collaborative may contract with any person, including an affiliated entity, to perform administrative, management, or any other required business functions on behalf of the

health care collaborative.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 4.01, eff. September 28, 2011.

Sec. 848.105. CORPORATION, PARTNERSHIP, OR ASSOCIATION POWERS. A health care collaborative has all powers of a partnership, association, corporation, or limited liability company, including a professional association or corporation, as appropriate under the organizational documents of the health care collaborative, that are not in conflict with this chapter or other applicable law.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 4.01, eff. September 28, 2011.

Sec. 848.106. QUALITY AND COST OF HEALTH CARE SERVICES. (a) A health care collaborative shall establish policies to improve the quality and control the cost of health care services provided by participating physicians and health care providers that are consistent with prevailing professionally recognized standards of medical practice. The policies must include standards and procedures relating to:

(1) the selection and credentialing of participating physicians and health care providers;

(2) the development, implementation, monitoring, and evaluation of evidence-based best practices and other processes to improve the quality and control the cost of health care services provided by participating physicians and health care providers, including practices or processes to reduce the occurrence of potentially preventable events;

(3) the development, implementation, monitoring, and evaluation of processes to improve patient engagement and coordination of health care services provided by participating physicians and health care providers; and

(4) complaints initiated by participating physicians, health care providers, and patients under Section 848.107.

(b) The governing body of a health care collaborative shall establish a procedure for the periodic review of quality improvement and cost control measures.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 4.01, eff. September 28, 2011.

Sec. 848.107. COMPLAINT SYSTEMS. (a) A health care collaborative shall implement and maintain complaint systems that provide reasonable procedures to resolve an oral or written complaint initiated by:

(1) a patient who received health care services provided by a participating physician or health care provider; or

(2) a participating physician or health care provider.

(b) The complaint system for complaints initiated by patients must include a process for the notice and appeal of a complaint.

(c) A health care collaborative may not take a retaliatory or adverse action against a physician or health care provider who files a complaint with a regulatory authority regarding an action of the health care collaborative.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 4.01, eff. September 28, 2011.

Sec. 848.108. DELEGATION AGREEMENTS. (a) Except as provided by Subsection (b), a health care collaborative that enters into a delegation agreement described by Section 1272.001 is subject to the requirements of Chapter 1272 in the same manner as a health maintenance organization.

(b) Section 1272.301 does not apply to a delegation agreement entered into by a health care collaborative.

(c) A health care collaborative may enter into a delegation agreement with an entity licensed under Chapter 841, 842, or 883 if the delegation agreement assigns to the entity responsibility for:

(1) a function regulated by:

- (A) Chapter 222;
- (B) Chapter 841;
- (C) Chapter 842;
- (D) Chapter 883;
- (E) Chapter 1272;
- (F) Chapter 1301;
- (G) Chapter 4201;

- (H) Section 1367.053; or
- (I) Subchapter A, Chapter 1507; or

(2) another function specified by commissioner rule.

(d) A health care collaborative that enters into a delegation agreement under this section shall maintain reserves and capital in addition to the amounts required under Chapter 1272, in an amount and form determined by rule of the commissioner to be necessary for the liabilities and risks assumed by the health care collaborative.

(e) A health care collaborative that enters into a delegation agreement under this section is subject to Chapters 404, 441, and 443 and is considered to be an insurer for purposes of those chapters.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 4.01, eff. September 28, 2011.

Sec. 848.109. VALIDITY OF OPERATIONS AND TRADE PRACTICES OF HEALTH CARE COLLABORATIVES. The operations and trade practices of a health care collaborative that are consistent with the provisions of this chapter, the rules adopted under this chapter, and applicable federal antitrust laws are presumed to be consistent with Chapter 15, Business & Commerce Code, or any other applicable provision of law.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 4.01, eff. September 28, 2011.

Sec. 848.110. RIGHTS OF PHYSICIANS; LIMITATIONS ON PARTICIPATION. (a) Before a complaint against a physician under Section 848.107 is resolved, or before a physician's association with a health care collaborative is terminated, the physician is entitled to an opportunity to dispute the complaint or termination through a process that includes:

- (1) written notice of the complaint or basis of the termination;
- (2) an opportunity for a hearing not earlier than the 30th day after receiving notice under Subdivision (1);
- (3) the right to provide information at the hearing, including testimony and a written statement; and
- (4) a written decision that includes the specific facts and reasons for the decision.

(b) A health care collaborative may limit a physician or group of physicians from participating in the health care collaborative if the limitation is based on an established development plan approved by the board of directors. Each applicant physician or group shall be provided with a copy of the development plan.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 4.01, eff. September 28, 2011.

SUBCHAPTER D. REGULATION OF HEALTH CARE COLLABORATIVES

Sec. 848.151. RULES. The commissioner and the attorney general may adopt reasonable rules as necessary and proper to implement the requirements of this chapter.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 4.01, eff. September 28, 2011.

Sec. 848.152. FEES AND ASSESSMENTS. (a) The commissioner shall, within the limits prescribed by this section, prescribe the fees to be charged and the assessments to be imposed under this section.

(b) Amounts collected under this section shall be deposited to the credit of the Texas Department of Insurance operating account.

(c) A health care collaborative shall pay to the department:

(1) an application fee in an amount determined by commissioner rule; and

(2) an annual assessment in an amount determined by commissioner rule.

(d) The commissioner shall set fees and assessments under this section in an amount sufficient to pay the reasonable expenses of the department and attorney general in administering this chapter, including the direct and indirect expenses incurred by the department and attorney general in examining and reviewing health care collaboratives. Fees and assessments imposed under this section shall be allocated among health care collaboratives on a pro rata basis to the extent that the allocation is feasible.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 4.01, eff. September 28, 2011.

Sec. 848.153. EXAMINATIONS. (a) The commissioner may examine the financial affairs and operations of any health care collaborative or applicant for a certificate of authority under this chapter.

(b) A health care collaborative shall make its books and records relating to its financial affairs and operations available for an examination by the commissioner or attorney general.

(c) On request of the commissioner or attorney general, a health care collaborative shall provide to the commissioner or attorney general, as applicable:

(1) a copy of any contract, agreement, or other arrangement between the health care collaborative and a physician or health care provider; and

(2) a general description of the fee arrangements between the health care collaborative and the physician or health care provider.

(d) Documentation provided to the commissioner or attorney general under this section is confidential and is not subject to disclosure under Chapter 552, Government Code.

(e) The commissioner or attorney general may disclose the results of an examination conducted under this section or documentation provided under this section to a governmental agency that contracts with a health care collaborative for the purpose of determining financial stability, readiness, or other contractual compliance needs.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 4.01, eff. September 28, 2011.

SUBCHAPTER E. ENFORCEMENT

Sec. 848.201. ENFORCEMENT ACTIONS. (a) After notice and opportunity for a hearing, the commissioner may:

(1) suspend or revoke a certificate of authority issued to a health care collaborative under this chapter;

(2) impose sanctions under Chapter 82;

(3) issue a cease and desist order under Chapter 83; or

(4) impose administrative penalties under Chapter 84.

(b) The commissioner may take an enforcement action listed in

Subsection (a) against a health care collaborative if the commissioner finds that the health care collaborative:

- (1) is operating in a manner that is:
 - (A) significantly contrary to its basic organizational documents; or
 - (B) contrary to the manner described in and reasonably inferred from other information submitted under Section 848.057;
- (2) does not meet the requirements of Section 848.057;
- (3) cannot fulfill its obligation to provide health care services as required under its contracts with governmental or private entities;
- (4) does not meet the requirements of Chapter 1272, if applicable;
- (5) has not implemented the complaint system required by Section 848.107 in a manner to resolve reasonably valid complaints;
- (6) has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive, or unfair manner or a person on behalf of the health care collaborative has advertised or merchandised the health care collaborative's services in an untrue, misrepresentative, misleading, deceptive, or untrue manner;
- (7) has not complied substantially with this chapter or a rule adopted under this chapter;
- (8) has not taken corrective action the commissioner considers necessary to correct a failure to comply with this chapter, any applicable provision of this code, or any applicable rule or order of the commissioner not later than the 30th day after the date of notice of the failure or within any longer period specified in the notice and determined by the commissioner to be reasonable; or
- (9) has or is utilizing market power in an anticompetitive manner, in accordance with established antitrust principles of market power analysis.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 4.01, eff. September 28, 2011.

Sec. 848.202. OPERATIONS DURING SUSPENSION OR AFTER REVOCATION OF CERTIFICATE OF AUTHORITY. (a) During the period a certificate of authority of a health care collaborative is suspended, the health care collaborative may not:

(1) enter into a new contract with a governmental or private entity; or

(2) advertise or solicit in any way.

(b) After a certificate of authority of a health care collaborative is revoked, the health care collaborative:

(1) shall proceed, immediately following the effective date of the order of revocation, to conclude its affairs;

(2) may not conduct further business except as essential to the orderly conclusion of its affairs; and

(3) may not advertise or solicit in any way.

(c) Notwithstanding Subsection (b), the commissioner may, by written order, permit the further operation of the health care collaborative to the extent that the commissioner finds necessary to serve the best interest of governmental or private entities that have entered into contracts with the health care collaborative.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 4.01, eff. September 28, 2011.

Sec. 848.203. INJUNCTIONS. If the commissioner believes that a health care collaborative or another person is violating or has violated this chapter or a rule adopted under this chapter, the attorney general at the request of the commissioner may bring an action in a Travis County district court to enjoin the violation and obtain other relief the court considers appropriate.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 4.01, eff. September 28, 2011.

Sec. 848.204. NOTICE. The commissioner shall:

(1) report any action taken under this subchapter to:

(A) the relevant state licensing or certifying agency or board; and

(B) the United States Department of Health and Human Services National Practitioner Data Bank; and

(2) post notice of the action on the department's Internet website.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 4.01,

eff. September 28, 2011.

Sec. 848.205. INDEPENDENT AUTHORITY OF ATTORNEY GENERAL. (a)
The attorney general may:

(1) investigate a health care collaborative with respect to anticompetitive behavior that is contrary to the goals and requirements of this chapter; and

(2) request that the commissioner:

(A) impose a penalty or sanction;

(B) issue a cease and desist order; or

(C) suspend or revoke the health care collaborative's certificate of authority.

(b) This section does not limit any other authority or power of the attorney general.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 4.01, eff. September 28, 2011.

SUBTITLE D. CASUALTY COMPANIES

CHAPTER 861. GENERAL CASUALTY COMPANIES

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 861.001. DEFINITIONS. In this chapter:

(1) "General casualty company" means an accident or casualty insurance company organized or engaging in the business of insurance under this chapter.

(2) "Incorporators" means those persons who associate by written articles of incorporation to organize a general casualty company.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER B. FORMATION AND STRUCTURE OF GENERAL CASUALTY COMPANY

Sec. 861.051. FORMATION OF COMPANY AUTHORIZED. Three or more persons, a majority of whom are residents of this state, may form a general casualty company in accordance with this chapter to write insurance described by Subchapter E.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 861.052. ARTICLES OF INCORPORATION; FILING AND RECORDING REQUIREMENT. (a) The articles of incorporation for a general casualty company must specify:

- (1) the general purpose of the company; and
- (2) the proposed duration of the company.

(b) The incorporators shall file with the department:

- (1) articles of incorporation for the general casualty company;
- (2) a charter fee in the amount determined under Chapter 202; and
- (3) an affidavit, made by two or more of the incorporators, that all of the general casualty company's stock is subscribed in good faith and fully paid for.

(c) On receipt of a filing under Subsection (b), the department shall record the articles of incorporation in records maintained for that purpose.

(d) On receipt of a fee in the amount determined under Chapter 202, the department shall provide the incorporators with a certified copy of the articles of incorporation.

(e) On receipt of a certified copy of the articles of incorporation, the general casualty company is a body politic and corporate, and the incorporators may complete organization of the company in accordance with Section 861.055.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.060, eff. April 1, 2009.

Sec. 861.053. PRELIMINARY OFFICERS AND DIRECTORS. The incorporators shall choose from among themselves a president, a secretary, a treasurer, and at least three directors who continue in office until:

- (1) the first anniversary of the date the articles of incorporation are filed; and
- (2) their successors are chosen and qualify.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 861.054. SUBSCRIPTION OF STOCK. The incorporators shall:

(1) open books for the subscription of stock in the general casualty company at the times and places the incorporators consider convenient and proper; and

(2) keep the books open until the full amount specified in the articles of incorporation is subscribed.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 861.055. ORGANIZATIONAL MEETING. (a) After receiving a certified copy of the articles of incorporation under Section 861.052, a general casualty company shall promptly call a meeting of the company's shareholders.

(b) At the meeting the shareholders shall:

(1) adopt bylaws to govern the company; and

(2) elect a board of directors composed of shareholders of the company.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER C. AUTHORITY TO ENGAGE IN BUSINESS

Sec. 861.101. CERTIFICATE OF AUTHORITY REQUIRED. A general casualty company may not engage in the business of insurance in this state without a certificate of authority issued under this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 861.102. ISSUANCE OF CERTIFICATE OF AUTHORITY. (a) The department shall issue a certificate of authority to a general casualty company authorizing the company to engage in the business of insurance under this chapter if:

(1) the company meets the requirements of this chapter;

and

(2) the commissioner has granted a charter to the company in the manner provided by Sections 822.051, 822.052, 822.053, 822.054, 822.057, 822.058, 822.059, 822.060, and 822.210.

(b) A certificate of authority is evidence of a general casualty company's authorization to engage in the business of insurance under this chapter and of the company's solvency and credits.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER D. POWERS AND DUTIES OF GENERAL CASUALTY COMPANY

Sec. 861.151. AUTHORITY OF BOARD OF DIRECTORS. Subject to the bylaws of the company as adopted or amended by the shareholders or directors, the board of directors of a general casualty company has full control and management of the company.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 861.152. GENERAL POWERS OF COMPANY. A general casualty company may:

- (1) sue or be sued in the name of the company;
- (2) make or enforce contracts in relation to the business of the company;
- (3) have and use a common seal;
- (4) in its own name, or through a trustee chosen by the board of directors, acquire, purchase, hold, and dispose of real and personal property to further the purposes of the company; and
- (5) through its board of directors, trustees, or managers, adopt and amend bylaws that include provisions establishing the qualifications, duties, and terms of office of and the manner of electing directors, trustees, or managers and officers of the company.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 861.153. AUTHORIZED SHARES. (a) A general casualty company may increase or decrease its capital stock after:

- (1) the intent to increase the stock is ratified by a two-thirds vote of the shareholders or the intent to decrease the stock is ratified by a majority vote of the shareholders; and
- (2) notice of the intent to increase or decrease the stock

is published in a newspaper of general circulation for five consecutive days.

(b) An increase in capital stock must be equal to an amount of at least \$50,000.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 861.154. DIVIDENDS. Except as authorized by Sections 403.001 and 403.051, the directors of a general casualty company may not issue dividends.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.061, eff. April 1, 2009.

Sec. 861.155. INTERFERENCE WITH CONDUCT OF BUSINESS PROHIBITED; EXCEPTIONS. A person, including the department and the commissioner, may not restrain or interfere with the conduct of business of a general casualty company, except in:

- (1) a revocation of the company's certificate of authority and appointment of a receiver under Section 861.701;
- (2) an action by a judgment creditor; or
- (3) a proceeding supplementary to execution.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER E. INSURANCE COVERAGE PROVIDED BY GENERAL CASUALTY COMPANIES

Sec. 861.201. KINDS OF INSURANCE AUTHORIZED. (a) A general casualty company may:

- (1) insure a person against:
 - (A) bodily injury, disability, or death that results from an accident; or
 - (B) disability that results from disease;
- (2) insure against loss or damage that results from an accident or injury sustained by an employee or other person, for which accident or injury the insured is liable;

(3) insure against loss or damage that results from an accident to or injury sustained by a person, for which loss the insured is liable, other than employers liability insurance under Subdivision (2);

(4) insure against loss or damage by burglary, theft, or housebreaking;

(5) insure glass against breakage;

(6) insure a steam boiler, elevator, electrical device, or engine and any machinery or appliance used or operated in connection with a steam boiler, elevator, electrical device, or engine;

(7) insure against loss or damage from injury to a person or property that results accidentally from an item described by Subdivision (6);

(8) insure against loss or damage by water to goods or premises that arises from the breakage or leakage of a sprinkler or water pipe;

(9) insure against loss that:

(A) results from accidental damage to an automobile;

or

(B) is caused accidentally by an automobile;

(10) insure a person, association, or corporation against loss or damage that results from giving or extending credit;

(11) insure against loss that results from the nonpayment of the principal of or interest on a bond, mortgage, or other evidence of indebtedness;

(12) write marine insurance, which may include insurance against the hazards and perils incident to war; or

(13) insure against any other casualty or insurance risk, other than fire or life insurance, specified in the company's articles of incorporation that:

(A) may be lawfully made the subject of insurance; and

(B) is not otherwise provided for by this chapter.

(b) A general casualty company may engage in one or more of the activities specified by Subsection (a).

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER F. REGULATION OF GENERAL CASUALTY COMPANY

Sec. 861.251. MINIMUM CAPITAL AND SURPLUS. (a) A general

casualty company must have at least the minimum capital and surplus applicable to casualty, fidelity, guaranty, surety, and trust companies under Sections 822.054, 822.210, and 822.211. At the time of incorporation, the required capital and surplus must be in cash.

(b) After incorporation and issuance of a certificate of authority, a general casualty company shall invest the minimum capital and surplus as provided by Section 822.204. The company shall invest all other funds of the company in excess of the minimum capital and surplus as provided by:

(1) a provision of Subchapter B, Chapter 424, other than Section 424.052, 424.072, or 424.073; and

(2) Section 862.002.

(c) A general casualty company may not loan any part of the company's capital or paid in surplus to an officer of the company.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.062, eff. April 1, 2009.

Sec. 861.252. SECURITY DEPOSIT. (a) Repealed by Acts 2013, 83rd Leg., R.S., Ch. 447, Sec. 2, eff. June 14, 2013.

(b) If, as a prerequisite to engaging in the business of insurance in another state, country, or province, a general casualty company is required to deposit with the appropriate officer of that state, country, or province, or with the comptroller, securities or cash, the company may deposit with the comptroller any authorized securities or cash sufficient to meet the requirement. The comptroller shall receive and hold the deposit exclusively for the protection of policyholders of the company.

(c) A general casualty company may withdraw a deposit made under Subsection (b) if the company files with the department satisfactory evidence, as determined by the commissioner, that the company:

(1) has withdrawn from business in the other state, country, or province; and

(2) has no unsecured liabilities outstanding in the other state, country, or province.

(d) A general casualty company may change the company's

securities on deposit with the comptroller by withdrawing those securities and substituting an equal amount of other securities consisting only of:

- (1) United States currency;
- (2) bonds of any state;
- (3) bonds or other evidences of indebtedness of the United States the principal and interest of which are guaranteed by the United States;
- (4) bonds or other interest-bearing evidences of indebtedness of a county or municipality of any state;
- (5) notes secured by first mortgages:
 - (A) on otherwise unencumbered real property in this state the title to which is valid; and
 - (B) the payment of which is insured wholly or partly by the United States; or
- (6) another form of security acceptable to the commissioner.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.063, eff. April 1, 2009.

Acts 2013, 83rd Leg., R.S., Ch. 447 (S.B. 801), Sec. 1, eff. June 14, 2013.

Acts 2013, 83rd Leg., R.S., Ch. 447 (S.B. 801), Sec. 2, eff. June 14, 2013.

Sec. 861.253. INTEREST ON SECURITY DEPOSITS. (a) A general casualty company with securities on deposit under this chapter is entitled to collect the interest on the deposits as the interest becomes due. The comptroller shall deliver to the company the coupons or other evidence of interest pertaining to the deposits.

(b) The comptroller shall collect a general casualty company's interest described by Subsection (a) as the interest becomes due and hold that interest as additional security if:

- (1) the company fails to deposit additional security as required by the commissioner; or
- (2) proceedings are pending to wind up or enjoin the company.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 861.254. ANNUAL STATEMENT; FILING FEE. (a) The president, vice president, and secretary of a general casualty company, or a majority of the directors or trustees of the company, shall, not later than the 60th day after January 1 of each year, deliver to the department a verified statement of the condition of the company as of December 31 of the preceding year.

(b) The statement must include:

- (1) the name and location of the company;
- (2) the names of the company's officers;
- (3) the amount of the company's capital stock;
- (4) the amount of the company's capital stock paid in;
- (5) the assets of the company;
- (6) the liabilities of the company;
- (7) the income of the company during the year;
- (8) the expenditures of the company during the year;
- (9) the amount paid by the company in fees during the year;
- (10) the amount paid by the company for losses during the year; and
- (11) the total amount of insurance issued by the company and in force.

(c) A general casualty company's assets under Subsection (b)(5) consist of:

- (1) the value of real property owned by the company;
- (2) the amount of cash on hand;
- (3) the amount of cash deposited with a bank or trust company;
- (4) the names, amounts, and par and market values of United States bonds and all other bonds;
- (5) the amount of loans secured by first mortgage on real estate;
- (6) the amount of all other bonds and loans and how secured, with rate of interest;
- (7) the amount of notes given for unpaid stock and how secured;
- (8) the amount of interest due and unpaid;
- (9) if the total value of the equipment exceeds \$2,000, the value of all electronic machines that comprise a data processing

system and of all other office equipment, furniture, machines, and labor-saving devices purchased for and used in connection with the business of an insurance company to the extent that the total actual cash market value of those assets is less than five percent of the other admitted assets of the company; and

(10) all other credits or assets.

(d) A general casualty company's liabilities under Subsection (b)(6) consist of:

- (1) the amount of losses due and unpaid;
- (2) the amount of claims for losses unadjusted; and
- (3) the amount of claims for losses resisted.

(e) A general casualty company's income under Subsection (b)(7) consists of:

- (1) the amount of fees received;
- (2) the amount of interest received from all sources; and
- (3) the amount of receipts from all other sources.

(f) A general casualty company's expenditures under Subsection (b)(8) consist of:

- (1) the amount paid for losses;
- (2) the amount of dividends paid to shareholders;
- (3) the amount of commissions and salaries paid to agents;
- (4) the amount paid to officers for salaries;
- (5) the amount paid for taxes; and
- (6) the amount of all other payments or expenditures.

(g) The commissioner may amend the form of the annual statement and require additional information as considered necessary to determine the standing of a general casualty company.

(h) Except as provided by Chapter 202, the department shall charge a fee of \$20 for filing the annual statement required by this section. The comptroller shall collect the fee.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 2E.064, eff. April 1, 2009.

Sec. 861.255. RULES REGARDING CERTAIN ASSETS. (a) The value of the electronic machines and systems, office equipment, furniture, other machines, and labor-saving devices specified in Section

861.254(c)(9), as determined under this section and in accordance with rules adopted by the commissioner, is an admitted asset of the company.

(b) The commissioner may adopt rules defining electronic machines and systems, office equipment, furniture, other machines, and labor-saving devices as specified in Section 861.254(c)(9) and stating the maximum period for which each class of equipment may be amortized.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 861.256. FAILURE TO MAKE DEPOSIT OR DELIVER ANNUAL STATEMENT. (a) If a general casualty company fails to make a deposit under Section 861.252 or to deliver an annual statement under Section 861.254 in a timely manner, the department shall notify the company that the company may not issue new insurance until the deposit is made or the statement is delivered to the department.

(b) A general casualty company may not issue an insurance policy in violation of this section.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 861.257. EXAMINATION OF COMPANY. A general casualty company is subject to:

- (1) Subchapter A, Chapter 86; and
- (2) Sections 401.051, 401.052, 401.054-401.062, 401.151, 401.152, 401.155, and 401.156.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 2E.065, eff. April 1, 2009.

Sec. 861.258. REAL PROPERTY. (a) A general casualty company is subject to Section 862.002 and may not purchase, hold, or convey real property except as authorized by that section.

(b) A general casualty company shall sell real property acquired in compliance with Subsection (a) not later than the 10th

anniversary of the date the real property was acquired.

(c) A general casualty company may retain real property after the date specified by Subsection (b) if the commissioner issues a certificate stating:

(1) that sale of the real property in compliance with Subsection (b) would cause the company to incur a material loss; and
 (2) a later date by which the real property must be sold.

(d) Subsection (b) does not apply to:

(1) real property occupied by buildings used in whole or in part by a general casualty company in the transaction of business;
 (2) an interest in minerals or royalty reserved on the sale of real property acquired under Sections 862.002(c)(1)-(3); and
 (3) investment real property acquired under Section 424.064.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
 Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.066, eff. April 1, 2009.

SUBCHAPTER O. DISCIPLINARY PROCEDURES AND PENALTY

Sec. 861.701. REVOCATION OF CERTIFICATE. (a) If, as a result of an examination under Section 861.257, the commissioner determines that a general casualty company has not complied with this chapter, the commissioner shall:

(1) revoke the company's certificate of authority; and
 (2) notify the attorney general of the revocation.

(b) On receipt of notification under Subsection (a)(2), the attorney general shall request court appointment of a receiver for the general casualty company. Under the direction of the court, the receiver shall wind up the affairs of the company.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 861.702. PENALTY. A general casualty company that violates Section 861.101 is subject to a penalty of \$100 for each day the company writes new business in this state without the certificate of authority required by that section.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 861.703. COLLECTION OF PENALTY. (a) The attorney general or a district or county attorney under the direction of the attorney general may file an action in the name of the state to collect a penalty under this chapter.

(b) An action filed under this section must be filed in Travis County or in the county in which the general casualty company's principal office is located.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

CHAPTER 862. FIRE AND MARINE INSURANCE COMPANIES

SUBCHAPTER A. REGULATION OF FIRE AND MARINE INSURANCE COMPANIES

Sec. 862.001. ANNUAL STATEMENT. (a) Each year the president or vice president and the secretary of a fire, marine, or inland marine insurance company shall:

(1) prepare under oath a complete and accurate statement of the condition of the company as of December 31 of the preceding year; and

(2) file the statement with the department before the 62nd day of the year in which it is prepared.

(b) The annual statement must show:

- (1) the name and location of the company;
- (2) the names and residences of the company's officers;
- (3) the amount of the capital stock of the company;
- (4) the amount of capital stock paid up;
- (5) the property and assets held by the company,

specifying:

(A) the location, description, and value, as near as may be, of real property owned by the company and, if the company is organized under the laws of this state, the annual statement must include an abstract of the title to that real property;

(B) the amount of cash on hand and on deposit in banks to the credit of the company and the names of those banks;

(C) the amount of cash held by agents of the company and the names of those agents;

(D) the amount of cash in the course of transmission;

(E) the amount of loans secured by a first mortgage on real property, the rate of interest on each loan, the location and value of each property, and the name of each mortgagor;

(F) the amount of all other bonds and loans, the rate of interest on each bond or loan, and a description of the security given for each bond or loan;

(G) the amount due the company from judgments that have been obtained and a description of each judgment;

(H) the amount of all stock owned by the company, including a description of the stock, the amount and number of shares, and the par and market values of each kind of stock;

(I) the amount of stock held by the company as collateral security for loans, including the amount loaned on the stock and the par and market values of the stock;

(J) the amount of interest due and unpaid to the company;

(K) a description and value of all other securities;
and

(L) if the total value of the equipment exceeds \$2,000, the value of all electronic machines that comprise a data processing system or systems and of all other office equipment, furniture, machines, and labor-saving devices purchased for and used in connection with the business of the insurance company to the extent that the total actual cash market value of those assets is less than five percent of the other admitted assets shown on the statement;

(6) the liabilities of the company, specifying:

(A) losses adjusted and due;

(B) losses adjusted and not due;

(C) losses unadjusted;

(D) losses in suspense and the cause for suspension;

(E) losses resisted and in litigation;

(F) dividends, in scrip or cash, specifying the amount of each declared but not due;

(G) dividends declared and due;

(H) the amount required by law as reserve on all unexpired risks, computed as required by this code;

(I) the amount due banks or other creditors, the name of each bank or creditor, and the amount due each bank or creditor;

(J) the amount of money borrowed by the company, the name of each lender, a description of the security given for each

loan, and the rate of any interest; and

(K) all other claims against the company and a description of each claim;

(7) the income of the company during the preceding year, specifying:

(A) separately the amount received, after deducting reinsurance, as fire, marine, and inland marine transportation premiums;

(B) the amount received as interest; and

(C) the amount received from all other sources;

(8) the expenditures of the company during the preceding year, specifying:

(A) the amount of losses paid, showing losses that accrued before and that accrued after the date of the preceding statement, and the amount at which losses were estimated in that statement;

(B) the amount paid as dividends;

(C) the amount paid for return premiums, commissions, salaries, expenses, and other charges of officers, agents, and employees;

(D) the amount paid for federal, state, and local taxes and duties; and

(E) the amount paid for all other expenses;

(9) the largest amount insured by the company in a single risk, naming that risk;

(10) the amount of risks written during the preceding year;

(11) the amount of risks in force that have less than one year to run;

(12) the amount of risks in force that have more than one year but less than three years to run;

(13) the amount of risks that have more than three years to run; and

(14) a statement of whether dividends are declared on premiums received for risks not terminated.

(c) The commissioner may adopt rules defining electronic machines and systems, office equipment, furniture, machines, and labor-saving devices as specified in Subsection (b)(5)(L) and stating the maximum period for which each class of equipment may be amortized.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 862.002. PROHIBITIONS RELATING TO HOLDING REAL PROPERTY; EXCEPTIONS. (a) A fire, marine, or inland marine insurance company may not purchase, hold, or convey real property, except as provided by Subsections (b) and (c).

(b) The company may erect and maintain buildings ample and adequate for the transaction of the company's business.

(c) Subsection (a) does not apply to:

(1) real property mortgaged to the company in good faith as security for a loan previously contracted or for money due;

(2) real property conveyed to the company in satisfaction of a debt previously contracted in the legitimate business of the company or for money due;

(3) real property purchased under a judgment, decree, or mortgage obtained or made for a debt under Subdivision (2); or

(4) a mineral or royalty interest reserved on the sale of real property acquired under Subdivision (1), (2), or (3) before January 1, 1942.

(d) A fire, marine, or inland marine insurance company may not invest more than 33-1/3 percent of the company's admitted assets in real property. A fire, marine, or inland marine insurance company may not invest any of its capital or minimum surplus in real property, other than real property described by Subsection (c).

(e) Section 861.258 applies to real property acquired under Subsection (c)(1), (2), or (3).

(f) The commissioner shall appoint at least two competent and disinterested residents of this state to appraise real property described by Subsection (b) when the property is acquired or when the company applies for amendment to its charter. The company shall pay to the commissioner the reasonable cost of the appraisal.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 862.003. ADMITTED ASSETS. The value of the property of the company shown on the report as determined under Section 862.001 and the rules adopted by the commissioner adopted under that section is considered to be an admitted asset of the company for all

purposes.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

**SUBCHAPTER B. INSURANCE COVERAGE PROVIDED BY FIRE AND MARINE
INSURANCE COMPANIES**

Sec. 862.051. KINDS OF INSURANCE AUTHORIZED. On filing notice of its intent with the department, an insurance company engaged in the business of insurance in this state under an appropriate certificate of authority may:

(1) insure houses, buildings, and other property against loss or damage by fire;

(2) insure goods, merchandise, and other property in the course of transportation by land or water, or vessels afloat, regardless of their location;

(3) insure motor vehicles, whether stationary or being operated under the motor vehicle's own power, against loss or damage by fire, lightning, windstorm, hail storm, tornado, cyclone, explosion, transportation by land or water, theft, and collision;

(4) lend money on bottomry or respondentia;

(5) obtain insurance against:

(A) any loss or risk the company has incurred in the course of its business; and

(B) any loss or risk on an interest that the company has in property because of a loan it has made on bottomry or respondentia; and

(6) take any action proper to promote an activity described by this section.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 862.052. PROHIBITIONS RELATING TO LIFE INSURANCE AND LIFE INSURANCE COMPANIES. (a) An insurance company authorized by its charter to write fire, marine, lightning, tornado, or inland marine insurance in this state may not write life insurance.

(b) An insurance company authorized to write life insurance in this state may not write fire, marine, or inland marine insurance or any other insurance described by Section 862.051.

(c) The commissioner shall enforce this section.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 862.053. FIRE INSURANCE: TOTAL LOSS OF REAL PROPERTY.

(a) A fire insurance policy, in case of a total loss by fire of property insured, shall be held and considered to be a liquidated demand against the company for the full amount of such policy. This subsection does not apply to personal property.

(b) An insurance company shall incorporate verbatim the provisions of Subsection (a) in each fire insurance policy issued as coverage on real property in this state.

(c) The commissioner shall require compliance with this section.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.220, eff. Sept. 1, 2003.

Sec. 862.054. FIRE INSURANCE: BREACH BY INSURED; PERSONAL PROPERTY COVERAGE. Unless the breach or violation contributed to cause the destruction of the property, a breach or violation by the insured of a warranty, condition, or provision of a fire insurance policy or contract of insurance on personal property, or of an application for the policy or contract:

- (1) does not render the policy or contract void; and
- (2) is not a defense to a suit for loss.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 862.055. FIRE INSURANCE: INTEREST OF MORTGAGEE OR TRUSTEE. (a) The interest of a mortgagee or trustee under a fire insurance contract covering property located in this state may not be invalidated by:

- (1) an act or neglect of the mortgagor or owner of the property; or
- (2) the occurrence of a condition beyond the mortgagor's or owner's control.

(b) A provision of a contract that conflicts with Subsection (a) is void.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER C. REINSURANCE AND RESERVES

Sec. 862.101. FIRE AND ALLIED LINES OF INSURANCE: AUTHORIZED AND REQUIRED REINSURANCE. (a) In this section, "fire and allied lines of insurance" has the meaning assigned by statute, rules adopted by the commissioner, or lawful custom.

(b) An insurance or reinsurance company that is authorized to write or reinsure fire and allied lines of insurance in this state may reinsure all or any part of a single risk in one or more other solvent insurers.

(c) An insurance company that is incorporated under the laws of the United States or a state of the United States and authorized to write fire and allied lines of insurance in this state may not, unless the excess is reinsured by the company in another solvent insurer, expose itself to any loss or hazard on a single risk in an amount that exceeds 10 percent of the company's paid-up capital stock and surplus.

(d) An insurance company that is incorporated under the laws of a jurisdiction other than the United States or a state of the United States and authorized to write fire and allied lines of insurance in this state may not, unless the excess is reinsured by the company in another solvent insurer, expose itself to any loss or hazard on a single risk in an amount that exceeds the sum of:

(1) 10 percent of the company's deposit with the statutory officer in the state through which the company is authorized to do business in the United States; and

(2) 10 percent of the other policyholders' surplus of the company's United States branch.

(e) Subsections (c) and (d) do not apply in connection with the writing of insurance for cotton in bales or for grain.

(f) Reinsurance that is required or permitted by this section must comply with:

(1) Subchapter A, Chapter 491; and

(2) Chapter 493.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 2E.067,

eff. April 1, 2009.

Acts 2017, 85th Leg., R.S., Ch. 594 (S.B. 1070), Sec. 3.09, eff. September 1, 2017.

Sec. 862.102. REINSURANCE OR RESERVES REQUIRED FOR FIRE INSURANCE. (a) An insurance company writing fire insurance in this state shall maintain reinsurance or unearned premium reserves on its policies in force.

(b) The commissioner may require that reserves required by Subsection (a) equal the unearned portions of the gross premiums in force after deducting reinsurance under Section 862.101, as computed on each respective risk from the policy's date of issue.

(c) If the commissioner does not impose a requirement under Subsection (b), the portions of the gross premium in force held as reinsurance or unearned premium reserves after deducting reinsurance under Section 862.101 shall be computed as follows:

<u>Term for Which Policy</u> <u>Was Written</u>	<u>Reserve for</u> <u>Unearned Premium</u>
1 year or less	1/2
2 years	1st year 3/4 2nd year 1/4
3 years	1st year 5/6 2nd year 1/2 3rd year 1/6
4 years	1st year 7/8 2nd year 5/8 3rd year 3/8 4th year 1/8
5 years	1st year 9/10 2nd year 7/10 3rd year 1/2 4th year 3/10 5th year 1/10
More than 5 years	pro rata

(d) Notwithstanding Subsection (c), an insurance company may compute, or the commissioner may require an insurance company to compute, the reserves on a quarterly, monthly, or more frequent pro rata basis.

(e) An insurance company that adopts a method for computing the reserve may not adopt another method without commissioner approval.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 862.103. REINSURANCE OR RESERVES REQUIRED FOR HOME WARRANTY INSURANCE COMPANIES. (a) An insurance company writing home warranty insurance in this state shall maintain reinsurance or unearned premium reserves on its policies in force.

(b) Reserves required by Subsection (a) shall be computed in the same manner and to the same extent as is fire insurance under Section 862.102.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 862.104. RESERVES REQUIRED FOR OCEAN AND INLAND MARINE TRIP INSURANCE COMPANIES. The total of the premiums on ocean and inland marine trip insurance risks not terminated is considered to be unearned, and the insurance company shall maintain a reserve equal to the total of the premiums for those policies.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER D. IMPAIRMENT OF SURPLUS

Sec. 862.151. REDUCTION OF CAPITAL STOCK AND PAR VALUE OF SHARES. (a) If the minimum surplus of a fire, marine, or inland marine insurance company is impaired in excess of the amount permitted under Subchapter B, Chapter 404, the commissioner may allow the company to amend its charter as provided by Sections 822.157 and 822.158 to reduce the amount of the company's capital stock and the par value of its shares in proportion to the extent of the permitted amount of impairment.

(b) A company acting under Subsection (a):

(1) may not reduce the par value of its shares below the sum computed under Section 822.055;

(2) may not deduct from the assets and property on hand more than \$125,000;

(3) shall retain the remainder of the assets and property

on hand as surplus assets;

(4) may not distribute any of the assets or property to the shareholders; and

(5) may not reduce the capital stock or surplus of the company to an amount less than the minimum capital and the minimum surplus required by Sections 822.202, 822.210, and 822.211, subject to Subchapter B, Chapter 404.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.068, eff. April 1, 2009.

Sec. 862.152. MAKING GOOD ON IMPAIRMENT. (a) This section applies to a fire, marine, or inland marine insurance company that receives notice from the commissioner under Subchapter B, Chapter 404, to make good within 60 days:

- (1) any impairment of the company's required capital; or
- (2) the company's surplus.

(b) The company shall promptly call on its shareholders for an amount necessary to make the company's capital and surplus equal to the amount required by Sections 822.054 and 822.210, subject to Subchapter B, Chapter 404.

(c) The shareholders of the company shall be informed of a call under Subsection (b):

- (1) by personal notice; or
- (2) by advertisement for the time and in the manner approved by the commissioner.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.069, eff. April 1, 2009.

Sec. 862.153. FAILURE OF SHAREHOLDER TO PAY. (a) If a shareholder of the insurance company who is given notice under Section 862.152 does not pay the amount called for by the company under that section, the company may:

- (1) require the return of the original certificate of stock

held by the shareholder; and

(2) issue a new certificate for a number of shares that the shareholder may be entitled to in the proportion that the value of the funds of the company, computed without inclusion of any money or other property paid by shareholders in response to the notice under Section 862.152, bears to the total amount of the original capital and the minimum surplus of the company required by Section 822.054 or 822.210, subject to Subchapter B, Chapter 404.

(b) The value of any shares for which new certificates are issued under Subsection (a)(2) shall be computed under the direction of the commissioner. The insurance company shall pay for the fractional parts of shares.

(c) Any interested person may pay all or any part of the amount of the deficit resulting from a shareholder default under Subsection (a). The company shall issue to each person who makes a payment a stock certificate that is representative of the number of shares to which the person is entitled. The certificate must be for the number of shares in proportion to the total number of forfeited shares that the payment made by the person bears to the deficit that resulted from the forfeited shares.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.070, eff. April 1, 2009.

Sec. 862.154. CREATION AND DISPOSAL OF NEW STOCK. (a) A fire, marine, or inland marine insurance company that complies with Sections 822.155, 822.157, and 822.158 may:

- (1) create new stock;
- (2) dispose of the new stock according to applicable law;

and

- (3) issue new certificates for the new stock.

(b) The insurance company shall sell any new stock created under Subsection (a) for an amount sufficient to make up any impairment of the company's required minimum capital and to make up the surplus of the company as required by Section 822.054 or 822.210, subject to Subchapter B, Chapter 404, but may not impair the capital of the company.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.071,
eff. April 1, 2009.

SUBTITLE E. MUTUAL AND FRATERNAL COMPANIES AND RELATED ENTITIES
CHAPTER 881. STATEWIDE MUTUAL ASSESSMENT COMPANIES
SUBCHAPTER A. GENERAL PROVISIONS

Sec. 881.001. DEFINITION. In this chapter, "statewide mutual assessment company" means a corporation engaged in the statewide business of mutually protecting or insuring members' lives with money provided by assessments on those members.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 881.002. LIMITED EXEMPTION FROM INSURANCE LAWS. (a) Except as provided by this chapter and Chapter 887, the insurance laws of this state do not apply to a statewide mutual assessment company.

(b) A law enacted after June 20, 1933, does not apply to statewide mutual assessment companies unless statewide mutual assessment companies are expressly designated in the law.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 881.003. COMPLIANCE WITH INSURANCE LAWS. An individual, firm, unincorporated association, or corporation may not engage in business as a statewide mutual assessment company in this state unless the entity complies with this chapter and Chapter 887.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 881.004. EXEMPTION FROM CHAPTER. This chapter applies only to a statewide mutual assessment company. This chapter does not apply to a company operating as a local mutual aid association, fraternal benefit society, or reciprocal exchange or to a foreign assessment company operating under any other law in this state.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 881.005. ORGANIZATION OF NEW COMPANY PROHIBITED. A new statewide mutual assessment company may not be organized under this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 881.006. ANNUAL STATEMENT. (a) For the filing of each annual statement, the department shall charge the appropriate fee. The fee must be deposited in the Texas Department of Insurance operating account.

(b) Sections 201.001 and 201.002 apply to the fee.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.072, eff. April 1, 2009.

SUBCHAPTER B. STRUCTURE AND OPERATION OF STATEWIDE MUTUAL ASSESSMENT COMPANIES

Sec. 881.051. AUTHORITY TO ACT AS STATEWIDE MUTUAL ASSESSMENT COMPANY. A corporation may engage in business as a statewide mutual assessment company only if the corporation:

- (1) was incorporated in this state under a law that was amended, repealed, or reenacted before June 20, 1933;
- (2) was engaged in business as a statewide mutual assessment company in this state on December 31, 1932;
- (3) does not have capital stock; and
- (4) is not for profit.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 881.052. APPLICABILITY OF TEXAS NON-PROFIT CORPORATION ACT. (a) Except to the extent of any conflict with this code, the Texas Non-Profit Corporation Act (Article 1396-1.01 et seq., Vernon's Texas Civil Statutes) applies to a statewide mutual assessment

company. The commissioner has each power and duty of, and shall perform each act to be performed by, the secretary of state under that Act with respect to statewide mutual assessment companies.

(b) On advance approval of the commissioner, a statewide mutual assessment company may pay dividends to its members.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 881.053. SEPARATE GROUPS, CLUBS, OR CLASSES. A statewide mutual assessment company may provide in its by-laws for the creation of separate groups, clubs, or classes based on reasonable classifications specified in the by-laws.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 881.054. MINIMUM MEMBERSHIP REQUIRED. A statewide mutual assessment company may not issue a certificate or policy unless the membership of the company or the group, class, or club of the company that is liable for assessments on the certificate or policy is sufficient in number at the assessment rate charged the company, group, class, or club to pay 50 percent of the maximum benefit in the certificate or policy.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 881.055. USE OF COMPANY NAME. A statewide mutual assessment company may not operate an independent branch office or a separate group, club, or class under a name different from the name of the company.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 881.056. ISSUANCE OF CERTIFICATE OR POLICY TO SEPARATE GROUPS, CLUBS, OR CLASSES. (a) A certificate or policy issued by the company to members of a group, club, or class may limit benefits under the certificate or policy to the assessments made, levied, and collected from the group, club, or class.

(b) The assets or benefits of a group, club, or class may not be pledged or transferred without the consent of at least three-fourths of the members of the group, club, or class.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 881.057. INSUFFICIENT MEMBERSHIP: CONSOLIDATION OR DISCONTINUATION OF GROUP, CLUB, OR CLASS OR LIQUIDATION OF COMPANY.

(a) If membership of a group, club, or class of a statewide mutual assessment company is less than the number required by Section 881.054, the company shall immediately notify:

- (1) the members of the group, club, or class; or
- (2) if the company has only one group, club, or class, the members of the company.

(b) Not later than six months after a statewide mutual assessment company notifies the members of a group, club, or class under Subsection (a)(1), the company shall:

- (1) increase the membership of the group, club, or class to at least the number required by Section 881.054;
- (2) consolidate the group, club, or class with another group, club, or class; or
- (3) discontinue the group, club, or class.

(c) Not later than six months after a statewide mutual assessment company notifies the members of the company under Subsection (a)(2), the company shall increase the membership to at least the number required by Section 881.054. If the membership is not increased to at least that number, the commissioner shall take steps to liquidate the company under Subchapter L, Chapter 887.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 881.058. AGENT. (a) A person who solicits an application for a certificate or policy providing insurance on the life of another is considered to be an agent of the statewide mutual assessment company that issues the certificate or policy in a controversy between the company and the insured or the insured's beneficiary.

(b) An agent described by Subsection (a) may not waive or alter the terms of an application, certificate, or policy.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER C. BENEFITS PROVIDED BY STATEWIDE MUTUAL ASSESSMENT COMPANIES

Sec. 881.101. TYPES OF CERTIFICATES OR POLICIES AUTHORIZED.

(a) A statewide mutual assessment company may issue only a certificate or policy that provides for the continuous payment of premiums or assessments during the policyholder's life.

(b) A statewide mutual assessment company may not:

(1) issue a certificate or policy on a limited payment plan; or

(2) promise to pay an endowment or annuity benefit.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 881.102. MAXIMUM BENEFIT UNDER CERTIFICATE OR POLICY. A statewide mutual assessment company may not issue a certificate or policy that provides a benefit that exceeds \$5,000.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 881.103. LOCATION OF ISSUANCE OF CERTIFICATES OR POLICIES.

A statewide mutual assessment company may issue certificates or policies only in the home office of the company.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 881.104. CERTIFICATE OR POLICY AND APPLICATION;

REPRESENTATIONS IN APPLICATION. (a) An application for a certificate or policy may not be used as a defense against a claim or loss under the certificate or policy unless a copy of the application is attached to the certificate or policy.

(b) A misrepresentation in an application for a certificate or policy may not be used as a defense against a claim or loss under the certificate or policy unless it is shown that the misrepresentation is material to the risk assumed.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER O. ENFORCEMENT; CRIMINAL PENALTY

Sec. 881.701. GENERAL CRIMINAL PENALTY. (a) A person commits an offense if:

(1) the person violates this chapter; or

(2) the person:

(A) is a corporation or a responsible officer of a corporation; and

(B) permits or participates in a violation of this chapter by a corporation.

(b) An offense under this section is a misdemeanor punishable by a fine not to exceed \$500.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 881.702. ENFORCEMENT BY ATTORNEY GENERAL. (a) The attorney general may enforce the penalty provided under Section 881.701 and Section 887.705 against a corporation or unincorporated association.

(b) Notwithstanding Section 887.209, venue of a prosecution under this section may be in Travis County.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

CHAPTER 882. MUTUAL LIFE INSURANCE COMPANIES

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 882.001. APPLICABILITY OF THIS CHAPTER AND OTHER LAW. Except to the extent of any conflict with this chapter, a law governing a company organized under Chapter 841 applies to a mutual life insurance company organized under this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 882.002. EXAMINATION OF COMPANY. The following provisions apply to a mutual life insurance company organized under this chapter:

- (1) Subchapter A, Chapter 86; and
- (2) Sections 401.051, 401.052, 401.054-401.062, 401.151, 401.152, 401.155, and 401.156.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.073, eff. April 1, 2009.

Sec. 882.003. ANNUAL STATEMENT. A mutual life insurance company shall file an annual statement with the department.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER B. FORMATION AND STRUCTURE OF MUTUAL LIFE INSURANCE COMPANY

Sec. 882.051. AUTHORITY TO FORM COMPANY; PURPOSE. A mutual life insurance company may be formed under this chapter to insure the lives of individuals on the mutual level premium and legal reserve plan.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 882.052. FORMATION OF COMPANY; ARTICLES OF INCORPORATION.
(a) Nine or more persons who are residents of this state may form a mutual life insurance company by executing and acknowledging articles of incorporation for that purpose.

(b) The articles of incorporation of the proposed company must state:

- (1) the name and residence of each incorporator;
- (2) the name of the company;
- (3) the location of the company's principal office at which company business is to be transacted;
- (4) the number of directors;
- (5) the name and residence of each initial director; and
- (6) the amount of the company's unencumbered surplus.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 882.053. COMPANY'S NAME. (a) The name of a mutual life insurance company must contain the words "Mutual Life Insurance Company."

(b) A mutual life insurance company's name may not be so similar to the name of another insurance company as to likely mislead the public.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 882.054. INITIAL BOARD OF DIRECTORS; TERM. An initial director named as provided in Section 882.052 serves until:

- (1) the first annual election of directors;
- (2) the initial director's successor qualifies for office;

or

(3) the initial director is removed from the board for improper practices.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 882.055. UNENCUMBERED SURPLUS REQUIREMENTS. A mutual life insurance company must possess at the time of incorporation unencumbered surplus in an amount of at least \$200,000. The unencumbered surplus may consist only of:

- (1) United States currency;
- (2) bonds of the United States, this state, or a county or municipality of this state; or

(3) government insured mortgage loans that are authorized by this chapter, with not more than 25 percent of the unencumbered surplus invested in first mortgage real estate loans.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 882.056. APPLICATION FOR CHARTER. (a) To obtain a charter for a mutual life insurance company under this chapter, the incorporators must pay the charter fee in the amount determined under Chapter 202 and file with the department:

- (1) an application for charter on the form and including the information prescribed by the commissioner;
- (2) the company's articles of incorporation; and
- (3) an affidavit made by two or more of the incorporators that states that:
 - (A) the unencumbered surplus requirements of Section 882.055 are satisfied;
 - (B) the unencumbered surplus is the bona fide property of the company; and
 - (C) the information in the application and articles of incorporation is true and correct.

(b) The commissioner may require that the incorporators provide at their expense additional evidence of a matter required in the affidavit before the commissioner takes further action on the application for the charter.

(c) The charter must state the name of each director who is to serve until the first annual election.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 2E.074, eff. April 1, 2009.

Sec. 882.057. APPLICATION PROCESS. (a) After the charter fee is paid and all items required for a charter under Section 882.056 are filed with the department, the commissioner shall approve, deny, or disapprove the application.

(b) On the applicant's request, the commissioner shall hold a hearing on a denial. Not later than the 30th day after the date of the applicant's request for a hearing, the commissioner shall request a hearing date.

(c) An interested party may participate fully and in all respects in any proceeding related to the application. An intervenor has the rights and privileges of a proper or necessary party in a civil suit in the courts of this state, including the right to be represented by counsel.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1022 (H.B. [4291](#)), Sec. 12, eff.

June 19, 2009.

Sec. 882.058. ACTION ON APPLICATION. (a) In considering the application, the commissioner shall determine if:

(1) the minimum unencumbered surplus required by Section 882.055 is the bona fide property of the mutual life insurance company;

(2) the proposed officers, directors, and managing executives of the company have sufficient insurance experience, ability, and standing to make success of the proposed company probable; and

(3) the applicants are acting in good faith.

(b) If the commissioner determines that the applicant has not met the standards set out by Subsection (a), the commissioner shall deny the application in writing, giving the reason for the denial. An application may not be granted unless it is adequately supported by competent evidence.

(c) Repealed by Acts 2009, 81st Leg., R.S., Ch. 1022, Sec. 19(6), eff. June 19, 2009.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1022 (H.B. 4291), Sec. 13, eff. June 19, 2009.

Acts 2009, 81st Leg., R.S., Ch. 1022 (H.B. 4291), Sec. 19(6), eff. June 19, 2009.

Sec. 882.059. EXAMINATION AFTER DETERMINATION. After making a determination on an application under Section 882.058, the commissioner shall immediately make or cause to be made a full and thorough examination of the mutual life insurance company. The company shall pay for the examination.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER C. AUTHORITY TO ENGAGE IN BUSINESS

Sec. 882.101. ISSUANCE OF CERTIFICATE OF AUTHORITY. (a) After the examination of a mutual life insurance company under Section

882.059, the commissioner shall issue a certificate of authority to the company if the commissioner finds that:

- (1) the company has complied with all applicable laws;
- (2) the company satisfies the unencumbered surplus requirements of Section 882.055; and
- (3) the company's unencumbered surplus is in the custody of the company's officers.

(b) A certificate of authority issued under this section authorizes the company to engage in the business of life, health, or accident insurance in this state as may be specified in the company's charter or charter application.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER D. MANAGEMENT OF MUTUAL LIFE INSURANCE COMPANY

Sec. 882.151. BOARD OF DIRECTORS. (a) The board of directors of a mutual life insurance company controls the business of the company.

(b) The board of directors consists of at least five directors as stated in the company's articles of incorporation.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 882.152. ADOPTION OF INITIAL BYLAWS. (a) At the first meeting of the initial board of directors of a mutual life insurance company after the department issues a certificate of authority to the company, the board shall adopt the initial bylaws of the company.

(b) The bylaws adopted under Subsection (a) shall govern the company until the first annual meeting of the board of directors.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 882.153. ANNUAL MEETING. (a) Except as provided by Subsection (b), after a mutual life insurance company is issued a certificate of authority under Section 882.101, the company shall hold an annual meeting of the policyholders on the fourth Tuesday in April at the home office of the company or another location properly announced to each policyholder.

(b) The bylaws of a mutual life insurance company may establish an annual meeting date different than the date under Subsection (a). A meeting date established under this subsection must be before April 30 of each year.

(c) At each annual meeting, the policyholders:

(1) shall elect the company's board of directors to serve until the next annual meeting, except as provided by Section 882.154; and

(2) may adopt, amend, or repeal the bylaws of the company.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 882.154. STAGGERED TERMS FOR LARGE BOARD OF DIRECTORS.

(a) This section applies only to a mutual life insurance company whose board of directors consists of at least nine members.

(b) The bylaws of a mutual life insurance company may provide that the company's directors, other than initial directors, may be elected to serve staggered terms as provided by this section.

(c) The company's directors shall be divided into two or three classes, with each class consisting of an equal number of directors to the extent possible. After the directors are divided into classes:

(1) the terms of the directors in the first class expire on the first annual meeting date after their initial election;

(2) the terms of the directors in the second class expire on the second annual meeting date after their initial election; and

(3) the terms of the directors in the third class, if any, expire on the third annual meeting date after their initial election.

(d) At each annual meeting after the directors are first elected, the policyholders shall elect the number of directors whose terms expire on that date. Directors are elected for:

(1) staggered two-year terms, if the board is divided into two classes; or

(2) staggered three-year terms, if the board is divided into three classes.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 882.155. VOTING BY POLICYHOLDERS. (a) At an annual or

special meeting of a mutual life insurance company, each policyholder is entitled to one vote for each \$500 of insurance held by the policyholder in the company.

(b) A policyholder may vote at an annual or special meeting by proxy, unless the proxy is revoked before the meeting.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 882.156. OFFICERS. (a) The board of directors of a mutual life insurance company shall elect the following officers for the company:

- (1) a president;
 - (2) the number of vice presidents as required by the company's bylaws;
 - (3) a secretary;
 - (4) a treasurer;
 - (5) a medical director; and
 - (6) other officers as required by the company's bylaws.
- (b) The board shall establish the compensation of each officer.
- (c) The duties of each officer shall be prescribed by the company's bylaws.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 882.157. OFFICER BONDS. The president, secretary, and treasurer of a mutual life insurance company shall each provide a bond for the protection of the company's policyholders:

- (1) in an amount and with sureties approved by the commissioner; and
- (2) conditioned on the faithful performance of the officer's duties.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 882.158. BYLAWS MUST COMPLY WITH LAW. The bylaws of a mutual life insurance company may not be inconsistent with this chapter or other laws of this state.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER E. AGENTS

Sec. 882.201. APPLICABILITY OF SUBCHAPTER. This subchapter does not apply to a mutual life insurance company organized under this chapter that has a surplus of at least the minimum amount of capital and surplus required of a capital stock company under Sections 841.054, 841.204, 841.205, 841.301, and 841.302.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 882.202. ISSUANCE OF LICENSE TO AGENT. On written request of a mutual life insurance company to which a certificate of authority has been issued under this chapter, the department shall issue a license to each agent of the company.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 882.203. LIMITATION ON AGENT COMPENSATION. A contract between a mutual life insurance company and an agent of the company to which a license has been issued under Section 882.202 may not provide a commission or other compensation to the agent that exceeds the expense loading in the premiums on policies that are issued on applications obtained by the agent and for which the premiums are collected and paid to the company in cash.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER F. GENERAL FINANCIAL REQUIREMENTS

Sec. 882.251. LIMITED AUTHORITY TO BORROW MONEY. (a) Except as provided by this subchapter, a mutual life insurance company may not borrow money for any purpose other than to pay a death loss.

(b) A company may not incur a debt on an account for which any part of the company's assets that exceeds the assets represented by or derived from the expense loading in the premiums collected by the company is subject to execution on a judgment.

(c) Subsection (b) does not prohibit a company from incurring a

debt on an account:

- (1) under a policy issued by the company; or
- (2) to borrow money to pay a death loss.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 882.252. INVESTMENT OF MONEY. (a) A mutual life insurance company shall invest the company's money in accordance with the law governing investments of life, health, and accident insurance companies organized under Chapter 841.

(b) An officer of a mutual life insurance company who does not invest the money of the company as required by Subsection (a) shall deposit the money in the name of the company in a bank that:

- (1) is subject to state or federal regulation; and
- (2) has been approved by the commissioner as a depository for that purpose.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 882.253. LOANS TO COMPANY. (a) An officer or director of a mutual life insurance company, or a person authorized under Chapter 825, may loan to the company money to:

- (1) promote or conserve the company's business; or
- (2) enable the company to comply with a legal requirement.

(b) The company may repay a loan and agreed interest, at an annual rate not to exceed 10 percent, from the surplus remaining after the company provides for the company's reserves and other liabilities.

(c) A loan under this section or interest on a loan is not otherwise a liability or claim against the company or any of its assets.

(d) A mutual life insurance company may not pay a commission or promotion expense in connection with a loan made to the company.

(e) A mutual life insurance company shall report in its annual statement the amount of each loan.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER G. UNENCUMBERED SURPLUS REQUIREMENTS

Sec. 882.301. AMOUNT OF UNENCUMBERED SURPLUS. (a) A mutual life insurance company that engages in the business of insurance in this state shall maintain an unencumbered surplus of at least \$100,000 that consists of cash or classes of investment as provided by Section 882.055.

(b) Except as otherwise authorized by this code, a company that does not maintain an unencumbered surplus as required by this section may not write new insurance.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 882.302. EXEMPTION FOR CERTAIN COMPANIES. A mutual life insurance company that was authorized and engaged in the business of insurance in this state before May 1, 1955, is not required to increase the amount or convert the class or form of the company's existing unencumbered surplus to comply with Section 882.301 and may not be prohibited from writing new insurance because the company does not maintain an unencumbered surplus as required by that section if the company complies with all other laws.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 882.303. UNENCUMBERED SURPLUS LESS THAN \$25,000. A mutual life insurance company whose unencumbered surplus is less than \$25,000 shall allocate at least 25 percent of the company's net earned surplus for the preceding calendar year to the company's unencumbered surplus until the company has obtained an unencumbered surplus of at least \$25,000.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 882.304. INVESTMENT OF EXCESS UNENCUMBERED SURPLUS. A mutual life insurance company that is granted a charter under this chapter may invest that part of the company's unencumbered surplus that exceeds \$100,000 as provided by this code for companies operating under Chapter 841.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 882.305. IMPAIRMENT OF UNENCUMBERED SURPLUS. (a) If one-third or more of a mutual life insurance company's unencumbered surplus as required by Section 882.301 is impaired, the company shall correct the impairment not later than the 60th day after the date the surplus is impaired.

(b) A company that does not correct an impairment of surplus as required by Subsection (a) may not write insurance in this state until the company corrects the impairment.

(c) In determining whether a company's surplus is impaired, the company shall compute its liabilities in the manner provided by state law.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 882.306. IMPAIRMENT OF UNENCUMBERED SURPLUS; APPOINTMENT OF RECEIVER. (a) If one-half or more of a mutual life insurance company's unencumbered surplus as required by Section 882.301 is impaired, the commissioner may apply to a court for the appointment of a receiver to wind up the affairs of the company.

(b) In determining whether a company's surplus is impaired, the company shall compute its reserve liability in the manner provided by state law.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER H. DIVIDENDS

Sec. 882.351. POLICYHOLDER'S ENTITLEMENT TO DIVIDEND. A policyholder of a mutual life insurance company is entitled to a credit or payment of a dividend from that part of the company's divisible surplus that may be fairly allocated to the policyholder's policy.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 882.352. ACCOUNTING AND PROCEDURE FOR ALLOCATION OF

DIVISIBLE SURPLUS; REPORT TO COMMISSIONER. (a) On December 31 of each year, or as soon after as practicable, each mutual life insurance company shall determine the amount of surplus earned by the company during that year.

(b) Not later than the end of the second year in which a policy issued by the company is in effect, the company shall provide to the policyholder:

(1) an annual accounting of the company's divisible surplus; and

(2) if all premiums due on the policy have been paid for at least two years, a fair allocation of the company's divisible surplus that remains after deducting:

(A) any amount approved by the commissioner for retirement of any unpaid loans made under Section 882.253;

(B) the company's contingency reserve; and

(C) any earned surplus the company allocated to unencumbered surplus as provided by this chapter.

(c) The company shall immediately submit to the commissioner a detailed report of an allocation of divisible surplus made under this section. The president or secretary of the company shall sign the report under oath.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 882.353. DEPARTMENT APPROVAL OF ALLOCATION; REVISIONS.

(a) The department shall approve a mutual life insurance company's allocation of divisible surplus under Section 882.352 if the department finds that the allocation is fair to the policyholders and complies with this chapter.

(b) If the department does not approve a company's allocation of surplus, the department shall revise the allocation in a manner that the department determines is fair to the policyholders and necessary to comply with this chapter. The department shall certify the revisions to the company.

(c) An allocation of surplus approved under Subsection (a) takes effect on the date of approval. An allocation of surplus revised by the department under Subsection (b) takes effect on the date the department certifies the revisions to the company.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 882.354. DIVIDEND PAYMENT METHOD. (a) A dividend declared by a mutual life insurance company under this subchapter shall be paid in:

(1) cash; or

(2) the equivalent of the dividend's cash value as provided by an option stated in the policy and selected by the policyholder.

(b) A policyholder shall notify the company in writing of an option selected by the policyholder under Subsection (a)(2).

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 882.355. LIMITATIONS ON DIVISIBLE SURPLUS. A mutual life insurance company's divisible surplus available for payment of dividends to the company's policyholders may not include:

(1) any part of the company's unencumbered surplus that has been:

(A) allocated from the company's earned surplus;

(B) transferred from the company's contingency reserve;

or

(C) otherwise acquired by the company;

(2) if the company was organized after September 5, 1955, any part of the company's unencumbered surplus required to comply with Section 882.301; or

(3) if the company's unencumbered surplus is less than \$25,000, the part of the company's earned surplus for the preceding calendar year in excess of 75 percent of the earned surplus.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 882.356. PAYMENT OF DIVIDENDS NOT REQUIRED. This subchapter does not require a mutual life insurance company to pay a dividend to a policyholder if the unencumbered surplus acquired by the company is impaired.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER I. CONTINGENCY RESERVE

Sec. 882.401. AMOUNT OF CONTINGENCY RESERVE. (a) A mutual life insurance company organized under this chapter may maintain a contingency reserve that exceeds the reserves and liabilities provided by this chapter. The amount of the contingency reserve may not exceed the greater of:

- (1) \$10,000;
- (2) an amount that:
 - (A) equals 20 percent of the company's policy reserves and policy liabilities plus one percent of the amount of the company's life insurance in force; and
 - (B) does not exceed \$750,000; or
- (3) an amount that equals 20 percent of the company's policy reserves and policy liabilities.

(b) In determining the amount of a company's policy reserves and policy liabilities for purposes of this section, the company may only include the following, after deducting the net value of the company's risks reinsured by other solvent assuming insurers:

- (1) the company's reserves on outstanding life insurance policies and annuity contracts, contracts issued as supplemental to the policies or contracts or in connection with the policies or contracts or provisions included in policies or contracts that insure against disability or accidental death; and
- (2) the company's liabilities for:
 - (A) optional modes of settlement; or
 - (B) dividends left on deposit at interest.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 882.402. EXCESS CONTINGENCY RESERVE. (a) The commissioner, for good cause shown, may issue an order authorizing a mutual life insurance company to maintain a contingency reserve that exceeds the amount of the reserve authorized by Section 882.401.

- (b) The order must state:
- (1) a period not exceeding one year during which the company may maintain the excess contingency reserve; and
 - (2) each reason for authorizing the excess contingency reserve.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 882.403. CONTINGENCY RESERVE REQUIREMENTS. (a) A mutual life insurance company's contingency reserve as authorized by this subchapter must be:

- (1) invested as provided by law; and
- (2) used only to pay death claims and dividends to policyholders.

(b) If the interest and earnings from the investment of a company's contingency reserve exceed the amount of reserve authorized by Section 882.401 or 882.402, the company shall pay the excess amount to the policyholders of the company in the form of dividends as provided by law.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 882.404. ALLOCATION OF CONTINGENCY RESERVE TO UNENCUMBERED SURPLUS. If a mutual life insurance company's unencumbered surplus is less than \$100,000, the company may allocate any part of the company's contingency reserve to the company's unencumbered surplus.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 882.405. DESIGNATION OF CONTINGENCY RESERVE AS UNASSIGNED SURPLUS. The contingency reserve described by this subchapter is and may be treated as unassigned surplus, including designating the contingency reserve as unassigned surplus in financial statements.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER J. POLICY REQUIREMENTS

Sec. 882.451. APPLICABILITY OF CERTAIN PROVISIONS. Sections 882.452, 882.453, and 882.454 do not apply to a mutual life insurance company organized under this chapter that has a surplus of at least the minimum amount of capital and surplus required of a capital stock company under Sections 841.054, 841.204, 841.205, 841.301, and 841.302.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 882.452. TYPE OF POLICY AUTHORIZED. A mutual life insurance company may issue a policy only on the participating plan with dividends payable annually as provided by Subchapter H.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 882.453. POLICY FORM. An insurance policy issued by a mutual life insurance company must:

- (1) be on a form approved by the department; and
- (2) contain the following statement on both the front and reverse sides of the policy: "The form of this policy is approved by the Texas Department of Insurance."

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 882.454. LIMITATION ON AMOUNT OF POLICY VALUE FOR CERTAIN COMPANIES. If the total amount of a mutual life insurance company's insurance in force is less than \$10 million, the company may not issue a policy that, after deducting any reinsurance, binds the company for more than \$5,000 on a single life.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 882.455. TABLE OF GUARANTEED VALUES. (a) Each insurance policy issued by a mutual life insurance company must contain a table of guaranteed values. The guaranteed values become nonforfeitable not later than the date of payment of the third full annual premium.

(b) The table of guaranteed values shall be drawn in accordance with the law governing life, health, and accident insurance companies.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER K. TOTAL ASSUMPTION REINSURANCE AGREEMENTS

Sec. 882.501. TOTAL ASSUMPTION REINSURANCE AGREEMENTS BETWEEN LIFE INSURANCE COMPANIES. (a) A domestic mutual life insurance company and any other domestic or foreign life insurance company may enter into a total assumption reinsurance agreement if the company assuming the policies under the agreement is authorized to engage in the kinds of insurance provided by those policies.

(b) Before a total assumption reinsurance agreement may be entered into:

- (1) the agreement must be submitted to the department; and
- (2) the commissioner must approve the agreement as fully protecting the interests of each domestic company's policyholders.

(c) After an assumption reinsurance agreement in which the ceding company is a domestic mutual insurance company is approved by the commissioner as required by Subsection (b), the agreement must be approved by the policyholders of the ceding domestic company in the same manner as required for a merger or consolidation under Subchapter L.

(d) When the reinsurance agreement described by Subsection (c) is effective, the assuming company is entitled to the same rights, privileges, and benefits granted a company that assumes a company by merger or consolidation as provided by Subchapter L.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER L. MERGERS AND CONSOLIDATIONS

Sec. 882.551. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a merger or consolidation in which at least one of the parties to the transaction is a mutual life insurance company.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 882.552. AUTHORITY TO MERGE OR CONSOLIDATE. A domestic or foreign mutual life insurance company may merge with a domestic or foreign mutual or stock legal reserve life insurance company or consolidate into a new domestic or foreign mutual or stock life insurance company as provided by this subchapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 882.553. PROPOSED PLAN OF MERGER OR CONSOLIDATION; FILING WITH COMMISSIONER. (a) If the boards of directors of at least two life insurance companies determine by majority vote to merge or consolidate, the boards of directors shall prepare a proposed plan of merger or consolidation. The plan may contain:

(1) a future allocation of divisible surplus; or
(2) any other fair arrangement by which any equitable interests of the mutual life insurance company's policyholders may be adjusted.

(b) The boards of directors shall file the proposed plan with the commissioner for approval.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 882.554. HEARING ON PLAN. As soon as practicable after a proposed plan is filed with the commissioner, the commissioner shall hold a hearing to determine whether to approve the plan.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 882.555. COMMISSIONER DETERMINATION ON PLAN. (a) As soon as practicable after the commissioner holds a hearing on a proposed plan under Section 882.554, the commissioner shall approve the plan unless the commissioner determines that:

(1) the plan is contrary to law; or
(2) implementation of the plan:
(A) would not be in the best interests of the policyholders of any mutual life insurance company that is a party to the plan; or

(B) would substantially reduce the security of or service to be rendered to policyholders of any mutual insurance company that is a party to the plan, regardless of whether the policyholders reside in this state or elsewhere.

(b) In determining whether to approve a proposed plan, the commissioner may consider all relevant financial or other information, including past, present, and future operations and accumulations of each company that is a party to the plan.

(c) If the commissioner approves the proposed plan, the commissioner shall notify each party to the plan of the approval.

(d) If the commissioner disapproves the proposed plan, the commissioner shall, within a reasonable time after holding a hearing under Section 882.554:

- (1) specify in detail each reason for the disapproval; and
- (2) notify each party to the plan.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 882.556. APPROVAL OF PLAN BY POLICYHOLDERS. (a) As soon as practicable after receiving from the commissioner notice of approval of a proposed plan under Section 882.555, the board of directors of each mutual life insurance company that is a party to the plan shall submit the plan to the policyholders for a vote at an annual or special meeting.

(b) Not later than the 15th day before the date of the meeting, the company shall provide written notice of the meeting to the policyholders as provided by the company's bylaws. The notice must:

- (1) be sent to the policyholder's last known address;
- (2) state that one of the purposes of the meeting is to vote on the proposed plan; and
- (3) be accompanied by a copy of the proposed plan.

(c) At a meeting under Subsection (a), each policyholder:

- (1) is entitled to the number of votes as provided by Section 882.155; and
- (2) may vote:
 - (A) in person;
 - (B) by written proxy; or
 - (C) by mailed ballot.

(d) A proposed plan is approved by the policyholders on the affirmative vote of at least two-thirds of the votes cast at the meeting.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 882.557. DOMESTIC STOCK LIFE INSURANCE COMPANY; APPROVAL OF PLAN BY SHAREHOLDERS. On notice of approval of a proposed plan under Section 882.555, the board of directors of each domestic stock life insurance company that is a party to the plan shall submit the plan for approval to the company's shareholders in the manner

provided by Section 824.003.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 882.558. FOREIGN LIFE INSURANCE COMPANY; APPROVAL OF PLAN BY POLICYHOLDERS OR SHAREHOLDERS. On notice of approval of a proposed plan under Section 882.555, the board of directors of each foreign life insurance company that is a party to the plan shall submit the plan for approval to the company's policyholders or shareholders as provided by the law of the appropriate jurisdiction.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 882.559. FILING OF AFFIDAVIT OF PLAN APPROVAL; ISSUANCE OF CERTIFICATE OF MERGER OR CONSOLIDATION. (a) On the approval of a proposed plan under Section 882.556, 882.557, or 882.558, the president or a vice president and the secretary or an assistant secretary of each company that is a party to the plan shall execute and file with the department an affidavit stating that the plan has been approved by the policyholders or shareholders of the company as required by this subchapter.

(b) If the department finds that the affidavit complies with law, the department shall:

(1) endorse the affidavit with:

(A) the word "filed"; and

(B) the date of filing;

(2) if the plan is a plan of merger, issue a certificate of merger to the surviving company or the company's representative; and

(3) if the plan is a plan of consolidation, issue a certificate of consolidation to the new company on the issuance of a charter and a certificate of authority to the new company after:

(A) submission of proper articles of incorporation to the department;

(B) approval by the department in accordance with procedures required for the issuance of a new charter; and

(C) submission of proof that the new company has policyholder surplus at least equal to that of the mutual life insurance company that is a party to the consolidation and has the largest surplus.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 882.560. EFFECTIVE DATE OF MERGER OR CONSOLIDATION. A merger or consolidation takes effect on the later of:

- (1) the date of issuance of the certificate of merger or consolidation; or
- (2) a date specified in the plan of merger or consolidation.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 882.561. ASSUMPTION OF OUTSTANDING INSURANCE POLICIES.

(a) On the effective date of a merger or consolidation under this subchapter, a new or surviving life insurance company resulting from the merger or consolidation assumes each insurance policy outstanding against each company that merges or consolidates on the same terms and under the same conditions as if the policy had continued in force through the original company.

(b) The new or surviving insurance company shall implement the terms of the policy.

(c) The new or surviving insurance company is entitled to:

- (1) all rights and privileges under the policy; and
- (2) all reserves and surplus that accumulated on the policy before the merger or consolidation.

(d) A policyholder of a mutual life insurance company that is a party to a merger or consolidation resulting in a new or surviving stock life insurance company is not entitled to any voting rights in the new or surviving company.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 882.562. ASSUMPTION OF LIABILITIES. On the effective date of a merger or consolidation under this subchapter, a new or surviving life insurance company resulting from the merger or consolidation assumes all liabilities of the original companies.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 882.563. EFFECT OF MERGER OR CONSOLIDATION ON PROPERTY.

On the effective date of a merger or consolidation under this subchapter, the property rights, including any right of recovery, of each company that is a party to the merger or consolidation are transferred to the new or surviving life insurance company resulting from the merger or consolidation without a deed or other transfer.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 882.564. EFFECT OF MERGER OR CONSOLIDATION ON CERTAIN INVESTMENTS. (a) This section applies to each investment of an affected life insurance company, including an investment in real property, that:

(1) was authorized as a proper asset, as of the date on which the investment was made and under the laws of the state in which the company was organized, for investment of funds of a life insurance company; and

(2) is taken over by the new or surviving company under the terms of the merger or consolidation.

(b) On the effective date of a merger or consolidation of two or more life insurance companies under this subchapter, an investment of the affected companies described by Subsection (a) is a proper asset under the laws of this state of the new or surviving company if the investment is:

(1) approved by the commissioner; and

(2) taken over on terms satisfactory to the commissioner.

(c) A new or surviving company that acquires, under the terms of the merger or consolidation, real property that exceeds the amount of real property permitted by the applicable sections of this code relating to owning or holding real property shall sell or dispose of the excess real property:

(1) within the period specified by those sections; or

(2) within a longer period if the company obtains a certificate from the commissioner:

(A) stating that the interests of the company will materially suffer by the forced sale or other disposition of the real property; and

(B) specifying the longer period for the sale or other disposition of the real property.

(d) This section does not preclude the designation and use of the excess real property as branch offices of the company in accordance with this code.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 882.565. EFFECT OF MERGER OR CONSOLIDATION ON DIVISIBLE SURPLUS. (a) This section applies only to a mutual life insurance company that is a new company or the surviving company resulting from a merger or consolidation under this subchapter.

(b) If the divisible surplus of each domestic mutual life insurance company that is a party to a merger or consolidation under this subchapter was available for allocation to policyholders as provided by Subchapter H immediately before the effective date of the merger or consolidation, the divisible surplus remains available to the policyholders of the new or surviving mutual life insurance company resulting from the merger or consolidation as provided by Subchapter H.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 882.566. EFFECT ON ANTITRUST LAWS. This subchapter does not affect in any manner the antitrust laws of this state.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER M. CONVERSION OF MUTUAL LIFE INSURANCE COMPANY TO STOCK LEGAL RESERVE LIFE INSURANCE COMPANY

Sec. 882.601. AUTHORITY TO CONVERT TO STOCK LEGAL RESERVE LIFE INSURANCE COMPANY; POLICYHOLDER AUTHORIZATION REQUIRED. A mutual life insurance company organized under this chapter may convert to a stock legal reserve life insurance company as provided by this subchapter only if the conversion is approved by the policyholders by a vote of at least two-thirds of the votes cast by the policyholders in person or by proxy at a meeting called for that purpose.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 882.602. AMENDMENT TO CHARTER OR ARTICLES OF INCORPORATION REQUIRED. If the policyholders of a mutual life insurance company authorize a conversion under Section 882.601, the board of directors and officers of the company shall amend the company's charter or articles of incorporation to comply with the requirements applicable to a stock legal reserve life insurance company under Chapter 841.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 882.603. CAPITAL AND SURPLUS REQUIREMENTS. (a) The capital and surplus of the converted stock legal reserve life insurance company must be at least equal to the minimum capital and surplus required for the organization of a stock legal reserve life insurance company under Chapter 841.

(b) If a contribution of United States currency is necessary to meet the capital and surplus requirements of this section, the contribution must be made before the effective date of the conversion.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 882.604. HEARING. (a) After public notice, the commissioner shall hold a hearing on a conversion authorized under Section 882.601.

(b) Any policyholder of the mutual life insurance company that is the subject of the conversion is entitled to appear and be heard at the hearing.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 882.605. CONVERSION ON COMMISSIONER APPROVAL. A mutual life insurance company is converted to a stock legal reserve life insurance company if:

- (1) the company complies with this subchapter; and
- (2) after hearing, the conversion is approved by the commissioner.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 882.606. APPLICABLE LAW AFTER CONVERSION. After a mutual life insurance company is converted to a stock legal reserve life insurance company, the converted company is governed in the same manner as a company organized under Chapter 841.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 882.607. OTHER TYPES OF CONVERSION NOT PROHIBITED. This subchapter does not prohibit a mutual life insurance company from converting to a stock legal reserve life insurance company by:

- (1) merger or consolidation;
- (2) a total direct or assumption reinsurance agreement; or
- (3) any other plan or procedure approved by the company's policyholders and the commissioner.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER N. CONVERSION OF CERTAIN MUTUAL ASSESSMENT COMPANIES OR ASSOCIATIONS TO MUTUAL LIFE INSURANCE COMPANIES

Sec. 882.651. AUTHORITY TO CONVERT. A mutual assessment company or association organized and operating under the laws of this state on May 17, 1943, may convert to a mutual life insurance company as provided by this subchapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 882.652. VOLUNTARY CONVERSION. The department may not require a mutual assessment company or association to convert to a mutual life insurance company under this subchapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 882.653. CONVERSION REQUIREMENTS. Except as provided by Section 882.654, a mutual assessment company or association may convert to a mutual life insurance company only if the company or

association:

(1) possesses an unencumbered surplus of at least \$1.4 million; and

(2) complies with the requirements of this chapter, including the requirements that the company or association execute articles of incorporation and obtain a charter and a certificate of authority.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 882.654. EXEMPTION FROM SURPLUS REQUIREMENTS. (a) A mutual assessment company or association is exempt from the surplus requirements of Section 882.653 if the company or association:

(1) possesses an unencumbered surplus of at least \$200,000; and

(2) converted to a mutual life insurance company before September 1, 1999.

(b) A mutual assessment company or association that is exempt under Subsection (a) and that was converted on or after September 1, 1989, shall immediately increase its surplus to an amount that satisfies Section 882.653 on:

(1) a change of control of at least 50 percent of the voting securities of the converted company or association; or

(2) if the converted company or association or the holding company that controls the converted company or association, if any, is not controlled by voting securities, a change of at least 50 percent of the ownership of the converted company or association or its holding company.

(c) For purposes of Subsection (b), a transfer of ownership because of death, regardless of whether the decedent died testate or intestate, is not considered a change of control of a converted mutual assessment company or association or its holding company, if ownership is transferred only to one or more individuals, each of whom would have been an heir of the decedent if the decedent had died intestate.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 882.655. APPLICABLE LAW AFTER CONVERSION. After a mutual

assessment company or association is converted to a mutual life insurance company, the converted company is governed by this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER O. ENFORCEMENT PROVISIONS

Sec. 882.701. **APPLICABILITY OF SUBCHAPTER.** This subchapter does not apply to a mutual life insurance company organized under this chapter that has a surplus of at least the minimum amount of capital and surplus required of a capital stock company under Sections 841.054, 841.204, 841.205, 841.301, and 841.302.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 882.702. **INVESTMENT AND DEPOSIT OF FUNDS; CRIMINAL PENALTY.** (a) A person commits an offense if the person is an officer or director of a mutual life insurance company and the person knowingly or wilfully violates or assents to the violation of Section 882.252.

(b) An offense under this section is punishable by imprisonment in the Texas Department of Criminal Justice for a term of not more than five years or less than one year.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 87 (S.B. 1969), Sec. 25.121, eff. September 1, 2009.

Sec. 882.703. **POLICY FORM; REVOCATION OF CERTIFICATE.** The department shall revoke the certificate of authority of a mutual life insurance company that issues a policy on a form that has not been approved by the department as required by Section 882.453.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER P. CONVERSION OF MUTUAL LIFE INSURANCE COMPANY TO INSURANCE HOLDING COMPANY AND STOCK LIFE INSURANCE COMPANY

Sec. 882.751. AUTHORITY TO CONVERT. A mutual life insurance company organized or operating under this chapter may convert by forming an insurance holding company based on a mutual plan and continuing the corporate existence of the converting mutual life insurance company as a stock life insurance company if the commissioner:

- (1) determines that the conversion is fair and equitable to the policyholders of the converting company; and
- (2) approves the proposed plan of conversion.

Added by Acts 2005, 79th Leg., Ch. 82 (S.B. 449), Sec. 1, eff. September 1, 2005.

Sec. 882.752. APPLICATION OF OTHER LAW. Except to the extent of a conflict with this subchapter, Chapter 826 applies to conversion of a mutual life insurance company under this subchapter.

Added by Acts 2005, 79th Leg., Ch. 82 (S.B. 449), Sec. 1, eff. September 1, 2005.

Sec. 882.753. JURISDICTION OF COMMISSIONER. The commissioner retains jurisdiction over a company that converts under this subchapter.

Added by Acts 2005, 79th Leg., Ch. 82 (S.B. 449), Sec. 1, eff. September 1, 2005.

Sec. 882.754. INCORPORATION REQUIREMENTS. A mutual insurance holding company that results from a conversion under this subchapter must be incorporated under and subject to this chapter and Chapter 22, Business Organizations Code.

Added by Acts 2005, 79th Leg., Ch. 82 (S.B. 449), Sec. 1, eff. September 1, 2005.

Sec. 882.755. ARTICLES OF INCORPORATION. The articles of incorporation of a mutual insurance holding company that results from

a conversion under this subchapter, and any amendments to the articles of incorporation, are subject to approval by the commissioner.

Added by Acts 2005, 79th Leg., Ch. 82 (S.B. 449), Sec. 1, eff. September 1, 2005.

Sec. 882.756. SALE OF SECURITIES. (a) A sale, issuance, or offering of securities under this subchapter is exempt from the registration and licensing provisions of The Securities Act (Title 12, Government Code).

(b) An officer, director, or employee of a mutual life insurance company or a mutual insurance holding company or stock life insurance company resulting from a conversion under this subchapter who participates in the conversion is exempt from the registration and licensing provisions of The Securities Act (Title 12, Government Code). A person may not receive compensation, other than that person's usual salary or compensation, for services performed under the exemption provided by this subsection.

Added by Acts 2005, 79th Leg., Ch. 82 (S.B. 449), Sec. 1, eff. September 1, 2005.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 491 (H.B. 4171), Sec. 2.33, eff. January 1, 2022.

CHAPTER 883. MUTUAL INSURANCE COMPANIES OTHER THAN MUTUAL LIFE INSURANCE COMPANIES

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 883.001. DEFINITIONS. In this chapter:

(1) "Domestic mutual insurance company" means a mutual insurance company organized under this chapter.

(2) "Foreign mutual insurance company" means a mutual insurance company organized under the laws of a jurisdiction other than this state and authorized to engage in the business of insurance on a mutual plan in any state, district, or territory.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 883.002. APPLICABILITY OF CERTAIN GENERAL LAWS. (a) Except as otherwise provided by law, domestic and foreign mutual insurance companies organized or operating under this chapter are subject to the laws applicable to:

- (1) a stock insurance company engaging in the same kind of insurance;
- (2) investments;
- (3) valued policies;
- (4) policy forms and rates;
- (5) reciprocal or retaliatory laws;
- (6) insolvency and liquidation; and
- (7) publication and defamatory statements.

(b) This chapter does not exempt a domestic mutual insurance company from being subject to other laws of this state governing the incorporation, organization, regulation, and operation of a company or organization writing insurance in this state.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 883.003. APPLICABILITY OF TEXAS NON-PROFIT CORPORATION ACT. Except to the extent of any conflict with this code, the Texas Non-Profit Corporation Act (Article 1396-1.01 et seq., Vernon's Texas Civil Statutes) applies to a domestic mutual insurance company. The commissioner has each power and duty of, and shall perform each act to be performed by, the secretary of state under that Act with respect to mutual insurance companies.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER B. FORMATION, STRUCTURE, AND MANAGEMENT OF COMPANY

Sec. 883.051. FORMATION OF COMPANY. (a) Twenty or more persons, a majority of whom are residents of this state, may incorporate in accordance with this chapter to engage in the business of mutual insurance as provided by this chapter.

(b) To form a mutual insurance company, each incorporator must sign and acknowledge the articles of incorporation of the company.

(c) The incorporators of a proposed mutual insurance company are subject to Sections 822.001, 822.051, 822.057(a)(1)-(3), (b), and (c), 822.058(a), 822.059, 822.060, and 822.201, except that:

(1) the minimum number of persons required to adopt and sign the proposed company's articles of incorporation under Section 822.051 is equal to the number of the proposed company's incorporators as provided by Subsection (a); and

(2) the unencumbered surplus of the mutual insurance company is capital structure for purposes of Section 822.201.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 883.052. ARTICLES OF INCORPORATION. Articles of incorporation of a proposed mutual insurance company must specify:

(1) the name of the company;

(2) the purpose for which the company is being formed;

(3) the location of the company's principal or home office;

(4) the name and place of residence of each incorporator;

and

(5) the name and address of each member of the initial board of directors.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 883.053. COMPANY'S NAME. (a) The name of a mutual insurance company must contain the word "mutual."

(b) A mutual insurance company's name may not be so similar to the name of any other mutual insurance company organized or engaging in business in the United States, that it is confusing or misleading.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 883.054. LOCATION OF PRINCIPAL OR HOME OFFICE. The principal or home office of a mutual insurance company must be located in this state.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 883.055. BEGINNING OF CORPORATE EXISTENCE. The corporate existence of a mutual insurance company begins on the date on which

the commissioner issues a certificate of authority to the company.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 883.056. BOARD OF DIRECTORS. (a) The board of directors named in a mutual insurance company's articles of incorporation shall manage the company until the initial meeting of the members of the company.

(b) After a mutual insurance company is issued a certificate of authority, the company's board of directors may:

- (1) adopt bylaws;
- (2) accept applications for insurance; and
- (3) transact the business of the company.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 883.057. MEMBERSHIP OF PUBLIC OR PRIVATE ENTITIES IN COMPANY AUTHORIZED. (a) Any public or private corporation, board, association, or estate may make an application for, enter into an agreement for, or hold a policy in a mutual insurance company. An officer, shareholder, trustee, or legal representative may act on behalf of the entity for that participation.

(b) An officer, shareholder, trustee, or legal representative of a public or private entity described by Subsection (a) may not be held personally liable on a contract of insurance executed by the person in the person's capacity as a representative of the entity under Subsection (a).

(c) The right of a corporation organized under the laws of this state to participate as a member of a mutual insurance company is:

- (1) incidental to the purpose for which the corporation was organized; and
- (2) in addition to the corporate rights or powers expressly conferred in the corporation's articles of incorporation.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 883.058. MEMBERSHIP VOTES. Each member of a mutual insurance company is entitled to one vote on each matter submitted to

a vote unless a different number of votes is authorized by the company's bylaws based on:

- (1) the insurance in force;
- (2) the number of policies held by the member; or
- (3) the amount of the premium paid by the member.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER C. AUTHORITY TO ENGAGE IN BUSINESS IN THIS STATE

Sec. 883.101. MUTUAL INSURANCE BUSINESS. Mutual insurance of any kind may not be written in this state except as authorized by this chapter or any other law.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 883.102. CHARTER AND CERTIFICATE OF AUTHORITY REQUIRED. A domestic mutual insurance company may not engage in the business of insurance until:

- (1) the company obtains a charter as provided by Chapter 822; and
- (2) the commissioner issues to the company a certificate of authority for that purpose.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 883.103. AUTHORIZATION OF FOREIGN MUTUAL INSURANCE COMPANY TO ENGAGE IN BUSINESS. (a) The department shall authorize a foreign mutual insurance company to write the kinds of insurance authorized by the company's charter or articles of incorporation in this state if the company:

- (1) is solvent as determined under this chapter;
- (2) files with the department:
 - (A) a copy of the company's bylaws certified by the company's secretary; and
 - (B) a certified copy of the company's charter or articles of incorporation;
- (3) appoints the commissioner as the company's agent for service of process as provided by Chapter 804;

(4) files a financial statement under oath in a form as required by the department; and

(5) complies with legal requirements applicable to the filing of documents and the furnishing of information by a stock insurance company that files an application with the department for authority to transact the same kind of insurance as the company.

(b) A foreign mutual insurance company's name may not be so similar to a name of a mutual insurance company or foreign mutual insurance company organized or authorized to engage in business in this state that it is confusing or misleading.

(c) A foreign mutual insurance company authorized to engage in the business of insurance under this section has, to the same extent, all of the powers granted to and privileges of a mutual insurance company organized and operating under this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER D. POWERS, DUTIES, AND OPERATION OF COMPANY

Sec. 883.151. AUTHORITY TO WRITE CERTAIN INSURANCE. A domestic mutual insurance company may write any kind of insurance that may be lawfully written in this state, other than life insurance.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 883.152. PRIOR AUTHORITY NOT AFFECTED. This chapter does not affect any authority that existed before September 6, 1955, that allowed mutual insurance companies to write non-assessable policies in this state, subject to any prerequisite imposed by law on that authority.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 883.153. POLICY RATES. A mutual insurance company operating under this chapter shall charge the insurance rates prescribed by the commissioner and is subject to the same rate requirements as a domestic insurance company.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 883.154. MAXIMUM PREMIUMS. (a) The maximum premium of an insurance policy issued by a domestic mutual insurance company must be stated in the policy.

(b) A policy's maximum premium may consist only of:

(1) a cash premium; or

(2) a cash premium and a contingent premium in an amount equal to one additional cash premium.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 883.155. ISSUANCE OF POLICY FOR CASH PREMIUM ONLY. (a) A domestic mutual insurance company may not issue an insurance policy for a cash premium only unless:

(1) the company possesses surplus above all liabilities in an amount at least equal to the minimum capital and surplus required of a stock insurance company engaging in the same kinds of insurance;

(2) the company files with the department:

(A) an application for the issuance of this type of policy; and

(B) a certified copy of the resolution of the company's board of directors authorizing the issuance; and

(3) the commissioner approves the documents filed under Subdivision (2).

(b) A mutual insurance company that issues a policy for a cash premium only may waive all contingent premiums in any outstanding policies.

(c) A foreign mutual insurance company authorized to engage in the business of insurance in this state may issue an insurance policy for a cash premium only and may waive contingent premiums on any of its outstanding policies in the same manner and subject to the same requirements as a mutual insurance company under this section that is engaged in the same kinds of insurance.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 883.156. ASSESSMENT ON POLICYHOLDERS. (a) A policyholder is not liable for an assessment imposed on a policy issued by a

mutual insurance company with approval of the commissioner under Section 883.155(a).

(b) An assessment may not be imposed on the holder of a policy described by Section 883.155(a) by:

- (1) the officers or directors of a mutual insurance company;
- (2) the department;
- (3) a receiver; or
- (4) a liquidator.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 883.157. REINSURANCE OF POLICY. (a) Subject to Subsection (c), a mutual insurance company authorized to engage in the business of insurance in this state may enter into an agreement with an insurer to cede to or accept from the insurer all or part of an insurance risk.

(b) A reinsurance agreement under this section does not create or confer contingent liability, participation, or membership unless otherwise provided by the agreement.

(c) A mutual insurance company may not enter into an agreement with a reinsurer that has been disapproved for that purpose by written order of the commissioner filed in the department's offices.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 883.158. REQUIREMENTS FOR COMPANIES WRITING BONDS. A mutual insurance company qualifying to write bonds under this chapter is subject to the same legal requirements as any other insurance company writing bonds under this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 883.159. NECESSARY OR INCIDENTAL POWERS. A domestic mutual insurance company has such powers as are necessary or incidental to the transaction of its business.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 883.160. RIGHTS AND PRIVILEGES OF CERTAIN COMPANIES RETAINED. A mutual insurance company engaged in business under Chapters 5, 9, 12, 13, 14, and 15, Title 78, Revised Statutes, before their repeal by Section 18, Chapter 40, Acts of the 41st Legislature, 1st Called Session, 1929, as amended by Section 1, Chapter 60, Acts of the 41st Legislature, 2nd Called Session, 1929, retains the rights and privileges under the repealed law to the extent provided by those sections.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 883.161. DIVIDENDS. On advance approval of the commissioner, a mutual insurance company may pay dividends to its members.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 883.162. LOANS TO COMPANY. (a) A person, including a director, officer, or member of a mutual insurance company, may loan to the company money necessary:

(1) for the company to engage in the company's business;
or

(2) to enable the company to comply with a legal requirement.

(b) The mutual insurance company may repay a loan and agreed interest, at an annual rate not to exceed 20 percent, only from the surplus remaining after the company provides for the company's reserves, other liabilities, and required surplus.

(c) A loan under this section or interest on a loan is not otherwise a liability or claim against the company or any of its assets.

(d) A mutual insurance company may not pay a commission or promotion expense in connection with a loan made to the company.

(e) A mutual insurance company shall report in its annual statement the amount of each loan made to the company.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 883.163. IMMEDIATE NOTIFICATION WHEN ASSETS ARE INSUFFICIENT; EXAMINATION. The president and the secretary of a mutual insurance company operating under the law providing for the incorporation of mutual fire, lightning, hail, and storm insurance companies shall immediately notify the commissioner any time the admitted assets of the company are less than the largest single risk for which the company is liable. The commissioner may make an examination into the affairs of the company as the commissioner considers best.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER E. REGULATION OF COMPANY

Sec. 883.201. SURPLUS REQUIREMENTS. A domestic mutual insurance company must possess a surplus over and above all liabilities in an amount equal to the minimum capital stock and surplus required of a stock insurance company engaged in the same kinds of insurance.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 883.202. REQUIRED DEPOSIT FOR COMPANIES WRITING BONDS.
(a) A domestic mutual insurance company that writes fidelity and surety bond coverage shall maintain on deposit with the comptroller cash or securities of the kind described by a provision of Subchapter B, Chapter 424, other than Section 424.052, 424.072, or 424.073, in an amount equal to the amount of cash or securities required of a domestic stock insurance company.

(b) The commissioner must approve for deposit the cash or securities required by this section.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 2E.075, eff. April 1, 2009.

Sec. 883.203. RESERVES. (a) A domestic mutual insurance company shall maintain unearned premiums and other reserves separately for each kind of insurance. The reserves must be maintained on the same basis as those reserves are required to be maintained by a domestic stock insurance company engaging in the same kinds of insurance.

(b) A mutual insurance company operating under this chapter is subject to the same reserve requirements as a domestic insurance company under law.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 883.204. ANNUAL REPORT. (a) Domestic and foreign mutual insurance companies organized or operating under this chapter shall submit to the commissioner an annual report in the form required by the commissioner.

(b) To the extent practicable, the commissioner shall adopt a form that is similar to a form that is generally used for submission of the annual report throughout the United States.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 883.205. EXAMINATION OF FOREIGN MUTUAL INSURANCE COMPANY. To the extent practicable, an examination of a foreign mutual insurance company must be conducted in cooperation with the insurance departments of other states in which the foreign company is authorized to transact business.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 883.206. FEES. Each domestic or foreign mutual insurance company organized or operating under this chapter is subject to a fee imposed by law on a stock insurance company engaging in the same kinds of insurance.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 883.207. PREMIUM TAX. Each domestic or foreign mutual insurance company organized or operating under this chapter is subject to taxes imposed by law on that company. The company shall pay the tax on the gross premiums received for direct insurance written on property or risks located in this state. The tax payable must be computed on the portion of the gross premiums remaining after deducting:

- (1) premiums charged on policies not taken;
- (2) premiums returned on canceled policies; and
- (3) any refund or other return made to the policyholders other than for the incurrence of a loss.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER O. CRIMINAL PENALTIES

Sec. 883.701. VIOLATION OF CHAPTER. (a) Except as otherwise provided by this subchapter, a person or corporation commits an offense if the person or corporation violates this chapter.

(b) An offense under this section is a misdemeanor punishable by a fine of not less than \$50 or more than \$500.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 883.702. FAILURE TO REPORT CONDITION. (a) A person commits an offense if the person is a president or secretary described by Section 883.163 and the person fails to make the report required by that section.

(b) An offense under this section is a misdemeanor punishable by a fine of not less than \$100 or more than \$500.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 883.703. FALSE STATEMENT OR MISAPPROPRIATION. (a) A person commits an offense if the person intentionally submits a false statement or misappropriates the funds of a mutual insurance company organized under the laws providing for the incorporation of mutual fire, lightning, hail, and storm insurance companies.

(b) An offense under this section is a felony punishable by

confinement in the Texas Department of Criminal Justice for not less than 5 years or more than 10 years.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 87 (S.B. 1969), Sec. 25.122, eff. September 1, 2009.

Sec. 883.704. UNAUTHORIZED MUTUAL FIRE INSURANCE. (a) A person commits an offense if the person engages in the business of mutual fire insurance in this state in violation of the laws regulating mutual fire insurance.

(b) An offense under this section is a misdemeanor punishable by a fine of not less than \$50 or more than \$500.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

CHAPTER 884. STIPULATED PREMIUM INSURANCE COMPANIES

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 884.001. DEFINITION. In this chapter, "stipulated premium company" means a:

- (1) stipulated premium life insurance company;
- (2) stipulated premium accident insurance company;
- (3) stipulated premium life and accident insurance company;
- (4) stipulated premium accident and health insurance company; or
- (5) stipulated premium life, accident, and health insurance company.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 884.002. APPLICABILITY OF OTHER LAW TO COMPANY. (a) Except as expressly provided by this code, a provision of this code, other than this chapter, does not apply to a stipulated premium company organized under this chapter.

(b) A law enacted after August 28, 1961, does not apply to a stipulated premium company unless stipulated premium companies are expressly designated in the law.

(c) The following provisions of this code apply to a stipulated premium company:

- (1) Article 21.47;
- (2) Section 38.001;
- (3) Chapter 86;
- (4) Subchapter A, Chapter 401;
- (5) Sections 401.051, 401.052, 401.054-401.062, 401.151, 401.152, 401.155, and 401.156;
- (6) Sections 403.001, 403.052, and 403.102;
- (7) Subchapter A, Chapter 404;
- (8) Section 421.001;
- (9) Subchapter D, Chapter 425;
- (10) Chapter 443;
- (11) Chapter 493, other than Section 493.051(b);
- (12) Chapter 541;
- (13) Sections 801.001-801.002;
- (14) Sections 801.051-801.055;
- (15) Section 801.057;
- (16) Sections 801.101-801.102;
- (17) Subchapter A, Chapter 821;
- (18) Chapter 824;
- (19) Chapter 828;
- (20) Section 841.251;
- (21) Section 841.259;
- (22) Section 841.261;
- (23) Section 841.703; and
- (24) Chapter 4152.

(d) The Securities Act (Title 12, Government Code) applies to a stipulated premium company.

(e) The Texas Business Corporation Act applies to a stipulated premium company to the extent that law is not inconsistent with an insurance law applicable to a stipulated premium company. The department shall perform a duty imposed by the Texas Business Corporation Act on the office of the secretary of state that is applicable to a stipulated premium company.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 2E.076, eff. April 1, 2009.

Acts 2017, 85th Leg., R.S., Ch. 594 (S.B. 1070), Sec. 3.10, eff. September 1, 2017.

Acts 2019, 86th Leg., R.S., Ch. 491 (H.B. 4171), Sec. 2.34, eff. January 1, 2022.

Sec. 884.003. ADMITTED ASSETS. A stipulated premium insurer may include among its admitted assets a net asset under Section 841.004.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER B. FORMATION AND STRUCTURE OF STIPULATED PREMIUM INSURANCE COMPANY

Sec. 884.051. FORMATION OF COMPANY. (a) Five or more, but not more than 35, residents of this state may form a stipulated premium company.

(b) To form a stipulated premium company:

- (1) each incorporator must sign and acknowledge the articles of incorporation of the company; and
- (2) the incorporators must file the articles of incorporation with the department.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 884.052. ARTICLES OF INCORPORATION. (a) Articles of incorporation of a stipulated premium company must specify:

- (1) the name and place of residence of each incorporator;
- (2) the name of the proposed stipulated premium company;
- (3) the location of the proposed company's home office;
- (4) the kinds of insurance business the proposed company will transact;
- (5) the amount of the proposed company's capital stock;
- (6) the number of shares of the proposed company's capital stock; and
- (7) the period of the proposed company's duration, which may not exceed 500 years.

(b) The incorporators of a stipulated premium company may include other provisions in the articles of incorporation.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 884.053. COMPANY'S NAME. (a) The name of a stipulated premium company must contain the words "Insurance Company."

(b) A stipulated premium company's name may not be so similar to the name of another insurance company as to likely mislead the public.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 884.054. CAPITAL STOCK AND SURPLUS REQUIREMENTS. (a) A proposed stipulated premium company's capital stock must be in an amount of at least \$200,000.

(b) All of the capital stock required by Subsection (a) must be fully subscribed and paid up and delivered to the incorporators before the articles of incorporation are filed.

(c) To be incorporated, a stipulated premium company must possess at the time of incorporation, in addition to its capital, surplus in an amount of at least \$75,000. The amount of the surplus is not required to be stated in the company's articles of incorporation.

(d) At the time of incorporation the minimum capital and surplus shall consist only of:

- (1) United States currency;
- (2) bonds of the United States, this state, or a county or municipality of this state; or
- (3) government insured mortgage loans that are authorized by this chapter, with not more than 50 percent of the minimum capital invested in first mortgage real property loans.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1309 (H.B. [2570](#)), Sec. 1, eff. September 1, 2009.

Sec. 884.055. SHARES OF STOCK. (a) The shares of stock of a stipulated premium company must have a par value of not less than \$1 or more than \$100.

(b) A stipulated premium company may issue and dispose of authorized shares for money or an instrument authorized for minimum capital under Section 884.054(d). After the company receives payment for a share of stock, the share is nonassessable.

(c) If all of the shares of stock authorized by the charter or an amendment to the charter are not subscribed and paid for when the charter is granted or the amendment is filed, respectively, the stipulated premium company shall file with the department a certificate authenticated by a majority of the directors stating the number of shares issued and the consideration received for those shares. The company shall file the certificate not later than the 90th day after the date of issuance of any of those remaining shares.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 884.056. APPLICATION FOR CHARTER. (a) To obtain a charter for a stipulated premium company under this chapter, the incorporators must pay a charter fee in an amount determined under Chapter 202 and file with the department:

(1) an application for charter on the form and containing the information prescribed by the department;

(2) the company's articles of incorporation; and

(3) an affidavit made by two or more of the incorporators that states that:

(A) the minimum capital and surplus requirements of Section 884.054 are satisfied;

(B) the capital and surplus is the bona fide property of the company; and

(C) the information in the application and articles of incorporation is true and correct.

(b) The department may require that the incorporators provide at their expense additional evidence of a matter required in the affidavit before the department takes further action on the application for the charter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 2E.077, eff. April 1, 2009.

Sec. 884.057. ACTION BY COMMISSIONER AND DEPARTMENT AFTER FILING. (a) After the charter fee is paid and all items required for a charter under Section 884.056 are filed with the department, the commissioner shall approve or deny the charter application.

(b) On the applicant's request, the commissioner shall hold a hearing on a denial. Not later than the 30th day after the date of the applicant's request for a hearing, the commissioner shall request a hearing date.

(c) An interested party may participate fully and in all respects in any proceeding related to the application. An intervenor has the rights and privileges of a proper or necessary party in a civil suit in the courts of this state, including the right to be represented by counsel.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1022 (H.B. [4291](#)), Sec. 14, eff. June 19, 2009.

Sec. 884.058. EXAMINATION AFTER DETERMINATION. After making a determination on an application under Section 884.057, the commissioner shall immediately make or cause to be made a full and thorough examination of the company. The company shall pay for the examination.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1022 (H.B. [4291](#)), Sec. 15, eff. June 19, 2009.

Sec. 884.059. ACTION ON APPLICATION. (a) In considering the application, the commissioner, not later than the 30th day after the date on which a hearing under Section 884.058 is completed, shall determine if:

(1) the minimum capital and surplus required by Section 884.054 are the bona fide property of the stipulated premium company;

(2) the proposed officers, directors, and managing executives of the company have sufficient insurance experience, ability, and standing to make success of the proposed company

probable; and

(3) the applicants are acting in good faith.

(b) If the commissioner determines by an affirmative finding any of the issues under Subsection (a) adversely to the applicants, the commissioner shall reject the application in writing, giving the reason for the rejection. An application may not be granted unless it is adequately supported by competent evidence.

(c) If the commissioner does not reject the application under Subsection (b), the commissioner shall approve the application and on receipt of a fee in the amount determined under Chapter 202 shall provide to the incorporators a certified copy of the application, articles of incorporation, and submitted affidavit.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.078, eff. April 1, 2009.

Sec. 884.060. BEGINNING OF CORPORATE EXISTENCE. On receipt of the certified copy of documents under Section 884.059(c), the stipulated premium company becomes a body politic and corporate and the incorporators may complete organization of the company under Section 884.061.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 884.061. ORGANIZATIONAL MEETING. (a) After receipt of the certified copy of documents under Section 884.059(c), the incorporators shall promptly call a meeting of the stipulated premium company's shareholders. The shareholders shall:

- (1) adopt bylaws to govern the company; and
- (2) elect the company's initial board of directors.

(b) The directors elected under this section serve until directors are first elected under Section 884.153.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER C. AUTHORITY TO ENGAGE IN BUSINESS

Sec. 884.101. SCHEDULE OF ASSETS. Two or more officers of the stipulated premium company shall execute and file with the department:

(1) a sworn schedule of each of the assets of the company exhibited to the department during the examination under Section 884.057 showing the value of the assets; and

(2) a sworn statement that the assets are bona fide, are the unconditional and unencumbered property of the company, and are worth the amount stated in the schedule.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 884.102. TEMPORARY CERTIFICATE OF AUTHORITY. (a) If the commissioner makes a determination favorable to the applicants on all issues under Section 884.059(a), the department, on compliance with the requirements of Section 884.101, shall promptly issue to the company a temporary certificate of authority. The temporary certificate must limit the activities of the company solely to negotiating and obtaining a direct reinsurance agreement, as described by Subchapter L, with a company that on August 28, 1961, was chartered and doing business under former Chapter 14 of this code.

(b) A temporary certificate of authority expires on the first anniversary of its date of issuance unless the department renews it for an additional one-year period.

(c) On the expiration of a temporary certificate of authority the incorporators of the stipulated premium company to which the certificate was issued shall promptly surrender the company's charter to the department for cancellation.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 884.103. REGULAR CERTIFICATE OF AUTHORITY. (a) If a direct reinsurance agreement described by Section 884.102(a) is entered into while the temporary certificate of authority is valid, the department shall promptly issue to the stipulated premium company a regular certificate of authority to transact the business of insurance in this state in accordance with Subchapter L.

(b) The regular certificate of authority shall provide for the

kind of insurance business that the stipulated premium company may conduct. If the other party to the agreement conducts the business of life insurance or is a burial association, the stipulated premium company is entitled to write life insurance policies under this chapter. If the other party is permitted under its charter to write accident insurance, health and accident insurance, or life, health, and accident insurance, the stipulated premium company is entitled to write that kind of insurance.

(c) If a stipulated premium company that holds a regular certificate of authority enters into a direct reinsurance agreement with another company engaged in business under Chapter 887 or 888, the stipulated premium company's certificate of authority shall be amended to authorize the writing of any kind of insurance authorized for the other company.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER D. MANAGEMENT OF STIPULATED PREMIUM COMPANY

Sec. 884.151. CONDUCTING SHAREHOLDERS' MEETING. (a) At a meeting of a stipulated premium company's shareholders, each shareholder is entitled to one vote for each fully paid share of stock appearing in the shareholder's name on the company's books.

(b) A shareholder may vote in person or by written proxy.

(c) At a shareholders' meeting, a quorum is any number of shareholders whose cumulative stock ownership in the stipulated premium company represents a majority of the company's paid up capital stock.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 884.152. BOARD OF DIRECTORS. (a) Subject to the bylaws of the stipulated premium company, as adopted or amended by the shareholders or directors, the board of directors has full management and control of the company.

(b) The board consists of not fewer than five directors.

(c) The directors shall keep a full and correct record of the board's transactions. The shareholders may inspect those records during business hours.

(d) The directors shall fill a vacancy that occurs on the board

or in any office of the company.

(e) A majority of the board is a quorum.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 884.153. ELECTION OF DIRECTORS. (a) On the second Tuesday of April of each year the shareholders of a stipulated premium company shall meet at the company's home office and shall elect the company's board of directors to serve one-year terms beginning immediately after the election.

(b) If the shareholders do not elect directors at that meeting, the shareholders may elect the directors at a special shareholders' meeting called for that purpose.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 884.154. OFFICERS. (a) A stipulated premium company's directors shall choose one of the directors to serve as the company's president.

(b) Other officers of the stipulated premium company shall be chosen in accordance with the bylaws of the company. An officer other than the president is not required to be a director or a shareholder unless such a qualification is required by the company's bylaws.

(c) The duties and compensation of a stipulated premium company's officers are as stated in the company's bylaws. If the bylaws do not state the duties or compensation of the officers, the directors shall establish the duties or compensation.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 884.155. AMENDMENT OF CHARTER OR ARTICLES. (a) The shareholders of a stipulated premium company by resolution may amend the company's charter or articles of incorporation at any shareholders' meeting.

(b) The amendment and a copy of the resolution certified by the president and secretary of the stipulated premium company shall be filed and recorded in the same manner as the charter.

(c) An amendment of the charter or articles takes effect when it is recorded.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER E. CAPITAL AND SURPLUS

Sec. 884.201. FORM OF CAPITAL AND SURPLUS. After a charter is granted under this chapter, the stipulated premium company:

(1) shall maintain the company's minimum capital at all times in a form described by Section 884.054(d); and

(2) may invest the company's surplus as provided by Sections 425.203-425.228.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 2E.079, eff. April 1, 2009.

Sec. 884.202. INCREASE OR DECREASE OF CAPITAL STOCK. (a) At any shareholders' meeting, shareholders of a stipulated premium company whose cumulative stock ownership represents a majority of the capital stock of the company by resolution may increase or decrease the amount of the company's capital stock subject to this section.

(b) Capital stock may be decreased to an amount that is less than \$200,000 only to avoid insolvency as provided by Section 884.205.

(c) Two officers of the stipulated premium company must sign and acknowledge a statement of the increase or decrease. The acknowledged statement and a certified copy of the resolution shall be filed and recorded in the same manner as the charter.

(d) For an increase or decrease of capital stock, the stipulated premium company may require the return of the original certificates evidencing the stock in exchange for new certificates. An issuance of new certificates that results in a transfer of stock is subject to Section 884.254.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1309 (H.B. [2570](#)), Sec. 2, eff.

September 1, 2009.

Sec. 884.203. PUBLIC OFFERING OF CAPITAL STOCK. A stipulated premium company may not make to the public an offering that is subject to The Securities Act (Title 12, Government Code), of any of its capital stock before the company possesses:

- (1) capital in an amount of at least \$100,000; and
- (2) unencumbered surplus in an amount of at least \$100,000.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 491 (H.B. 4171), Sec. 2.35, eff. January 1, 2022.

Sec. 884.204. COMPANY'S REPURCHASE OF STOCK. (a) Subject to Section 884.202, a stipulated premium company may purchase in the name of the company outstanding shares of the company's capital stock as provided by the Texas Business Corporation Act.

(b) A purchase of stock under this section is not considered an investment and does not violate the provisions of this code relating to eligible investments for a stipulated premium company.

(c) A stipulated premium company that purchases stock under this section shall file with the department not later than the 10th day after the date of the purchase a statement that contains the name of each shareholder from whom the shares were purchased and the sum of money paid for those shares.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 884.205. IMPAIRMENT OF CAPITAL STOCK. (a) If, when computing the liabilities of a stipulated premium company under this chapter, one-third or more of the company's capital stock becomes impaired, the company shall correct the impairment not later than the 60th day after the date the company becomes subject to this subsection by:

- (1) reducing the company's capital stock;
- (2) adjusting the premium rate if permitted by policy contract; or

(3) both reducing capital stock and adjusting the premium rate.

(b) If, when computing a stipulated premium company's reserve liability under this chapter, 50 percent or more of the company's capital stock becomes impaired, the commissioner may apply to a court for the appointment of a receiver to wind up the affairs of the company.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1309 (H.B. 2570), Sec. 3, eff. September 1, 2009.

Sec. 884.206. COMMISSIONER MAY REQUIRE LARGER CAPITAL AND SURPLUS AMOUNTS. (a) The commissioner by rule may require a stipulated premium company that writes or assumes life insurance, annuity contracts, or accident and health insurance for a risk to one person in an amount that exceeds \$10,000 to maintain capital and surplus in amounts that exceed the minimum amounts required by this chapter because of:

(1) the nature and kind of risks the company underwrites or reinsures;

(2) the premium volume of risks the company underwrites or reinsures;

(3) the composition, quality, duration, or liquidity of the company's investment portfolio;

(4) fluctuations in the market value of securities the company holds; or

(5) the adequacy of the company's reserves.

(b) A rule adopted under Subsection (a) must be designed to ensure the financial solvency of a stipulated premium company for the protection of policyholders and may not require that the total admitted assets of a company exceed 106 percent of its total liabilities.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 884.207. NEW BUSINESS PROHIBITED WHEN CAPITAL REQUIREMENTS NOT SATISFIED. (a) A stipulated premium company may not write new

business in this state unless the company possesses the minimum capital required under this chapter.

(b) A stipulated premium company subject to Section 884.205(a) that does not correct the impairment on or before the date provided by that subsection may not write new business in this state after that date until the impairment is corrected.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER F. GENERAL POWERS AND DUTIES OF STIPULATED PREMIUM COMPANY

Sec. 884.251. DEPOSIT OF COMPANY'S FUNDS. (a) A director, member of a committee, officer, or clerk of a stipulated premium company who has the duty of handling or investing the company's funds shall deposit or invest those funds in the corporate name of the company.

(b) An individual described by Subsection (a) may not:

- (1) borrow the funds of the stipulated premium company;
- (2) have an interest in any way in a loan, pledge, security, or property of the company, except as shareholder; or
- (3) take or receive for the individual's use a fee, brokerage, commission, gift, or other consideration for, or on account of, a loan made by or on behalf of the company.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 884.252. PAYMENTS TO OFFICERS, DIRECTORS, AND EMPLOYEES.

(a) Unless first authorized by a vote of a stipulated premium company's board of directors or a committee of the board that has the duty of authorizing the payment, the company may not pay:

- (1) any compensation or emolument to an officer or director of the company; or
- (2) compensation or emolument in an amount that exceeds \$50,000 in any year to an individual, firm, or corporation that is not an officer or director of the company.

(b) This section does not prevent a stipulated premium company from contracting with its agents for the payment of renewal commissions.

(c) The shareholders of a stipulated premium company may authorize the creation of one or more plans for the payment of

pensions, retirement benefits, or group insurance for its officers and employees. The shareholders may delegate to the company's board of directors the power and duty to prepare, effect, finally approve, administer, and amend a plan.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 884.253. DIVIDENDS. (a) A stipulated premium company may declare or pay a dividend to its shareholders only from the profits made by the company, not including surplus from the sale of stock.

(b) A stipulated premium company may not pay a dividend, other than a stock dividend, unless:

(1) any deficiency reserve under Section 884.453 has been eliminated; and

(2) the capital of the company is maintained in an amount of at least \$100,000.

(c) A stipulated premium company that complies with Subsection (b) may pay cash dividends in accordance with Sections 403.001 and 403.052.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.080, eff. April 1, 2009.

Sec. 884.254. TRANSFER OF STOCK. (a) A stipulated premium company's shares of stock are transferable on the company's books, in accordance with law and the bylaws of the company, by the owner or the owner's authorized agent.

(b) Each person who becomes a shareholder by a transfer of shares succeeds to all rights of the former holder of those shares, by reason of that ownership.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 884.255. USE OF CERTAIN TERMS IN ADVERTISING. A stipulated premium company may not use in its advertising or representation of a policy the words "legal reserve company," "stock

company," "old line legal reserve company," or words of similar meaning that might lead the public to believe that a policy provides nonforfeiture values.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 884.256. ANNUAL STATEMENT; FILING FEE. (a) Except as provided by Section 884.406, not later than March 31 of each year a stipulated premium company shall:

(1) prepare a statement showing the condition of the company on December 31 of the preceding year; and

(2) deliver the statement to the department accompanied by a filing fee in the amount determined under Chapter 202.

(b) The statement must be under the oath of two of the stipulated premium company's officers and must show in detail:

(1) the character of the company's assets and liabilities on December 31 of the preceding year;

(2) the amount and character of business transacted and money received during the year and how money was spent during the year;

(3) the number and amount of the company's policies in force on that date; and

(4) the total amount of the company's policies in force on that date.

(c) For purposes of Subsection (b), an insured under a family group policy to which Section 884.451(b) applies is accounted for only if a reserve is required for that insured under that section.

(d) The department shall prescribe the form of the statement.

(e) Fees collected under this section shall be deposited to the credit of the Texas Department of Insurance operating account. Sections 201.001 and 201.002 apply to fees collected under this section.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.081, eff. April 1, 2009.

SUBCHAPTER G. POWERS AND DUTIES RELATING TO COVERAGES

Sec. 884.301. REINSURANCE OF POLICY. (a) A stipulated premium company may reinsure on an individual indemnity policy basis any risk or part of a risk that the company underwrites or assumes.

(b) The reinsurer must be a legal reserve company that:

(1) is authorized to write life, health, and accident insurance in this state; and

(2) has capital and surplus in an amount of at least \$200,000.

(c) After reinsuring under Subsection (a), a stipulated premium company may take a credit for the reinsurance against the aggregate reserves required by Subchapter J.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 884.302. LIMITS ON LIFE INSURANCE. (a) Until the amount of the surplus of a stipulated premium company is at least \$50,000, the company may not insure one life for more than \$1,000 in the event of death from natural causes or more than \$2,000 in the event of death from accidental causes, unless the company reinsures the amount of coverage greater than that applicable amount under Section 884.301.

(b) Subsection (a) does not apply to a policy of insurance assumed by a stipulated premium company under Subchapter L.

(c) If the amount of the surplus of a stipulated premium company is at least \$50,000 but less than \$200,000, the company shall reinsure the insurance amount that exceeds \$15,000 on a life insurance risk on one life.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 884.303. ISSUANCE OF LIFE INSURANCE POLICIES BY CERTAIN COMPANIES. (a) A stipulated premium company that possesses capital and unencumbered surplus in a combined amount of at least \$100,000 may issue life insurance policies as authorized for a company operating under Chapter 841.

(b) A stipulated premium company may not insure one life under this section for more than \$25,000, except as provided by Section 884.304 or Subchapter I.

(c) A stipulated premium company may issue a policy under this

section only on an endowment or limited pay basis.

(d) A stipulated premium company must reserve and reinsure a policy issued under this section as required for a company operating under Chapter 841.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1309 (H.B. 2570), Sec. 4, eff. September 1, 2009.

Sec. 884.304. LIFE INSURANCE OF MORE THAN \$25,000.(a) Except as provided by this section, a stipulated premium company may not assume liability on a life insurance risk on one life in an amount that exceeds \$25,000.

(b) If a stipulated premium company assumes a life insurance risk under a life insurance policy, the initial death benefit of \$25,000 or less may increase to an amount greater than \$25,000 subject to this section.

(c) For each policy year of a policy for which, after issuance, the death benefit exceeds \$25,000, the amount of the increase of the death benefit at the end of that policy year from the end of the preceding policy year may not exceed the greater of:

(1) the amount computed using the maximum rate of increase provided by the policy, which rate may not exceed five percent a year, compounded annually; or

(2) the amount computed using the consumer price index for all urban consumers for all items and for all regions of the United States combined, as determined by the United States Department of Labor, Bureau of Labor Statistics, on September 30 of the year preceding the year in which the policy year ends, compounded annually.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1309 (H.B. 2570), Sec. 5, eff. September 1, 2009.

Sec. 884.305. PREMIUMS ON LIFE INSURANCE POLICIES. The premiums charged on a life insurance policy issued by a stipulated

premium company may not be less than the renewal net premium computed under the reserve standard adopted by the stipulated premium company and approved by the department.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 884.306. LIFE INSURANCE CONTRACT. A life insurance policy issued by a stipulated premium company constitutes the entire contract, except that if a copy of the application for the policy is attached to the policy, the policy and application constitute the entire contract.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 884.307. ISSUANCE OF ANNUITY CONTRACT. (a) A stipulated premium company that possesses capital and unencumbered surplus in a combined amount of at least \$100,000 more than all of its liabilities, including contingent liabilities, may issue annuity contracts as authorized by Chapters 3 and 1701 and Title 7.

(b) The stipulated premium company shall maintain reserves on the contracts in accordance with the statutes governing reserves on equivalent contracts issued by a legal reserve company.

(c) A stipulated premium company that writes annuity contracts under this section shall maintain capital and unencumbered surplus in at least the combined amount required by Subsection (a).

(d) A stipulated premium company that does not comply with Subsection (c) is considered to be insolvent.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 2E.082, eff. April 1, 2009.

Sec. 884.308. LIMITS ON AMOUNT OF ACCIDENT AND HEALTH INSURANCE POLICIES. (a) A stipulated premium company may not assume liability on or indemnify one person for any risk under one or more accident, health, or hospitalization insurance policies, or any combination of those policies in an amount that exceeds \$10,000, unless the amount

of the issued, outstanding, and stated capital of the company is at least \$700,000.

(b) A stipulated premium company that before January 1, 2002, ceases to assume liability on, or indemnify any risk under a policy described by Subsection (a) in the amount specified by Subsection (a), and notifies the commissioner of that action is exempt from the requirements of Subsection (a) until the date the company resumes writing those policies. A company that resumes assuming liability on or indemnifying risks under these policies shall comply with Subsections (a) and (c). For purposes of this subsection, renewal of a policy is not considered to be writing a policy.

(c) A stipulated premium company that is exempt under Subsection (b) shall maintain its issued, outstanding, and stated capital in an amount that is at least:

(1) \$100,000, if the last date that the company writes a policy described by Subsection (a) is before January 1, 1993;

(2) \$160,000, if the last date that the company writes a policy described by Subsection (a) is during 1993;

(3) \$220,000, if the last date that the company writes a policy described by Subsection (a) is during 1994;

(4) \$280,000, if the last date that the company writes a policy described by Subsection (a) is during 1995;

(5) \$340,000, if the last date that the company writes a policy described by Subsection (a) is during 1996;

(6) \$400,000, if the last date that the company writes a policy described by Subsection (a) is during 1997;

(7) \$460,000, if the last date that the company writes a policy described by Subsection (a) is during 1998;

(8) \$520,000, if the last date that the company writes a policy described by Subsection (a) is during 1999;

(9) \$580,000, if the last date that the company writes a policy described by Subsection (a) is during 2000; and

(10) \$640,000, if the last date that the company writes a policy described by Subsection (a) is during 2001.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 884.309. ADJUSTMENT OF PREMIUMS. (a) The board of directors of a stipulated premium company by resolution may, subject

to this chapter, increase or otherwise adjust a rate of premium on any insurance policy it issues, reinsures, or assumes when, in the board's discretion, the adjustment is necessary.

(b) In making a comprehensive adjustment of one or more classes of the stipulated premium company's policies, the board of directors may provide that an insured who is required to pay an increased premium may choose to pay a part or none of the amount of the increase and receive a reduction of the corresponding insurance benefits proportionate to the value of the unpaid part of the increase.

(c) This section does not apply to a policy:

(1) issued by a stipulated premium company that on the date the policy is issued possesses an unencumbered surplus in an amount of at least \$50,000;

(2) on which the stipulated premium company has relinquished the right to adjust rates; and

(3) under which the premium for life insurance requires the payment of a premium for life insurance that alone is sufficient to maintain reserves at least equal to those computed on the basis of the 1958 Commissioners Standard Ordinary Table of Mortality with interest not to exceed 3-1/2 percent a year.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 884.310. AGENT. Each agent of a stipulated premium company must be licensed under Title 13.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.221(a), eff. Sept. 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.083, eff. April 1, 2009.

Sec. 884.311. LAW GOVERNING INVESTMENTS; ELECTION. (a) A stipulated premium insurance company issuing life, health, or accident coverages or maintaining policies in force that were issued in accordance with Subchapter I may elect that the company's investments and transactions be governed by Subchapter C, Chapter

425.

(b) The election under Subsection (a) must be made by written notice to the commissioner and is effective on the first day of the calendar quarter following the day on which the notice is filed with the commissioner.

(c) After the second anniversary of the effective date of an initial election authorized by this section, the stipulated premium insurance company may elect that the company's investments and transactions be governed by Sections 425.203-425.228.

(d) The subsequent election under Subsection (c) must be made by written notice to the commissioner and is effective on the first day of the calendar quarter following the day on which the notice is filed with the commissioner.

(e) After a stipulated premium insurance company has made a subsequent election under Subsection (c), the company may make another election under this section, subject to the approval of the election by the commissioner.

Added by Acts 2003, 78th Leg., ch. 487, Sec. 1, eff. Sept. 1, 2003.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.084, eff. April 1, 2009.

SUBCHAPTER H. CONTENTS OF APPLICATIONS AND POLICIES

Sec. 884.351. GENERAL REQUIREMENTS FOR POLICY AND APPLICATION FORMS. (a) Each stipulated premium company policy or application form must contain on its face immediately after the name of the company "A Stipulated Premium Company."

(b) A stipulated premium company shall provide for an adjustment of the premium rate on the insurance contract in each insurance policy it issues, reinsures, or assumes that is subject to a premium adjustment under Section 884.309. Each policy subject to a premium adjustment under that section must contain on the front of the policy a statement that the premium is subject to readjustment.

(c) A stipulated premium company's policy of insurance may not contain "Approved by the Commissioner of Insurance" or words of a similar meaning.

(d) A life insurance policy issued by a stipulated premium company or an application for the policy may not contain language or

be in a form that misleads the policyholder or applicant about the kind of insurance offered or the rights or benefits of the policyholder or applicant.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 884.352. REQUIREMENTS FOR ACCIDENT, HEALTH, AND HOSPITALIZATION INSURANCE POLICIES. An accident, health, or hospitalization insurance policy issued, reinsured, or assumed by a stipulated premium company must contain a premium redetermination clause that permits the company's board of directors to adjust the premium rate.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 884.353. LIFE INSURANCE APPLICATION FORMS. (a) An application for a life insurance policy issued by a stipulated premium company must be signed by the applicant. If the applicant is a minor, the application may be signed by a parent or guardian.

(b) The application for a policy that provides that a misstatement relating to the applicant's health or physical condition may void the policy within the contestable period must state that provision in language approved by the department. The statement must be in not less than 10-point type.

(c) In the absence of fraud each statement in an application is regarded as a representation and not a warranty.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 884.354. LIFE INSURANCE POLICY FORMS; INCONTESTABILITY.

(a) Each life insurance policy issued by a stipulated premium company must state on the front page:

(1) the amount of death benefit to be paid; and

(2) the circumstances or conditions under which the benefit is to be paid.

(b) Each condition of a life insurance policy must be stated in the policy.

(c) A life insurance policy must provide that a policy in force

for two years becomes incontestable, except for nonpayment of premiums, on the second anniversary of the date of issuance, if the insured does not die before that date.

(d) A life insurance policy must provide that if the age of the insured is misstated, the amount of insurance is the amount that the premium paid would have purchased if the age had been stated correctly, based on premium rates in effect when the insured dies.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 884.355. DESIGNATION OF BENEFICIARIES. The designation of a beneficiary under a life insurance policy issued by a stipulated premium company must comply with Subchapter B, Chapter 1103, and Subchapter A, Chapter 1104.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 884.356. LIFE INSURANCE BENEFIT REDUCTIONS OR INCREASES.

(a) A life insurance policy may provide for reduced benefits if the insured:

(1) dies or is injured while engaged in:

(A) military, naval, or aerial service or aerial flight during peace or war; or

(B) a hazardous occupation specified in the policy; or

(2) dies by the insured's own hand, regardless of whether the insured is sane or insane.

(b) The front page of a life insurance policy must call attention to any reduction or exclusion of benefits provided by the policy. The circumstances or conditions under which the reduction or exclusion applies must be stated plainly in the policy.

(c) If a policy that provides natural death benefits contains a provision for reducing the greatest death benefit provided by the policy for a specified insured for a reason other than a reason specified by Subsection (a):

(1) the reduced death benefit for the insured must at all times when the reduction is in effect equal or exceed 120 percent of the total premium paid on that policy by the insured; and

(2) the reduction must end before the fifth anniversary of the date the policy is issued.

(d) Subsection (c) does not apply to a life insurance policy on which the reduction of the death benefit does not apply at the time of the death of the insured.

(e) If a life insurance policy provides for an increase of the initial amount of the death benefit for a specified insured one or more times during the first five years of the policy, the amount of death benefit for the insured must at all times during the period of the increasing benefit equal at least 120 percent of the premiums paid on that policy by the insured during the period of the increase.

(f) Subsection (e) does not apply to a life insurance policy that has been in force for more than five years from the date the policy is issued.

(g) This section does not apply to a family group life insurance policy described by Section 884.451(b).

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 884.357. FORM APPROVAL. The approval of a form of an insurance policy issued by a stipulated premium company is governed by Chapter 1701.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 2E.085, eff. April 1, 2009.

SUBCHAPTER I. AUTHORITY TO ISSUE OTHER COVERAGE

Sec. 884.401. AUTHORITY CUMULATIVE. The authority provided by this subchapter is in addition to the authority provided by this chapter for the issuance of other insurance coverage.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 884.402. ADDITIONAL COVERAGE. A stipulated premium company that, at the time it begins to issue coverages under this subchapter, possesses the amounts of capital and unencumbered surplus equal to or greater than the corresponding amounts required for organization of a life and health company under Sections 841.052,

841.054, 841.204, 841.205, 841.301, and 841.302 may, subject to Section 884.403:

(1) issue any kind of life insurance coverage authorized by Chapter 3, 841, or 1701 or Title 7;

(2) issue any kind of health or accident insurance coverage authorized by:

(A) Title 7;

(B) Chapter 3, 704, 841, 846, 982, 1201, 1202, 1203, 1210, 1251, 1252, 1253, 1254, 1301, 1351, 1354, 1359, 1364, 1368, 1501, 1504, 1505, 1552, 1575, 1576, 1579, 1581, 1625, 1651, 1652, or 1701;

(C) Chapter 493, other than Section 493.051(b);

(D) Subchapter B, Chapter 38, Subchapter D, Chapter 425, Subchapter A or F, Chapter 1204, Subchapter A, Chapter 1273, Subchapter A, B, or D, Chapter 1355, Subchapter A, Chapter 1366, or Subchapter A, Chapter 1507;

(E) Section 1204.151, 1204.153, 1204.154, or 1451.051;

or

(F) Chapter 177, Local Government Code; or

(3) issue life insurance coverage through policies without cash surrender values or nonforfeiture values and that exceed \$10,000 on one life.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 2E.086, eff. April 1, 2009.

Acts 2017, 85th Leg., R.S., Ch. 594 (S.B. [1070](#)), Sec. 3.11, eff. September 1, 2017.

Sec. 884.403. POLICY REQUIREMENTS. (a) A policy issued under Section 884.402(1) or (2) must be reserved and must comply with the law, including rules, applicable to a policy issued by a company authorized to engage in or engaging in the business of insurance under Chapter 841.

(b) A policy of life insurance issued under Section 884.402(3):

(1) must be reserved in accordance with a reserve table adopted by the department as appropriate for that type of policy;

(2) must contain:

(A) on its first page, a notice that the policy does not provide cash surrender values or other paid up nonforfeiture benefits or loan values; and

(B) provisions for a grace period for the payment of each premium after the first payment during which the policy remains in force; and

(3) may not be approved until the commissioner has adopted the standard of valuation, including an appropriate mortality table and interest rate.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 884.404. CAPITAL AND SURPLUS REQUIREMENTS. (a) A stipulated premium company that issues any insurance coverage under this subchapter shall maintain at all times the capital and unencumbered surplus required under Section 884.054.

(b) A stipulated premium company that does not comply with this section is considered to be impaired unless it reinsures all insurance coverages written under this subchapter with a company that:

(1) is authorized to engage in the business of insurance in this state under this chapter or Chapter 841 or 882 or is an accident insurance company, health insurance company, or life insurance company authorized to engage in the business of insurance in this state under Chapter 982, as appropriate; and

(2) complies with the requirements prescribed by this subchapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1309 (H.B. [2570](#)), Sec. 6, eff. September 1, 2009.

Sec. 884.405. AGENT; LICENSE. (a) An agent may not solicit or write any coverage authorized by this subchapter unless the agent:

(1) holds a license issued under Chapter 4054; and

(2) is appointed by the stipulated premium company for which the agent is soliciting and writing coverage under this subchapter.

(b) The commissioner may issue under Chapter 4054 a license for an agent to solicit and write any coverage authorized by this subchapter for a stipulated premium company. Chapter 4054 applies to the stipulated premium company as if the company were a legal reserve life insurance company.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.087, eff. April 1, 2009.

Sec. 884.406. ANNUAL STATEMENT. A stipulated premium company that issues or maintains in force policies under this subchapter shall file the annual statement required by Section 884.256 not later than March 1 of each year.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 884.407. RELATIONSHIP OF SUBCHAPTER TO OTHER PROVISIONS OF CHAPTER. (a) Section 884.305 and Subchapter J do not apply to a policy issued under this subchapter.

(b) The provisions of Sections 884.309 and 884.351 relating to the adjustment of premiums do not apply to a life insurance policy issued under this subchapter.

(c) The department may not consider losses sustained by a stipulated premium company on a policy issued under this subchapter when applying Section 884.206 or 884.308 to the company's life insurance policies not issued under this subchapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 884.408. IMPLEMENTATION OF SUBCHAPTER. The commissioner shall adopt reasonable rules to implement this subchapter, including:

(1) rules adopting mortality and reserving tables required by Sections 884.403(b)(1) and (3); and

(2) reasonable and necessary rules for the content, form, and style of the notice and terms of the grace period required under Section 884.403(b)(2).

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER J. RESERVES

Sec. 884.451. RESERVES ON INDIVIDUAL AND GROUP LIFE INSURANCE POLICIES. (a) A stipulated premium company shall maintain reserves on each of its individual life insurance policies in accordance with the reserve standard adopted by the company and approved by the department. The standard must provide reserves that in the aggregate are equal to at least the reserve amounts computed using the 1956 Chamberlain Reserve Table with interest that does not exceed 3-1/2 percent per year. A stipulated premium company may use the 1956 Chamberlain Reserve Table.

(b) A stipulated premium company shall maintain reserves on family group life insurance policies on which a group premium is charged and under which the amount of a benefit depends on the sequence of deaths. The amount of the reserves must be equal to the reserves that would be required under Subsection (a) on individual life insurance policies on the lives of:

(1) the two oldest living members of the family group, with the amount of insurance for those two members determined assuming that the elder of the two will die first; or

(2) the living members of the family group, with the amount of insurance for each member of the family group determined assuming that each member will die first.

(c) A stipulated premium company may select the method to be used to compute the amount of the reserves under Subsection (b).

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 884.452. RESERVES ON ACCIDENT AND HEALTH INSURANCE POLICIES. A stipulated premium company shall maintain reserves on each accident and health insurance policy issued by the company in the manner required of a company authorized to issue that type of policy under Chapter 841.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 884.453. DEFICIENCY RESERVE. (a) On the effective date

of a direct reinsurance agreement under Subchapter L, the stipulated premium company shall compute:

(1) the amount of the reserves required under this chapter on the policies assumed under the agreement; and

(2) the amount of the net assets transferred to the stipulated premium company under the agreement.

(b) If the amount of the net assets transferred is not equal to the amount of the required reserve, the difference shall be designated and carried as a deficiency reserve. The deficiency reserve does not create insolvency of the stipulated premium company if the company, beginning with the first calendar year that begins after the effective date of the direct reinsurance agreement, reduces the computed deficiency amount, including interest at the assumed rate, by at least 10 percent during each year as computed on December 31 of that year. The reduction must result in the deficiency reserve being eliminated on December 31 of the year for which the 11th annual statement is filed after the company enters into the direct reinsurance agreement. The required reduction in the deficiency reserve may not exceed the cumulative aggregate amount of 10 percent a year.

(c) If in any year a stipulated premium company has not reduced its deficiency reserve as required by Subsection (b), the company's board of directors by appropriate action shall increase premium rates by advancing the age of each insured at the date the insured's policy is issued or otherwise equitably adjust premium rates to correct that failure. The board shall take that action not later than the 30th day after the date the reserves are computed.

(d) If the board does not comply with Subsection (c), the stipulated premium company is considered to be insolvent for purposes of this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 884.454. COMMISSIONER'S COMPUTATION OF RESERVE LIABILITY.

(a) As soon as practical each year, the department shall compute the reserve liability of each stipulated premium company that has outstanding insurance policies.

(b) To make the computations, the department:

(1) shall use the net premium basis in accordance with the

reserve table and interest rate adopted by the stipulated premium company and approved by the commissioner; and

(2) may use group methods and approximate averages for fractions of a year.

(c) The reserve liability may be computed on not more than a one-year preliminary term with allowance for any deficiency reserve under Section 884.453.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 884.455. REQUIRED SECURITIES. The commissioner shall require that a stipulated premium company have securities of the class and character required by Sections 425.203-425.228 in the amount of the reserve liability computed for the company under Section 884.454 less any deficiency reserve under Section 884.453 after all the debts and claims against the company and the minimum capital required by this chapter have been applied.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.088, eff. April 1, 2009.

Sec. 884.456. INCREASE OF RESERVES. (a) If a stipulated premium company does not have the reserves required by this subchapter and the minimum capital required under this chapter, the company's board of directors by appropriate action shall increase premium rates on policies in force by advancing the age of each insured at the date the insured's policy is issued or otherwise equitably adjust premium rates to correct the reserve inadequacy. The board shall take that action not later than the 30th day after the date the reserves are computed.

(b) If the board of directors does not comply with Subsection (a), the stipulated premium company is treated as if the company had not corrected an impairment under Section 884.205(a).

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER K. DIRECT REINSURANCE AGREEMENTS

Sec. 884.501. DIRECT REINSURANCE AGREEMENTS BETWEEN STIPULATED PREMIUM COMPANIES. (a) Stipulated premium companies organized under this chapter may enter into a total or partial direct reinsurance agreement if the company assuming the policies under the agreement is authorized to transact the kinds of insurance provided by those policies.

(b) Before a stipulated premium company may enter into a total direct reinsurance agreement:

(1) the company must submit the agreement to the department; and

(2) the department must approve the agreement as fully protecting the interests of all the holders of policies being assumed.

(c) A partial direct reinsurance agreement shall be filed with the department before the effective date of the agreement.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 884.502. DIRECT REINSURANCE AGREEMENT WITH LEGAL RESERVE COMPANY. (a) A stipulated premium company may enter into a total or partial direct reinsurance agreement with a legal reserve life insurance company authorized to engage in the business of insurance in this state.

(b) Before a reinsurance agreement under this section may take effect, it must be:

(1) approved by a majority vote of the board of directors of each company;

(2) submitted to the department; and

(3) approved by the department as complying with Section 884.503 or 884.504, as applicable.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 884.503. DIRECT REINSURANCE OF ACCIDENT OR HEALTH INSURANCE POLICIES. (a) In the direct reinsurance of a stipulated premium accident or health insurance policy under Section 884.502, the company assuming the policy under the agreement must assume the exact obligations of the policy.

(b) If a policy is non-cancellable or guaranteed renewable, the assuming company may include in the assumption certificate a premium redetermination clause instead of the clause required by Section 884.352.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 884.504. DIRECT REINSURANCE OF CERTAIN POLICIES. (a) A reinsurance agreement authorized by Section 884.502 for the direct reinsurance of life insurance policies or a combination of life and accident or health insurance policies must contain provisions that comply with this section.

(b) If the legal reserve life insurance company is the reinsurer and issues an assumption certificate providing whole life coverage for the life benefit, the policyholder is not entitled to receive the policyholder's individual reserve in cash by surrendering the assumption certificate.

(c) If the reserves and premium under the stipulated premium policy are inadequate to provide whole life coverage under the legal reserve assumption certificate and a term coverage assumption is made available, each affected policyholder must be allowed to select:

(1) payment in cash of the amount of the individual reserve, reduced by the deficiency reserve, if any, to the policyholder on surrender of the policy;

(2) an assumption certificate of another stipulated premium company engaging in the business of insurance under this chapter; or

(3) the legal reserve life insurance company's assumption certificate for term coverage that is renewable for the life of the insured without evidence of insurability and the rate for which is based on the legal reserve table selected by the assuming company at the attained age of the insured on the date of the renewal increased by an appropriate expense factor.

(d) To exercise the option described by Subsection (c)(1) the policyholder must request that option not later than the 60th day after the date that the notice of the options available to the policyholder is mailed. A policyholder is entitled to exercise the option under Subsection (c)(2) or (3) not later than the 60th day after the date the assumption certificate of the legal reserve life insurance company is mailed to the policyholder.

(e) If the legal reserve life insurance company makes term coverage available, the company shall use each policyholder's individual reserve, less the amount of the deficiency, if any, as:

(1) a reserve credit to permit the legal reserve assumption certificate to be backdated to the earliest date the reserve credit allows; or

(2) an annuity to reduce the required premium during the initial period of the term coverage.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 884.505. EFFECT OF TOTAL DIRECT REINSURANCE AGREEMENT.

(a) A stipulated premium company that enters into a total direct reinsurance agreement under Section 884.501 or 884.502 under which it is the ceding company shall promptly surrender its certificate of authority to the department.

(b) The stipulated premium company's shareholders and board of directors shall effect the company's dissolution.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 884.506. ASSUMPTION CERTIFICATE. The company assuming a policy under a partial direct reinsurance agreement shall issue to the holder of the assumed policy an assumption certificate to be attached to the policy.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER L. DIRECT REINSURANCE AGREEMENTS WITH MUTUAL ASSESSMENT COMPANIES

Sec. 884.551. DEFINITIONS. In this subchapter:

(1) "Mutual assessment company" means any entity regulated under Chapter 887 or 888.

(2) "Net assets" means a company's funds that are available for the payment of the company's obligations in this state, including uncollected premiums that are not more than three months past due, after the deduction of all unpaid losses and claims, claims for losses, and all other debts.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 884.552. AUTHORITY TO CONTRACT. A mutual assessment company may enter into a direct reinsurance agreement with a stipulated premium company in accordance with this subchapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 884.553. REINSURANCE AGREEMENT. (a) A reinsurance agreement under this subchapter must provide that the stipulated premium company is to assume the policies of the mutual assessment company.

(b) The reinsurance agreement must provide for the computation, on the effective date of the agreement, of:

(1) the amount of the net assets, including mortuary and expense funds, of the mutual assessment company that is to be transferred to the stipulated premium company after the payment of all liabilities;

(2) the amount of the required reserves to be established under the reserve and interest table used in the agreement; and

(3) the amount of any deficiency reserve resulting from the computation of Subdivisions (1) and (2).

(c) The deficiency reserve is subject to Section 884.453, except that instead of reducing the deficiency as required by that section, the reinsurance agreement may provide for immediate premium rate adjustments, in accordance with accepted actuarial practices and standards, to eliminate the deficiency at the time of reinsurance or during the period allowed for eliminating the deficiency under Section 884.453.

(d) For purposes of computing the reserves of members of a mutual assessment company, the total net assets of the company shall be apportioned among the members assessed. The percentage of the total amount of the net assets allotted to a member is computed by dividing the amount of the required reserve for that member insured under the reinsurance agreement by the total amount of the required reserve for all members under the agreement.

(e) The reinsurance agreement must provide that each policyholder who is dissatisfied with the agreement and who does not

want to accept the assumption certificate offered by the stipulated premium company is entitled to receive the amount of the reserve under the policyholder's policy reduced by the amount of any deficiency reserve applicable to the policy. The policyholder must make a written request for that option to the stipulated premium company not later than the 60th day after the date the assumption certificate is mailed.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 884.554. APPROVAL BY DEPARTMENT. (a) A mutual assessment company's board of directors may determine by a majority vote to submit a proposed direct reinsurance agreement to the members of the company. Before the agreement may be submitted to the members, the board must prepare detailed plans for the reinsurance and must submit the agreement to the department.

(b) If the department determines that the proposed direct reinsurance agreement complies with this chapter, the department shall approve the agreement for submission to the members of the company.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 884.555. MEMBERS MEETING; NOTICE. (a) After the department approves a proposed direct reinsurance agreement, the board of directors of the mutual assessment company shall:

(1) call a meeting of the company's members in accordance with the company's bylaws for voting on ratification of the direct reinsurance agreement; and

(2) mail to each member:

(A) a copy of the proposed agreement; and

(B) a copy of the notice of the meeting.

(b) The meeting may not be held before the 16th day after the date on which the copies are mailed under Subsection (a)(2).

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 884.556. MEMBERS MEETING; PROCEDURES. (a) In a meeting

called under Section 884.555, a member may vote in person, by proxy to whomever the member designates, or by mail.

(b) All votes must be cast by ballot. A two-thirds vote of the members participating in the election is required to ratify the reinsurance agreement.

(c) The person presiding at the meeting shall supervise and direct the procedure of the meeting and shall appoint an adequate number of inspectors to conduct the voting at the meeting.

(d) The inspectors may determine all questions concerning the qualifications of the voters and the verification, canvassing, and validity of the ballots.

(e) At the conclusion of the meeting, the inspectors shall certify under oath the result of the election to the department and to the stipulated premium company that is a party to the proposed agreement.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 884.557. SUBMISSION OF MEETING FACTS TO DEPARTMENT. Not later than the 90th day after the date of the meeting of the members, all facts relating to the meeting, including the accounting of the meeting and the computation of the required reserves, shall be submitted under oath to the department.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 884.558. EFFECTIVE DATE OF AGREEMENT. A direct reinsurance agreement that is ratified under Section 884.556 takes effect on the date specified in the agreement.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 884.559. ACTION AFTER AGREEMENT RATIFICATION. (a) After ratification of the reinsurance agreement under Section 884.556, the mutual assessment company shall cease doing business and shall transfer all of its assets to the assuming stipulated premium company.

(b) The stipulated premium company shall assume:

(1) all policy liability in accordance with the reinsurance agreement; and

(2) all other liabilities in accordance with the method of payment of those liabilities.

(c) On transfer of a mutual assessment company's assets:

(1) the company shall promptly surrender its certificate of authority and charter to the department; and

(2) the company's corporate existence ceases.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 884.560. ASSUMPTION CERTIFICATE. Immediately after ratification of the reinsurance agreement under Section 884.556, the stipulated premium company shall issue to each member of the mutual assessment company an assumption certificate that states:

(1) the terms of the assumption; and

(2) the reserve and interest table under which the policy is assumed.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 884.561. ADJUSTMENT OF LIFE INSURANCE PREMIUMS. (a) If the premium charged on a life insurance policy assumed by the stipulated premium company is less than the renewal net premium computed under the reserve standard adopted in the reinsurance agreement, the stipulated premium company shall adjust the premium rate to provide an amount that is at least equal to the renewal net premium based on the age of the insured on the date the policy was issued by the mutual assessment company.

(b) Notwithstanding Subsection (a), if the gross premium charged on a family group policy reinsured by a stipulated premium company is less than the renewal net premium for that policy, the stipulated premium company may choose to not adjust the rate if:

(1) the deficiency reserve of the business of the mutual assessment company is less than 25 percent of the required reserve on the business to be reinsured, including the deficiency premium reserve required by Subdivision (3);

(2) at the time of reinsurance, the gross premium of all family group policies to be reinsured by the stipulated premium

company is in the aggregate equal to at least 120 percent of the required net premiums on those family group policies; and

(3) the stipulated premium company maintains on that policy, in addition to any other reserve required by law, a deficiency premium reserve that is equal to the present value, computed using the reserve standard adopted in the reinsurance agreement, of an annuity, the amount of which is equal to the difference between the premium charged and that net premium and the term of which in years is equal to the number of annual premiums for the remainder of the premium paying period.

(c) The deficiency premium reserve required by Subsection (b)(3) is a part of the company's deficiency reserve and shall be reduced in the manner provided by Section 884.453.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 884.562. APPROVAL OF RATE ADJUSTMENT. A stipulated premium company may not adjust a life insurance premium rate under this subchapter before:

- (1) obtaining the approval of the department; and
- (2) providing notice to the policyholder.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER M. CONVERSION TO LEGAL RESERVE COMPANY

Sec. 884.601. AUTHORIZATION TO CONVERT. (a) The shareholders of a stipulated premium company that possesses capital in an amount equal to at least \$700,000, unencumbered surplus in an amount equal to at least \$700,000, and sufficient reserves on hand for the company's policies as required under provisions of Chapter 425, other than Sections 425.002-425.005, may convert the company to a legal reserve company that operates under Chapter 841 by complying with each requirement applicable to a company operating under that chapter.

(b) The department may approve the conversion only after determining that the converting company has complied with the requirements applicable to that company under Subsection (a).

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.089, eff. April 1, 2009.

Sec. 884.602. ASSUMPTION CERTIFICATE. (a) Not later than the 30th day after the date of a conversion under this subchapter, the converted company shall issue to each policyholder an assumption certificate by which the policy liability is assumed by the converted company.

(b) The certificate must contain all of the provisions applicable to a policy issued by a company operating under Chapter 841.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 884.603. EXEMPTION FROM CAPITAL AND SURPLUS REQUIREMENTS.

(a) A stipulated premium company is exempt from the capital and surplus requirements of Section 884.601(a) if the company:

(1) was organized before September 1, 1989;

(2) possesses capital in an amount equal to at least \$100,000 and unencumbered surplus in an amount equal to at least \$100,000; and

(3) converted to a company that operates under Chapter 841 before September 1, 1999.

(b) A stipulated premium company that is exempt under Subsection (a) shall immediately increase its capital and surplus to amounts that satisfy Section 884.601(a) on:

(1) a change of control of at least 50 percent of the voting securities of the converted company; or

(2) if the converted company or the holding company that controls the converted company, if any, is not controlled by voting securities, a change of at least 50 percent of the ownership of the converted company or its holding company.

(c) For purposes of Subsection (b), a transfer of ownership that occurs because of death, regardless of whether the decedent died testate or intestate, may not be considered a change in the control of a converted stipulated premium company or holding company if ownership is transferred solely to one or more individuals, each of

whom would be an heir of the decedent if the decedent had died intestate.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER O. GENERAL FINANCIAL REGULATION

Sec. 884.701. HAZARDOUS FINANCIAL CONDITION, SUPERVISION, CONSERVATORSHIP, AND LIQUIDATION. Subchapter A, Chapter 404, and Chapters 441 and 443 apply to a stipulated premium company engaged in the business of insurance in this state.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.090, eff. April 1, 2009.

CHAPTER 885. FRATERNAL BENEFIT SOCIETIES

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 885.001. DEFINITIONS. In this chapter:

(1) "Benefit certificate" means a document issued as written evidence of a benefit contract.

(2) "Benefit contract" means an agreement for provision of benefits authorized by Section 885.301, as that agreement is described by Section 885.306.

(3) "Benefit member" means an adult designated by the laws or rules of a fraternal benefit society as a benefit member under a benefit contract.

(4) "Fraternal benefit society's laws" means a fraternal benefit society's articles of incorporation, constitution, and bylaws, however designated.

(5) "Lodge" means a subordinate member unit of a fraternal benefit society. The term includes a camp, court, council, or branch.

(6) "Premium" means a premium, a rate, dues, or another required contribution that is payable under a benefit certificate or benefit contract.

(7) "Rule" means a rule, regulation, or resolution adopted by the supreme governing body or board of directors that has general application to the members of a fraternal benefit society.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.002. LIMITED EXEMPTION FROM INSURANCE LAWS. (a) Except as provided by this chapter, a fraternal benefit society is governed by this chapter and is exempt from all other insurance laws of this state for all purposes.

(b) A law enacted after July 1, 1913, does not apply to fraternal benefit societies unless a fraternal benefit society is expressly designated in the law.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.003. EXEMPTION FROM TAXATION. (a) A fraternal benefit society organized or holding a certificate of authority under this chapter, including the former Chapter 10 of this code and Chapter 8, Title 78, Revised Statutes, is a charitable and benevolent institution. Except as provided by Subsection (b), all funds of a fraternal benefit society described by this subsection are exempt from any state, county, district, municipal, or school tax, including an occupation tax.

(b) Real estate or office equipment used for a purpose other than a lodge purpose is subject to taxation.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.004. INAPPLICABILITY TO CERTAIN SOCIETIES. (a) Except as provided by Subsection (b), this chapter does not apply to:

(1) a grand or subordinate lodge of Masons, Odd Fellows, Knights of Pythias, or the Junior Order of the United American Mechanics;

(2) a society that limits its membership to those engaged in one or more hazardous occupations in the same or similar lines of business;

(3) a society that does not issue benefit certificates;

(4) an association of local lodges of a society engaged in business in this state on July 1, 1913, that provides:

(A) death benefits of not more than \$500 to any one individual;

(B) disability benefits of not more than \$300 in any one year to any one individual; or

(C) both death benefits described by Paragraph (A) and disability benefits described by Paragraph (B);

(5) a contract of reinsurance on a plan in this state described by Subdivision (4);

(6) a domestic society that limits its membership to the employees of:

(A) a particular municipality; or

(B) a designated firm or corporation; or

(7) a domestic lodge, order, or association of a purely religious, charitable, and benevolent description that does not provide:

(A) death benefits of more than \$100; or

(B) disability benefits of more than \$150 to any one individual in any one year.

(b) This chapter applies to:

(1) the insurance department of the supreme lodge Knights of Pythias; and

(2) the beneficiary degree of insurance branch of the Junior Order of the United American Mechanics.

(c) The department may require from any society information that will permit the department to determine whether the society is exempt from this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.005. FRATERNAL BENEFIT SOCIETIES THAT PROVIDE BENEFITS RESULTING FROM ACCIDENTS ONLY. (a) A fraternal benefit society that provides benefits for death or disability resulting from accidents only and does not provide death benefits or benefits for sickness may hold a certificate of authority under this chapter if the society:

(1) was organized and incorporated before July 1, 1913; and

(2) operates as provided by Sections 885.051-885.054 and 885.062.

(b) A fraternal benefit society that holds a certificate of authority as provided by Subsection (a) may exercise all the privileges provided by and is subject to this chapter other than:

- (1) provisions requiring medical examination;
- (2) provisions requiring that a benefit certificate specify the amount of benefits; and
- (3) provisions relating to the valuation of benefit certificates.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.006. TREATMENT OF CERTAIN GRAND LODGES. A grand lodge, by whatever name known and without regard to whether incorporated, that holds a charter from any supreme governing body and that was engaging in business in this state on July 1, 1913, as a fraternal beneficiary association under the separate jurisdiction plan is considered to be a single state organization.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER B. STRUCTURE OF FRATERNAL BENEFIT SOCIETY

Sec. 885.051. FRATERNAL BENEFIT SOCIETY DEFINED. A corporation, society, order, or voluntary association is a fraternal benefit society if it:

- (1) has a lodge system and a representative form of government or limits its membership to a secret fraternity that has a lodge system and a representative form of government;
- (2) is organized and operated solely for the mutual benefit of its members and their beneficiaries and not for profit;
- (3) does not have capital stock; and
- (4) provides for the payment of benefits in accordance with Section 885.301.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.052. CONTROL OF FRATERNAL BENEFIT SOCIETY. (a) In this section, "control" has the meaning described by Sections 823.005 and 823.151.

(b) Control of a fraternal benefit society must be ultimately vested in the membership as provided by this chapter. Control of a fraternal benefit society may be exercised by lodges and a supreme

governing body elected under Section 885.054.

(c) The methods provided by this section for exercising control over a fraternal benefit society are exclusive.

(d) Chapter 823 applies to a fraternal benefit society. Each change in control of a fraternal benefit society must be consistent with the nature of a fraternal benefit society as specified by this section, Sections 885.051, 885.053, and 885.054, and other applicable law.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.053. LODGE SYSTEM DEFINED. A fraternal benefit society is considered to be operating on the lodge system if the society:

- (1) has a supreme governing body; and
- (2) has lodges:
 - (A) into which members are admitted in accordance with the fraternal benefit society's laws, rituals, and rules; and
 - (B) that are required by the fraternal benefit society's laws to hold periodic meetings.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.054. REPRESENTATIVE FORM OF GOVERNMENT DEFINED. A fraternal benefit society has a representative form of government if:

- (1) the society has a supreme governing body constituted as:
 - (A) an assembly, as described by Section 885.055; or
 - (B) a board, as described by Section 885.057;
- (2) the officers of the society are elected by the supreme governing body or the board of directors;
- (3) only a benefit member is eligible to serve as a member of the supreme governing body, the board of directors, or an intermediate assembly of the society;
- (4) only a benefit member may vote on the management of the society's insurance affairs;
- (5) a voting member of the society has only one vote; and
- (6) a voting member of the society may not cast a vote by proxy.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.055. ASSEMBLY AS SUPREME GOVERNING BODY. (a) The supreme governing body of a fraternal benefit society is an assembly if the body is composed of:

(1) delegates elected directly by the members or at intermediate assemblies or conventions by the members or their representatives; and

(2) other delegates as prescribed by the fraternal benefit society's laws.

(b) The elected delegates to an assembly must:

(1) constitute a majority of the assembly in number; and

(2) be entitled to cast the greater of:

(A) two-thirds of the votes in the assembly; or

(B) the number of votes required to amend the fraternal benefit society's laws.

(c) A fraternal benefit society may provide for election of delegates by mail.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.056. ASSEMBLY MEETINGS; DIRECTORS. (a) An assembly that is the supreme governing body of a fraternal benefit society shall:

(1) meet at least once every four years; and

(2) elect a board of directors to conduct the business of the society between meetings of the assembly.

(b) A vacancy on the board of directors that occurs between elections may be filled in the manner prescribed by the fraternal benefit society's laws.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.057. BOARD AS SUPREME GOVERNING BODY. (a) The supreme governing body of a fraternal benefit society is a board if the body is composed of:

(1) individuals elected directly by the members or at intermediate assemblies by the members or their representatives; and

(2) other individuals as prescribed by the fraternal benefit society's laws.

(b) The individuals elected to the board must:

(1) constitute a majority of the board in number; and

(2) have at least the number of votes required to amend the fraternal benefit society's laws, other than laws, if any, that must be amended by direct vote of the members.

(c) A fraternal benefit society may provide for election of the board by mail.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.058. BOARD MEMBERS; MEETINGS. (a) The term of a member of a board that is the supreme governing body of a fraternal benefit society may not exceed four years.

(b) A vacancy on the board that occurs between elections may be filled in the manner prescribed by the fraternal benefit society's laws. An individual filling the unexpired term of an elected board member is considered to be an elected member.

(c) A board shall meet at least annually to conduct the business of the fraternal benefit society.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.059. LOCATION OF MEETINGS OF SUPREME GOVERNING BODY.

(a) A domestic fraternal benefit society may provide that its supreme governing body may hold meetings in any state, district, province, or territory in which the society has a lodge.

(b) All business transacted at a meeting authorized under Subsection (a) is as valid in all respects as if the meeting were held in this state.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.060. FRATERNAL BENEFIT SOCIETY'S LAWS BINDING. A fraternal benefit society's laws may provide that a lodge or a subordinate officer or member of the society may not waive any provision of those laws. Those laws are binding on:

- (1) the society;
- (2) each member of the society; and
- (3) each beneficiary of a member.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.061. AMENDMENT OF FRATERNAL BENEFIT SOCIETY'S LAWS.

(a) A fraternal benefit society transacting business under this chapter shall file with the department a certified copy of each amendment of the fraternal benefit society's laws not later than the 90th day after the date of enactment of the amendment.

(b) A printed copy of a fraternal benefit society's laws, as amended, that is certified by the society's secretary or corresponding officer is prima facie evidence that the laws were legally adopted.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.062. QUARTERLY LODGE MEETINGS REQUIRED. A fraternal benefit society's laws must require each lodge to hold regular meetings at least once each calendar quarter to further the society's purposes.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.063. MERGER OR TRANSFER OF MEMBERSHIP OR FUNDS. (a) A domestic fraternal benefit society may not merge with or accept a transfer of the membership or funds of another fraternal benefit society unless:

(1) the merger or transfer is evidenced by a written contract that fully sets out the terms of the merger or transfer; and

(2) the societies file with the department:

(A) a copy of the contract;

(B) a sworn statement of the financial condition of each society by its president and secretary or corresponding officers; and

(C) a certificate of those officers, verified under

oath, that the merger or transfer has been approved by a vote of two-thirds of the members of the supreme governing body of each society.

(b) On submission, the commissioner shall examine the contract, financial statements, and certificates. The commissioner shall approve the merger or transfer and issue a certificate to that effect if the commissioner determines that:

(1) the contract conforms with this section and Section 885.052(d);

(2) the financial statements are correct;

(3) the merger or transfer is just and equitable to the members of each society; and

(4) the new or surviving society complies with each requirement of a fraternal benefit society under this chapter.

(c) A contract of merger or transfer takes effect on issuance of a certificate under Subsection (b).

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER C. MEMBERS

Sec. 885.101. QUALIFICATIONS FOR FRATERNAL BENEFIT SOCIETY MEMBERSHIP. (a) A fraternal benefit society shall specify in the fraternal benefit society's laws or rules:

(1) subject to Subsection (b), the eligibility standards for each membership class;

(2) the process for admission for each membership class; and

(3) subject to Subsection (c), the rights and privileges of each membership class.

(b) If a fraternal benefit society provides benefits on the lives of children, the minimum age for adult membership may not be less than 15 years or more than 21 years.

(c) Only a benefit member may vote on the management of the insurance affairs of a fraternal benefit society.

(d) Membership rights in a fraternal benefit society are personal to the member, and a member may not assign those rights.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.102. SOCIAL MEMBERS. A fraternal benefit society may

admit social members. A social member may not vote in the management of the insurance affairs of the society.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.103. CHILDREN. (a) A fraternal benefit society may organize and operate branches for children on whose lives the society provides insurance or annuities.

(b) A child is not required to be a member of a lodge or to be initiated in a lodge.

(c) A child may not have any voice in the management of a fraternal benefit society.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.104. GRIEVANCE OR COMPLAINT PROCEDURES. A fraternal benefit society's laws or rules may provide for grievance or complaint procedures for members.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER D. AUTHORITY TO ENGAGE IN BUSINESS

Sec. 885.151. APPLICABILITY TO CERTAIN FRATERNAL BENEFIT SOCIETIES CONTINUOUSLY AUTHORIZED TO ENGAGE IN BUSINESS. This subchapter does not apply to a fraternal benefit society authorized to engage in business in this state on June 1, 1965, as long as the society's certificate of authority or any renewal or extension of its certificate of authority continues in force.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.152. ELIGIBILITY TO PROVIDE BENEFITS. After June 1, 1965, a corporation, society, order, or voluntary association may qualify as a fraternal benefit society as defined by Section 885.051 for the purpose of providing for the payment of benefits as provided by Section 885.301 only if it:

- (1) has at least 500 members and at least 10 lodges; and

(2) has been in continuous operation for at least the five years preceding the filing of its articles of incorporation or association as provided by Section 885.153.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.153. FILING OF ARTICLES OF INCORPORATION OR ASSOCIATION. A corporation, society, order, or voluntary association eligible under Section 885.152 may qualify as a fraternal benefit society by filing with the department:

(1) certified articles of incorporation or association that set out:

(A) the name of the society;

(B) the purpose for which the society is formed; and

(C) the manner in which the society's corporate powers are to be exercised;

(2) certified copies of the fraternal benefit society's laws and rules;

(3) copies of all proposed forms of benefit certificates, applications for benefit certificates, and circulars to be issued by the society;

(4) a surety bond as required by Section 885.156; and

(5) additional information that the commissioner considers necessary.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.154. NAME OF FRATERNAL BENEFIT SOCIETY. The name of a fraternal benefit society may not so closely resemble the name of any society or insurance company engaging in business in this state as to mislead the public or lead to confusion.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.155. PURPOSES OF FRATERNAL BENEFIT SOCIETY. (a) The purposes for which a fraternal benefit society is organized may not include more liberal powers than are granted by this chapter. Any lawful, social, intellectual, educational, charitable, benevolent,

moral, fraternal, patriotic, or religious advantages may be set out among the society's purposes.

(b) A fraternal benefit society's purposes may be implemented directly by the society or indirectly through subsidiary corporations or affiliated organizations.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.156. SURETY BOND. (a) A fraternal benefit society must file with the department a bond in an amount not less than \$300,000 and not more than \$1.5 million, as required by the commissioner, with sureties approved by the commissioner.

(b) The bond must be conditioned on the return of advance payments to applicants for benefit certificates as provided by this subchapter if the fraternal benefit society fails to qualify under this subchapter within one year.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.157. ISSUANCE OF PRELIMINARY CERTIFICATE OF AUTHORITY. If the purposes of a fraternal benefit society conform to the requirements of this chapter and all provisions of law have been complied with, the commissioner shall:

- (1) certify that the society is in compliance with all provisions of law;
- (2) retain and record the articles of incorporation or association; and
- (3) issue to the society a preliminary certificate of authority.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.158. POWERS AND DUTIES UNDER PRELIMINARY CERTIFICATE OF AUTHORITY; QUALIFICATION. (a) On receipt of a preliminary certificate of authority from the department under Section 885.157, a fraternal benefit society:

- (1) may solicit from its members applications for insurance benefits for the purpose of completing the society's qualification;

(2) shall collect from each applicant an amount equal to at least one regular monthly payment, in accordance with the society's table of rates as provided by the fraternal benefit society's laws; and

(3) shall issue to each applicant a receipt for the amount collected under Subdivision (2).

(b) A fraternal benefit society operating under a preliminary certificate of authority may not incur a liability other than for advance payments collected under Subsection (a)(2), issue a benefit certificate, or pay, allow, or offer or promise to pay or allow to any person a death or disability benefit until:

(1) the society has established 10 lodges into which at least 500 applicants have been initiated;

(2) the society has received bona fide applications for death benefit certificates on at least 500 lives for at least \$2,000 each;

(3) each applicant for death benefits under Subdivision (2) has been regularly examined by a legally qualified practicing physician;

(4) a certificate of each medical examination has been filed with and approved by the chief medical examiner of the society;

(5) the society submits to the department a list of the applicants for death benefits under Subdivision (2); and

(6) the society shows to the department, by the sworn statement of its treasurer or corresponding officer, that at least 500 applicants have each paid in cash in advance at least one regular monthly payment per \$1,000 of indemnity to be provided and that the payments in the aggregate amount to at least \$150,000.

(c) The list of applicants for death benefits submitted under Subsection (b)(5) must be under oath of the fraternal benefit society's president and secretary or corresponding officers and must provide for each applicant:

(1) the applicant's name and address;

(2) the date the applicant was examined;

(3) the date the applicant was approved;

(4) the date the applicant was initiated;

(5) the name and number of the lodge of which the applicant is a member;

(6) the amount of benefits to be granted; and

(7) the rate of stated premiums.

(d) The rate of stated premiums under Subsection (c)(7) must be sufficient to provide for meeting the obligations the fraternal benefit society has contracted to pay, when valued for death benefits on the basis of the National Fraternal Congress Table of Mortality, as adopted by the National Fraternal Congress, August 23, 1899, or, at the society's option, any higher standard, and for disability benefits or combined death and permanent total disability benefits by tables based on reliable experience, with an interest assumption not greater than a rate of four percent a year.

(e) A fraternal benefit society shall hold advance payments received under this section in trust during the period of completing qualification. The society shall credit the advance payments to the mortuary or disability fund on account of the applicants and may not use any part of the payments for expenses. If the society does not complete its qualification within one year, as provided by this subchapter, the society shall return the advance payments to the applicants.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.159. TERMINATION OF AUTHORITY UNDER PRELIMINARY CERTIFICATE OF AUTHORITY. (a) Unless a fraternal benefit society has qualified under this subchapter, a preliminary certificate of authority granted under Section 885.157 is void on the first anniversary of the date the certificate is issued.

(b) The department, on cause shown, may extend the period prescribed by Subsection (a). An extension may not exceed one year.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.160. ISSUANCE OF CERTIFICATE OF AUTHORITY. (a) The department may make an examination and require information in addition to that required by Section 885.158(b) that the department considers advisable. On presentation of satisfactory evidence that a fraternal benefit society has complied with all provisions of law, the department shall issue to the society a certificate of authority.

(b) The certificate of authority issued is prima facie evidence of the qualification of the fraternal benefit society as of the date of the certificate.

(c) The department shall make a record of a certificate of authority issued under Subsection (a). A certified copy or duplicate of the department's record shall be accepted in evidence with the same effect as the original certificate.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER E. FOREIGN FRATERNAL BENEFIT SOCIETIES

Sec. 885.201. CERTIFICATE OF AUTHORITY REQUIRED. A foreign fraternal benefit society organized and engaging in business before July 1, 1913, that was not authorized to engage in business in this state as of that date may not engage in business in this state without a certificate of authority from the commissioner.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.202. ADMISSION OF FOREIGN FRATERNAL BENEFIT SOCIETY.

(a) To engage in business in this state, a foreign fraternal benefit society described by Section 885.201 must:

- (1) have the qualifications required of a domestic fraternal benefit society under this chapter; and
- (2) have its assets invested as required by the laws of the state, territory, district, province, or country in which the society is organized.

(b) A foreign fraternal benefit society described by Section 885.201 is entitled to a certificate of authority to engage in business in this state on filing with the department:

- (1) a certified copy of the society's charter or articles of association;
- (2) a copy of the fraternal benefit society's laws, certified by its secretary or corresponding officer;
- (3) a statement of the society's business;
- (4) a certificate from the proper official in the society's home state, province, or country showing that the society is legally organized;
- (5) a copy of the society's benefit contract;
- (6) information showing that the society's assets are invested as required by Subsection (a)(2); and
- (7) additional information the commissioner considers

necessary to demonstrate the society's business and method of operation.

(c) A statement of business filed by a foreign fraternal benefit society under Subsection (b)(3) must:

- (1) be under oath of the society's president and secretary or corresponding officers;
- (2) be in the form required by the commissioner; and
- (3) be verified by an examination made by the supervising insurance official of the society's home state or another state satisfactory to the commissioner.

(d) A benefit contract filed by a foreign fraternal benefit society under Subsection (b)(5) must show that benefits are provided for by premiums paid by persons holding similar contracts.

(e) The commissioner shall issue a certificate of authority to a foreign fraternal benefit society that complies with Subsection (b).

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.203. REFUSAL TO ISSUE CERTIFICATE OF AUTHORITY TO FOREIGN FRATERNAL BENEFIT SOCIETY. (a) If the commissioner refuses to issue a certificate of authority to a foreign fraternal benefit society under Section 885.202, the commissioner shall:

- (1) make the refusal in writing;
- (2) file the refusal in the department's office; and
- (3) on request, provide a copy of the refusal and a statement of the commissioner's reasons for the refusal to the society's officers.

(b) The commissioner's refusal to issue a certificate of authority to a foreign fraternal benefit society for authority to engage in business in this state is reviewable by proper proceedings in a state court.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.204. NOTICE OF INTENT TO REVOKE FOREIGN FRATERNAL BENEFIT SOCIETY'S CERTIFICATE OF AUTHORITY. (a) The commissioner shall notify a foreign fraternal benefit society engaging in business under this chapter of the commissioner's determination if, following

an investigation, the commissioner determines that the society:

- (1) has failed to comply with this chapter;
- (2) has exceeded its powers;
- (3) is not fulfilling its contracts in good faith; or
- (4) is engaging in business fraudulently.

(b) A notification under Subsection (a) must:

- (1) state in writing the grounds of the commissioner's dissatisfaction; and
- (2) require that the society, after reasonable notice and on the date stated in the notice, show cause why the society's certificate of authority should not be revoked.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.205. REVOCATION OF FOREIGN FRATERNAL BENEFIT SOCIETY'S CERTIFICATE OF AUTHORITY. (a) The commissioner may revoke a foreign fraternal benefit society's certificate of authority to engage in business in this state if, on the date stated in the notice under Section 885.204, the society:

- (1) has not, to the commissioner's satisfaction, removed the commissioner's objections; or
- (2) does not present good and sufficient reason why its certificate of authority should not be revoked.

(b) Section 885.203 applies to a decision by the commissioner to revoke a foreign fraternal benefit society's authority to engage in business in this state as if it were a decision to refuse to issue a certificate of authority.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.206. CONTINUANCE OF CONTRACTS FOLLOWING REVOCATION OF CERTIFICATE OF AUTHORITY. This subchapter may not be construed to prevent a foreign fraternal benefit society that has had its certificate of authority refused under former Article 10.23, Insurance Code, or a predecessor to that statute, or that has had its certificate of authority revoked, from continuing in good faith each contract made in this state during the time the society was authorized to engage in business in this state.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER F. POWERS AND DUTIES OF FRATERNAL BENEFIT SOCIETY

Sec. 885.251. GENERAL POWERS. A fraternal benefit society may:

- (1) make a constitution and bylaws for the government of the society, the admission of its members, the management of its affairs, and the setting and readjusting of premiums;
- (2) amend its constitution and bylaws; and
- (3) exercise other powers necessary and incidental to achieving its purposes.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.252. POWERS OF CERTAIN FRATERNAL BENEFIT SOCIETIES.

(a) A fraternal benefit society engaged in business in this state on July 1, 1913, may exercise:

- (1) each right conferred by this chapter; and
- (2) if the society is incorporated, each right, power, or privilege exercised or possessed as of July 1, 1913, by the society under its charter or articles of incorporation consistent with this chapter.

(b) A fraternal benefit society engaged in business in this state on July 1, 1913, that is a voluntary association may incorporate under this chapter.

(c) A fraternal benefit society organized as of July 1, 1913, is not required to reincorporate under this chapter and may amend the society's articles of incorporation in the manner provided in the articles or the fraternal benefit society's laws. A society shall file an amendment described by this subsection with the department. The amendment becomes operative on filing unless a later time is provided in the amendment or in the fraternal benefit society's articles of incorporation or laws.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.253. PRINCIPAL OFFICE OF DOMESTIC FRATERNAL BENEFIT SOCIETY. A domestic fraternal benefit society shall have its principal office in this state.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.254. IMMUNITY. (a) A director, officer, employee, member, or volunteer of a fraternal benefit society serving without compensation is not personally liable for damages resulting from an act or omission in the exercise of judgment or discretion in connection with the duties of that person for the society unless the act or omission involved wilful or wanton misconduct.

(b) This section does not limit a fraternal benefit society's direct or indirect liability.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.255. INDEMNIFICATION OR REIMBURSEMENT. (a) A fraternal benefit society may indemnify and reimburse a person for expenses reasonably incurred by, and liabilities imposed on, that person in connection with or arising out of a proceeding, whether civil, criminal, administrative, or investigative, in which the person is involved, or in connection with or arising out of a threat of a proceeding against that person, because that person is or was a director, officer, employee, or agent of:

(1) the society; or

(2) a firm, corporation, or organization with which the person served in any capacity at the request of the society.

(b) The right of indemnification and reimbursement under Subsection (a) is not exclusive of other rights to which a person may be entitled as a matter of law and inures to the benefit of the person's devisees, legatees, heirs, and estate.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.256. INDEMNIFICATION OR REIMBURSEMENT IN RELATION TO BREACH OF DUTY PROHIBITED. (a) Except as provided by Subsection (b), a person may not be indemnified or reimbursed under Section 885.255 in relation to:

(1) a matter in a proceeding in which the person is finally adjudged guilty of breach of a duty as a director, officer, employee, or agent of the fraternal benefit society; or

(2) an agreement that settles:

(A) a matter in a proceeding described by Subdivision (1); or

(B) the threat of a proceeding involving the person's alleged breach of a duty as a director, officer, employee, or agent of a fraternal benefit society.

(b) A fraternal benefit society may indemnify or reimburse a person in relation to a matter described by Subsection (a) only if the supreme governing body, the board of directors, or a court determines that:

(1) the person acted in good faith for a purpose the person reasonably believed to be in or not opposed to the best interests of the society; and

(2) in a criminal proceeding, the person had no reasonable cause to believe that the person's conduct was unlawful.

(c) A determination by a supreme governing body or board of directors under Subsection (b) must be made by majority vote of a quorum consisting of persons who were not parties to the proceeding under review.

(d) The termination of a proceeding by judgment, order, settlement, or conviction or on a plea of no contest does not create a conclusive presumption that a person does not meet the standard of conduct required to justify indemnification and reimbursement.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.257. INSURANCE FOR DIRECTORS, OFFICERS, EMPLOYEES, OR AGENTS. (a) A fraternal benefit society may purchase and maintain insurance on behalf of a person who is or was a director, officer, employee, or agent of the society or who is or was serving at the request of the society as a director, officer, employee, or agent of another firm, corporation, or organization against a liability asserted against that person or incurred by that person in any capacity or arising out of that person's status as a director, officer, employee, or agent of the society or the other firm, corporation, or organization.

(b) A fraternal benefit society may purchase and maintain insurance under this section regardless of whether the society has the power to indemnify or reimburse the person with respect to the

covered liability under Sections 885.255 and 885.256.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.258. MANAGEMENT AND USE OF ASSETS AND FUNDS. (a) A fraternal benefit society shall hold, invest, and disburse all assets for the use and benefit of the society. A member or beneficiary may not have or acquire individual rights in the assets of a fraternal benefit society or become entitled to any apportionment or surrender of any part of a society's assets except as provided by a benefit contract.

(b) A fraternal benefit society may create, maintain, invest, disburse, and apply any special fund necessary to implement any purpose permitted by the fraternal benefit society's laws.

(c) A fraternal benefit society may create, maintain, invest, disburse, and apply an emergency surplus or other similar fund in accordance with the fraternal benefit society's laws. Unless otherwise provided by a benefit contract, a fraternal benefit society shall hold, invest, and disburse a fund created under this subsection for the use and benefit of the society. A member or beneficiary may not have or acquire individual rights in a fund created under this subsection or become entitled to any apportionment or the surrender of any part of the fund except as provided by Section 885.301.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.259. SOURCE OF FUNDS. (a) A fraternal benefit society shall derive the funds from which the society pays benefits and the funds from which the society defrays its expenses from:

- (1) premiums paid by members of the society; and
- (2) accretions of those funds.

(b) A domestic or foreign fraternal benefit society may not engage in business in this state unless the society provides for stated premiums sufficient to permit meeting the obligations contracted, when valued in accordance with the reserving standards specified by this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.260. SPECIFIED PAYMENTS. (a) A fraternal benefit society may provide in the fraternal benefit society's laws and benefit certificates for specified payments on account of the expense or general fund.

(b) A payment under this section may or may not be mingled with the general fund of the fraternal benefit society as provided by the society's constitution and bylaws.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.261. CONTROL OF FUND BY LODGE. (a) This section applies if the constitution and bylaws of the grand lodge or governing body of a fraternal benefit society:

(1) provide that all or part of the beneficiary, mortuary, or insurance fund of the society that is paid by or collected from the members of a lodge may be retained in the custody of and controlled and managed by the lodge; and

(2) designate an officer of the lodge to have custody and control of a fund described by Subdivision (1) and authority to loan or invest the fund.

(b) A lodge officer having custody and control of a fund described by Subsection (a)(1) shall execute a bond or other written instrument to be prescribed and approved in terms and amount by the commissioner to indemnify the fund against waste, depletion, or loss. The lodge officer shall file the bond or other written instrument with the department, if required to do so by the department.

(c) A fund secured as provided by Subsection (b) is exempt from this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.262. INVESTMENT OF FRATERNAL BENEFIT SOCIETY FUNDS.

(a) Except as provided by Subsection (b), a fraternal benefit society may invest its funds only in securities permitted by state law for the investment of the assets of life insurance companies.

(b) A foreign fraternal benefit society authorized to or seeking to engage in the business of insurance in this state that invests its funds in accordance with the laws of the state in which the society is incorporated is considered to meet the requirements of

this chapter for the investment of funds.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.263. TREATMENT OF DEFERRED CLAIMS. (a) A deferred payment or an installment of a claim is considered to be a fixed liability on the occurrence of the contingency on which the payment or installment is to be paid. The amount of the liability is the present value of the future payment or installment at the rates of interest and mortality assumed by the fraternal benefit society for valuation.

(b) A fraternal benefit society shall maintain a fund sufficient to meet each fixed liability under Subsection (a) regardless of proposed future collections to meet the liability.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER G. BENEFITS PROVIDED BY FRATERNAL BENEFIT SOCIETIES

Sec. 885.301. TYPES OF BENEFITS PERMITTED. (a) A fraternal benefit society may provide for the payment of:

- (1) death benefits in any form;
- (2) endowment benefits;
- (3) annuity benefits;
- (4) benefits for temporary or permanent disability resulting from disease or accident;
- (5) benefits for hospital, medical, or nursing expenses resulting from sickness, bodily infirmity, or accident;
- (6) benefits for the erection of a monument or tombstone to the memory of a deceased member;
- (7) funeral benefits; and
- (8) any other benefit that may be provided by a life, accident, or health insurance company and that is:
 - (A) offered in compliance with a law described by Section 841.002 applicable to a life, accident, or health insurance company; and
 - (B) consistent with this chapter.

(b) A fraternal benefit society shall:

- (1) specify in the fraternal benefit society's laws or rules those persons to whom a benefit certificate may be issued or

who may be covered by benefits; and

(2) make the provision of those benefits consistent with the provision of benefits to members and their beneficiaries.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.091, eff. April 1, 2009.

Sec. 885.302. ISSUANCE OF BENEFIT CONTRACTS ON VARIABLE BASIS. A fraternal benefit society may, as provided by a resolution of its supreme governing body, establish and operate one or more separate accounts and issue benefit contracts on a variable basis, subject to laws regulating a life insurance company that establishes those types of accounts and issues those types of contracts. To comply with applicable federal or state laws or rules, the society may:

(1) issue on a variable basis contracts to which Sections 885.306(b) and (c) and 885.311(a) do not apply; and

(2) adopt special procedures for conducting the business and affairs of a separate account and provide special voting and other rights for a person having beneficial interests in a separate account, including special procedures and rights relating to:

(A) investment policy;

(B) investment advisory services;

(C) selection of certified public accountants; and

(D) selection of a committee to manage the business and affairs of the account.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.303. BENEFITS FOR CHILDREN. (a) A fraternal benefit society may provide by its laws, in addition to other benefits provided for by the fraternal benefit society's laws, for insurance or annuities, or insurance and annuities, on the lives of children of any age, on the application of an adult individual related to or interested in the child, as provided by the fraternal benefit society's laws.

(b) A life insurance benefit contract issued on the life of an individual who is younger than a fraternal benefit society's minimum

age for adult membership may provide for transfer of control or ownership to the insured at an age specified in the benefit certificate. A fraternal benefit society may require approval of an application for membership in order to make the transfer and may provide in all other respects for control of the benefit certificate and rights, obligations, and liabilities incident and connected to the certificate. Ownership rights under the benefit certificate before a transfer must be specified in the certificate.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.304. BENEFICIARIES. (a) The owner of a benefit contract may change the beneficiary at any time in accordance with a fraternal benefit society's laws or rules unless the owner waives that right by specifically requesting in writing that the beneficiary designation be irrevocable.

(b) A fraternal benefit society may, through the fraternal benefit society's laws or rules, limit the scope of beneficiary designations and shall provide that a person whose designation as a beneficiary is revocable may not have or obtain a vested interest in the proceeds, in conformity with the benefit contract.

(c) If, at the death of an insured, a lawful beneficiary to whom the proceeds of the benefit contract are payable does not exist under the benefit contract, a fraternal benefit society shall pay the amount of the benefit under the benefit contract:

- (1) to the personal representative of the insured; or
- (2) if the owner of the benefit certificate is a person other than the insured, to the owner of the certificate.

(d) Subsection (c) does not apply to the extent funeral benefits may be paid under the benefit contract.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.305. ORGANIZATION AS BENEFICIARY. A fraternal benefit society may provide in the fraternal benefit society's laws for the issuance to its members of benefit certificates under which an association, society, or corporation that is organized and operated for religious, eleemosynary, or educational purposes is named as beneficiary.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.306. BENEFIT CERTIFICATE. (a) A fraternal benefit society may not deliver or issue for delivery in this state a benefit certificate unless the form of the certificate has been filed under Chapter 1701.

(b) Each benefit certificate issued by a fraternal benefit society must:

- (1) specify the amount of benefits provided under the certificate;
- (2) state the amount of premiums that are payable under the certificate; and
- (3) provide that the certificate, the society's charter or articles of incorporation or, if the society is a voluntary association, the society's articles of association, the fraternal benefit society's laws, the application for membership and medical examination, signed by the applicant, and all amendments to each of those constitute the agreement between the society and the member.

(c) An amendment to a fraternal benefit society's charter, articles of incorporation or association, or laws made or enacted after the issuance of a benefit certificate:

- (1) binds the member and the member's beneficiaries; and
- (2) controls the agreement in all respects as if the amendment had been in force at the time of the application for membership.

(d) A life, accident, health, or disability insurance benefit certificate or annuity benefit certificate issued by a fraternal benefit society must meet the requirements applicable to similar policies issued by an insurer in this state that are not inconsistent with this chapter as determined by rule of the commissioner.

(e) A copy of a document described by Subsection (b)(3), certified by a fraternal benefit society's secretary or corresponding officer, shall be admitted as evidence of the terms of the agreement between the society and the member.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 2E.092, eff. April 1, 2009.

Sec. 885.307. GRACE PERIOD. A fraternal benefit society shall include in the terms of a benefit certificate a grace period of at least one month for payment of premiums.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.308. ASSIGNMENT OF LIFE INSURANCE BENEFIT CONTRACT. A fraternal benefit society may specify the terms for the assignment of a life insurance benefit contract.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.309. NONFORFEITURE BENEFITS. (a) The value of a nonforfeiture benefit provided under a benefit certificate issued before January 1, 2001, must comply with the law applicable to the certificate immediately before that date.

(b) The value of a nonforfeiture benefit provided under a benefit certificate issued on or after January 1, 2001, is computed as provided under:

(1) the provisions of Chapters 1105 and 1107 applicable to life insurance companies issuing policies containing similar benefits; and

(2) the applicable tables required by those chapters.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.310. ENFORCING PAYMENT OF PREMIUMS; CONTROL OF BENEFIT CERTIFICATES. A fraternal benefit society may provide for:

(1) enforcing payment of premiums;

(2) designating beneficiaries; and

(3) controlling benefit certificates and all rights, obligations, and liabilities incident to the certificates not in conflict with this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.311. DEFICIENCY PAYMENTS. (a) A fraternal benefit society shall provide in the fraternal benefit society's laws that if the society's reserves for any class of the society's benefit certificates become impaired, the society's supreme governing body or board of directors may require the certificate holders to pay the society an equitable proportion of the deficiency as determined by the governing body or board. The aggregate assessment for the impaired reserves may not exceed the total amount required to comply with Section 885.408.

(b) If a holder of a benefit certificate does not pay a fraternal benefit society the amount determined under Subsection (a), the holder, in a manner determined by the society, may elect to accept:

(1) the amount determined under Subsection (a) as an indebtedness against the certificate, with the amount drawing interest at a rate that does not exceed the rate specified for a certificate loan under a certificate that has cash value;

(2) a proportionate reduction in the benefits payable under the certificate; or

(3) a combination of the limitations on the certificate described by Subdivisions (1) and (2).

(c) A fraternal benefit society may determine a presumed election for a holder of a benefit certificate under Subsection (b) if the holder fails to make an election.

(d) Not later than the 90th day before the proposed effective date of an assessment under Subsection (a), the fraternal benefit society shall file with the department an application for approval of the assessment and a statement sworn to by the president and secretary or corresponding officers of the society. The statement must:

(1) include:

(A) the terms of the assessment, including the proposed effective date; and

(B) a narrative statement of the financial condition of the fraternal benefit society; and

(2) state that the assessment:

(A) received approval by a majority vote of the supreme governing body or board of directors of the society; and

(B) complies with the requirements of this section.

(e) After the department receives a completed application, the

commissioner may approve or disapprove the application. If the commissioner does not approve or disapprove the application before the 60th day after the date the department receives the completed application, the application is considered approved. The commissioner may impose an effective date earlier than the date requested in the application if the earlier effective date is in the best interests of the certificate holders.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 762 (H.B. [1251](#)), Sec. 1, eff. September 1, 2019.

Sec. 885.312. CONTINUATION OF BENEFIT CERTIFICATE ON EXPULSION OR SUSPENSION OF MEMBER. If a fraternal benefit society's laws provide for expulsion or suspension of a member, the benefit certificate must provide that a member who is expelled or suspended may maintain the certificate in force by continuing payment of the required premium unless the expulsion or suspension:

- (1) is for nonpayment of a premium; or
- (2) occurs within the contestable period of the benefit contract and is for material misrepresentation in the application for membership or insurance.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.313. CONTINUATION OF BENEFIT CERTIFICATE ISSUED ON CHILD. If the membership in a fraternal benefit society of a person responsible for the support of a child on whose account a benefit certificate has been issued terminates, the certificate may be continued for the benefit of:

- (1) the child's estate, if payment of the premiums is continued; or
- (2) any other person responsible for the support and maintenance of the child, if the person assumes the payment of the required premiums.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.314. RESPONSIBILITY FOR PAYMENT OF BENEFITS. (a) An officer or member of the supreme, the grand, or any subordinate body of an incorporated fraternal benefit society is not individually liable for the payment of any disability or death benefit provided for by the fraternal benefit society's laws and contracts.

(b) Benefits are payable only out of the fraternal benefit society's funds and in the manner provided by the fraternal benefit society's laws.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.315. DAMAGES FOR FAILURE TO TIMELY PAY BENEFITS. A fraternal benefit society that is liable for a loss and that does not pay benefits before the 61st day after the date of the demand for payment is liable to the holder of the benefit certificate, in addition to the amount of the loss, for damages of 12 percent of the amount of the loss and reasonable attorney's fees for the prosecution and collection of the loss.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.316. EXEMPTION OF BENEFITS. Money or another benefit or charity to be paid or provided by a fraternal benefit society, before or after payment is not subject to attachment, garnishment, or other process and may not be seized or applied by any legal or equitable process or operation of law to pay any debt or liability of a member, a beneficiary, or any other person who may have a right under the benefit contract.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER H. AGENTS

Sec. 885.351. AGENTS. (a) A fraternal benefit society may appoint an agent licensed by the department under Subchapter B, Chapter 4054, to sell benefits listed under Section 885.301(a) to society members.

(b) Except as provided by Section 885.352, a person may not solicit or procure benefit contracts for a fraternal benefit society

unless the person is licensed as a general life, accident, and health agent or a life agent under Subchapter B, Chapter 4054.

(c) The licensing and regulation of agents for fraternal benefit societies is subject to Title 13 and other laws regulating those agents.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.222(a), eff. Sept. 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 548 (S.B. 1263), Sec. 2.08, eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.093, eff. April 1, 2009.

Reenacted by Acts 2009, 81st Leg., R.S., Ch. 87 (S.B. 1969), Sec. 14.011, eff. September 1, 2009.

Sec. 885.352. EXCEPTION. (a) Section 885.351(b) does not apply to an agent, representative, or member of a fraternal benefit society who devotes less than 50 percent of the person's time to the solicitation and procurement of benefit contracts for that society.

(b) For purposes of this section, a person is presumed for a calendar year to have devoted at least 50 percent of the person's time to the solicitation or procurement of benefit contracts if, in the preceding calendar year, the person solicited or procured on behalf of a fraternal benefit society:

(1) life insurance contracts that have generated, in the aggregate, more than \$20,000 of direct premiums for all lives insured;

(2) benefit contracts other than life insurance contracts that have insured the individual lives of more than 25 persons; or

(3) variable life insurance or variable annuity contracts.

(c) A person to whom this section applies may not solicit or procure on behalf of a fraternal benefit society an interest-sensitive life insurance contract that exceeds \$35,000 of coverage on an individual life unless the person holds the designation of fraternal insurance counselor.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.222(b), eff.

Sept. 1, 2003.

Sec. 885.353. EMPLOYMENT OF CERTAIN PERSONS TO SOLICIT BUSINESS PROHIBITED. A fraternal benefit society may not employ or otherwise retain a person to solicit business if the person has had a license revoked under Chapter 4005.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.094, eff. April 1, 2009.

SUBCHAPTER I. REGULATION OF FRATERNAL BENEFIT SOCIETIES

Sec. 885.401. ANNUAL REPORT. (a) Each fraternal benefit society engaged in business in this state shall annually, on or before March 1:

(1) file with the department in the form required by the commissioner a statement, under oath of the society's president and secretary or corresponding officers, of:

(A) the society's condition and standing on the preceding December 31; and

(B) the society's transactions for the preceding calendar year; and

(2) provide additional information the commissioner considers necessary to demonstrate the society's business and method of operation.

(b) The commissioner may periodically require any additional statement the commissioner considers necessary relating to a fraternal benefit society.

(c) The department or the state may use the report required under Subsection (a) in determining a fraternal benefit society's financial solvency.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.402. REPORTS OF CERTAIN GRAND LODGES. The officers of the supreme state governing body of a grand lodge considered to be a single state organization under Section 885.006 shall make each

report required by this chapter. The report must include the transactions, liabilities, and assets of the state organization.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.403. VALUATION OF BENEFIT CERTIFICATES. (a) A fraternal benefit society shall include in its report under Section 885.401 a valuation of the society's benefit certificates in force on the preceding December 31. The report of valuation shall show:

(1) as contingent liabilities, the present midyear value of the promised benefits provided by the fraternal benefit society's laws under the benefit certificates subject to valuation; and

(2) as contingent assets, the present midyear value of the future net premiums provided by the fraternal benefit society's laws as the premiums are in practice actually collected.

(b) At the option of a fraternal benefit society, instead of the valuation determined under Subsections (a)(1) and (2), the valuation may show the net value of benefit certificates subject to valuation under Subsection (a). The net value, when computed in case of monthly premiums, may be the mean of the terminal values for the end of the preceding and of the current insurance years.

(c) The valuation, including the valuation of benefit certificates, must be certified by an actuary or, at the request and expense of the fraternal benefit society, verified by the actuary of the insurance department of the society's home state.

(d) The legal minimum standard of valuation for all benefit certificates, other than benefit certificates for accident and health benefits, is computed using a mortality table and interest rate specified by Section 885.404.

(e) Each valuation report must set out clearly and fully the mortality and interest rates and the method of valuation.

(f) The report required by Section 885.401 must also include a valuation of benefit certificates in accordance with Section 885.408.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.404. MORTALITY TABLES; INTEREST RATES. (a) In valuing benefit certificates under Section 885.403, a fraternal benefit society, at the option of the society, may use:

(1) the National Fraternal Congress Table of Mortality, as adopted by the National Fraternal Congress, August 23, 1899;

(2) any table producing reserves in the aggregate at least as great as the reserves produced by the table described by Subdivision (1);

(3) the Commissioners 1941 Standard Ordinary Mortality Table;

(4) the Commissioners 1958 Standard Ordinary Mortality Table; or

(5) except as provided by Subsection (e), a table based on the society's own experience of at least 20 years and covering at least 100,000 lives.

(b) Notwithstanding Subsection (a), a fraternal benefit society may value the society's benefit certificates in accordance with valuation standards otherwise authorized by state law for the valuation of similar policies issued by life insurance companies.

(c) For any category of benefit certificates issued to insure a female risk, a modified net premium or present value referred to in Subchapter B, Chapter 425, may be computed according to an age not more than six years younger than the actual age of the insured.

(d) The interest assumption used with a mortality table described by Subsection (a)(1), (2), (3), or (4) may not be more than 4-1/2 percent a year. The interest assumption used with a mortality table described by Subsection (a)(5) may not be more than four percent a year.

(e) A fraternal benefit society may not use a table based on the society's own experience for a benefit certificate issued on or after January 1, 1989.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.095, eff. April 1, 2009.

Sec. 885.405. VALUATION OF AND SEPARATE FUND FOR DISABILITY BENEFITS. (a) A fraternal benefit society that provides for disability benefits shall keep the net premiums for disability benefits in a fund separate from all other benefit and expense funds and the valuation of all other business of the society.

(b) Notwithstanding Subsection (a), if a fraternal benefit society uses a combined premium table for both death and permanent total disability benefits:

(1) the valuation must be according to tables of reliable experience; and

(2) the society is not required to maintain a separation of those funds.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.406. PUBLICATION OF VALUATION AND CONDITION. A fraternal benefit society shall publish, in the society's official paper, a statement of:

(1) the valuation provided by Sections 885.403 and 885.405; and

(2) an explanation of the facts concerning the society's condition disclosed by that valuation.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.407. SOLVENCY. (a) If a fraternal benefit society reports admissible assets greater than the society's liabilities in an amount that authorizes the commissioner to place the society under regulatory control and the commissioner reasonably believes the society's hazardous financial condition will not be promptly remedied without intervention by the department, the commissioner may order the society to promptly seek and negotiate an agreement to transfer in accordance with this section all benefit members, benefit certificates, assets, and liabilities of the society to another fraternal benefit society. A transfer under this section:

(1) may be by merger, consolidation, assumption, or otherwise;

(2) constitutes an entire novation of each benefit certificate transferred by the society in a hazardous financial condition, and the receiving society is legally and contractually responsible for each transferred certificate;

(3) must conclude before the deadline set by the commissioner;

(4) may be approved by a vote of the majority of the

supreme governing body or board of directors of the society in a hazardous financial condition, notwithstanding Section 885.063(a)(2)(C) or any provision of the society's laws to the contrary; and

(5) is subject to approval by the commissioner.

(b) Not later than the seventh day before the date the supreme governing body or board of directors of a fraternal benefit society votes on a transfer proposed under Subsection (a), the governing body or board shall provide the society's certificate holders written notice of and an opportunity to comment on the proposed transfer. If the governing body or board approves the transfer, the governing body or board shall provide the certificate holders' comments to the commissioner.

(c) The supreme governing body or board of directors of a fraternal benefit society receiving benefit certificates pursuant to a transfer under an agreement described by Subsection (a) may suspend or modify qualifications for membership in the receiving society to the extent necessary to permit the society to accept the certificate holders of the society transferring certificates under the agreement, notwithstanding any provision of the receiving society's laws to the contrary.

(d) The commissioner may grant to a fraternal benefit society that is not authorized to engage in the business of insurance in this state the authority to service benefit certificates transferred pursuant to Subsection (a) and fulfill all obligations to the holders of the certificates. Commissioner action under this subsection does not authorize the fraternal benefit society to otherwise engage in the business of insurance in this state.

(e) A transfer under Subsection (a) may be made to an insurer that is not a fraternal benefit society if the insurer is authorized to engage in the business of insurance in this state. A holder of a certificate subject to a transfer as authorized by this subsection is deemed to agree that any term in the certificate, including a term that makes the certificate subject to the transferring society's laws or that provides for maintenance of the transferring society's solvency that is inconsistent with transfer to an insurer that is not a fraternal benefit society, is void on transfer of the certificate. The receiving insurer shall endorse on a form approved by the commissioner each benefit certificate received by a transfer made under this section to reflect any terms of the certificate voided by

this subsection. A certificate holder's obligation to pay an outstanding assessment under Section 885.311 that is not released under the transfer agreement is not released or voided by this subsection.

(f) The commissioner may request the attorney general bring an action under Section 885.502 to terminate a fraternal benefit society that fails to comply with an order under this section or fails to remedy the financial condition that gave rise to the order.

(g) The powers and authority of the commissioner under this section are cumulative and in addition to all other powers and authority to remediate the financial condition of a fraternal benefit society available to the commissioner.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 762 (H.B. [1251](#)), Sec. 2, eff. September 1, 2019.

Sec. 885.408. RESERVES FOR ACCIDENT AND HEALTH INSURANCE. (a) A fraternal benefit society shall establish reserves for the types of coverage specified by Sections 885.301(a)(4) and (5) in the same manner and to the same extent as required for a company organized under Chapter 841.

(b) Sections 425.203-425.228 apply to reserve investments for a domestic fraternal benefit society.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 2E.096, eff. April 1, 2009.

Sec. 885.409. REPORTING OF RESERVES. The report of a fraternal benefit society under Section 885.401 must show as a liability the reserves required by this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.410. EXAMINATION OF DOMESTIC FRATERNAL BENEFIT

SOCIETIES. A domestic fraternal benefit society is subject to:

- (1) Subchapter A, Chapter 86;
- (2) Subchapter A, Chapter 401; and
- (3) Sections 401.051, 401.052, 401.054-401.062, 401.151, 401.152, 401.155, and 401.156.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.097, eff. April 1, 2009.

Sec. 885.411. EXAMINATION OF FOREIGN FRATERNAL BENEFIT SOCIETIES. (a) The commissioner or a person appointed by the commissioner may examine a foreign fraternal benefit society transacting or applying for admission to engage in business in this state. The commissioner may employ assistants for this purpose.

(b) The commissioner or a person appointed by the commissioner to examine a foreign fraternal benefit society:

(1) is entitled to free access to all books, papers, and documents that relate to the business of the society; and

(2) may summon, qualify as witnesses under oath, and examine the society's officers, agents, and employees and other persons in relation to the affairs, transactions, and conditions of the society.

(c) Instead of an examination under this section, the commissioner may accept the examination of the insurance department of the state, territory, district, province, or country in which a foreign fraternal benefit society is organized.

(d) If a foreign fraternal benefit society or the society's officers refuse to permit an examination under this section or to comply with the provisions of law relating to an examination, the commissioner shall suspend the society's authority to write new business in this state or refuse the society's application for a certificate of authority. A suspension or refusal under this subsection continues until the commissioner receives satisfactory evidence relating to the condition and affairs of the society. A foreign fraternal benefit society may not write any new business in this state during a suspension under this subsection.

(e) A foreign fraternal benefit society is subject to the

provisions of Subchapter A, Chapter 86, and Sections 401.051, 401.052, 401.054-401.062, 401.151, 401.152, 401.155, and 401.156 that apply to an insurer that is not organized under the laws of this state but is authorized to engage in business in this state.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.098, eff. April 1, 2009.

Sec. 885.412. ADVERSE PUBLICATION PROHIBITED. (a) Pending, during, or after an examination or investigation of a fraternal benefit society, the commissioner may not make public a financial statement, report, or finding, or permit a financial statement, report, or finding affecting the status, standing, or rights of the society to become public, until:

- (1) the commissioner serves a copy of the statement, report, or finding on the society at its home office; and
- (2) the society has been provided a reasonable opportunity to:
 - (A) answer the statement, report, or finding; and
 - (B) make a showing in connection with the statement, report, or finding as the society desires.

(b) This section does not apply to a proceeding involving a fraternal benefit society instituted by the commissioner or the state, including an administrative hearing, a proceeding under Chapter 441 or 443, or a court proceeding.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.099, eff. April 1, 2009.

Sec. 885.413. FEES. The department shall deposit fees collected under this chapter to the credit of the Texas Department of Insurance operating account. Sections 201.001 and 201.002 apply to fees collected under this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.100, eff. April 1, 2009.

Sec. 885.414. REMEDIES NOT EXCLUSIVE. (a) This chapter does not prevent or limit any action by or remedy available to the department or the state under Chapter 441 or 443 or other applicable law.

(b) In addition to any other provision of law relating to disciplinary action regarding a fraternal benefit society, Chapter 82 applies to a fraternal benefit society.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.101, eff. April 1, 2009.

SUBCHAPTER J. CONVERSION OF FRATERNAL BENEFIT SOCIETY

Sec. 885.451. CONVERSION OF FRATERNAL BENEFIT SOCIETY TO MUTUAL OR STOCK COMPANY. (a) Subject to Subsection (b), a fraternal benefit society engaging in business in this state may convert to a mutual life insurance company or incorporated stock company by complying with this subchapter.

(b) A fraternal benefit society may not convert to a mutual life insurance company or incorporated stock company except on terms that, in the commissioner's opinion, will fully protect the rights and interests of the society's members and holders of benefit certificates.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.452. MEETING OF LODGE REPRESENTATIVES; NOTICE. (a) The governing body of a fraternal benefit society that proposes converting to a mutual life insurance company or incorporated stock company shall call a meeting of lodge representatives. The meeting may not be held before the 90th day after the date the meeting is called.

(b) Not later than the 40th day before the date of the meeting,

the fraternal benefit society shall mail to each society member or holder of a benefit certificate, at the member's or holder's mailing address as shown by the society's records, and to each lodge:

- (1) notice of the meeting; and
- (2) a general plan of the proposed conversion.

(c) Not later than the 20th day after the date of receipt of the notice, each lodge shall meet in a regular or called session to act on the proposal and choose a representative to the governing body for the state, if the society operates in more than one state.

(d) The lodge representatives chosen under Subsection (c) shall meet and choose the requisite number of representatives to which the state is entitled to the supreme or grand lodge, if that body is located in this state.

(e) A fraternal benefit society shall submit the plan of the proposed conversion to the commissioner, and the commissioner must approve the plan, before the society may submit the plan to the society's members, holders of benefit certificates, and lodges.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.453. RESOLUTION TO CONVERT; ADDITIONAL REQUIREMENTS.

(a) As provided by the notice under Section 885.452 and after convening the supreme governing body of the fraternal benefit society, the lodge representatives shall vote on whether to adopt a resolution authorizing the conversion of the society to a mutual life insurance company or incorporated stock company. To take effect, the resolution must be approved by lodge representatives of lodges that constitute at least 60 percent of the total membership of the fraternal benefit society.

(b) The resolution authorizing the conversion must:

- (1) set out or ratify a certificate of incorporation amending the fraternal benefit society's charter; and
- (2) state:
 - (A) the society's name;
 - (B) the name of the new company by which the society will be known;
 - (C) the object of the company;
 - (D) the location of the company's principal office;
 - (E) the names of the principal officers of the company,

who serve until their successors are elected and qualified; and

(F) the period, if any, of the duration of the company.

(c) If the fraternal benefit society is converting to a mutual life insurance company:

(1) the resolution authorizing the conversion must also state the amount of the unencumbered surplus;

(2) the amount and form of the unencumbered surplus must comply with Sections 882.055, 882.301(a), 882.302, 882.304, and 882.404; and

(3) the conversion must comply with Sections 882.056(a) and (b), 882.057, 882.058, 882.059, and 882.101.

(d) If the fraternal benefit society is converting to an incorporated stock company:

(1) the resolution authorizing the conversion must also state:

(A) the amount of the surplus, the amount of capital stock authorized, and the number of shares into which the capital stock is divided; and

(B) the amount of capital stock to be immediately paid in;

(2) the amounts and form of the surplus and capital must comply with Sections 841.054, 841.055, 841.056, 841.057, 841.204, 841.205, 841.301, and 841.302; and

(3) the conversion must comply with Sections 841.058, 841.059(a)(1), 841.060, 841.061, 841.062, and 841.063.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.454. CONVERSION DOCUMENTS. (a) A fraternal benefit society that converts to a mutual life insurance company or incorporated stock company shall file with the department:

(1) the certificate of incorporation as adopted or amended; and

(2) a report of the meeting of lodge representatives, certified by the presiding officers under the corporate seal of the fraternal benefit society.

(b) The certificate of incorporation must be incorporated in the charter of the proposed company.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.455. SALE OF STOCK OF CONVERTED FRATERNAL BENEFIT SOCIETY. (a) If a fraternal benefit society converts to an incorporated stock company, each holder of a benefit certificate or other member of the society has a preference right to subscribe for the proportion of the total capital stock offered for sale that the amount of the member's insurance bears to the society's total insurance in force at the time the society's supreme governing body authorizes the conversion. The right provided by this subsection expires on the 90th day after the date the society's supreme governing body authorizes the conversion.

(b) Before an incorporated stock company that is converted from a fraternal benefit society may offer any stock for public sale, the society's membership has a preference right to purchase the stock. A member may not subscribe for or purchase more than:

- (1) 25 percent of the capital stock of the new company; or
- (2) 10 percent of the capital stock of the new company, if there are other members applying in writing to purchase stock whose subscriptions are not filled.

(c) If the membership of a converted fraternal benefit society has not subscribed for the total capital stock authorized, the new company may permit others who were not society members at the time of the conversion to subscribe for stock and hold equal rights in the ownership of the stock.

(d) Not later than the 10th day after the date a fraternal benefit society approves a resolution authorizing the society to convert to an incorporated stock company, the society shall notify each holder of a benefit certificate or other member of:

- (1) the member's right to subscribe for and purchase the stock of the incorporated stock company;
- (2) the amount of stock for which the member is entitled to subscribe; and
- (3) all other terms of the subscription and purchase.

(e) The notice required under Subsection (d) must be in a form approved by the department. Proof of depositing a letter addressed to each holder of a benefit certificate or other member providing the notice in the approved form is considered proof of compliance with the requirements of Subsection (d) and this subsection.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.456. LEGAL EFFECT OF CONVERSION TO MUTUAL LIFE INSURANCE COMPANY. A fraternal benefit society that converts to a mutual life insurance company is subject to Chapter 882.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.457. COMPLETION AND LEGAL EFFECT OF CONVERSION TO STOCK COMPANY. (a) The conversion of a fraternal benefit society to an incorporated stock company is complete when the society has:

- (1) complied with this subchapter and other state law regulating the incorporation of a life insurance company; and
- (2) received from the commissioner its charter or certificate of authority to transact business as an incorporated stock company.

(b) A fraternal benefit society that converts to an incorporated stock company:

- (1) is considered by law to have each right, privilege, power, or authority of any other stock corporation organized for engaging in the business of life insurance in this state;
- (2) is subject to laws applicable to a stock corporation organized under Chapter 841 for engaging in the business of life insurance in this state;
- (3) is considered by law to be a continuation of the business of the fraternal benefit society on the formation of the new company or amendment of its former charter; and
- (4) succeeds to and is invested with each right, privilege, or franchise and all property of the former society, including debts due on any account and all choses in action.

(c) On conversion of a fraternal benefit society to an incorporated stock company, the title to any real estate by deed or otherwise vested in the society vests in the company, and the title is not in any way impaired because of the conversion.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.458. CONTINUING OBLIGATIONS OF CONVERTED FRATERNAL

BENEFIT SOCIETY. (a) The rights of each member, holder of a benefit certificate, or creditor and the standing of each claim against a fraternal benefit society that converts under this subchapter must be preserved unimpaired under the new corporation.

(b) Each debt, liability, and duty of a converted fraternal benefit society attaches to the new corporation and may be enforced against it to the same extent as if the debt or liability had been incurred or contracted by the new corporation.

(c) Each outstanding benefit certificate issued by a converted fraternal benefit society is a valid obligation of the new corporation without the issuance of a new certificate.

(d) A new corporation formed from a converted fraternal benefit society is obligated to perform each obligation owing by the society to a holder of a benefit certificate issued by the society. The holder may enforce a benefit certificate against the new corporation to the same extent as if the certificate had been issued by the new corporation after conversion.

(e) A pending suit in which a converted fraternal benefit society was a party is not affected by the conversion and may be prosecuted by or against the new corporation as if the conversion had not taken place.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.459. NAME OF CONVERTED FRATERNAL BENEFIT SOCIETY. The name of a mutual life insurance company or incorporated stock company to which a fraternal benefit society converts:

(1) must, if possible, be a continuation of the society's name; and

(2) may not, if the new company's name is changed from the society's name, be:

(A) the same as that of any other company engaging in business in this state; or

(B) a name similar to that of any other company engaging in business in this state.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.460. PRINCIPAL OFFICE OF CONVERTED FRATERNAL BENEFIT

SOCIETY. The principal office of a mutual life insurance company or incorporated stock company created by the conversion of a fraternal benefit society under this subchapter must be located in this state.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.461. SOCIAL OR CHARITABLE CLUBS FORMED BY MEMBERS OF CONVERTED FRATERNAL BENEFIT SOCIETY. The members of a converted fraternal benefit society or the policyholders in the new corporation may form local clubs for social and charitable purposes. A club formed under this section:

- (1) may not be connected with the management of the corporation; and
- (2) does not affect the corporation's liability or the insurance in effect.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER K. TERMINATION OF FRATERNAL BENEFIT SOCIETY

Sec. 885.501. DISCONTINUATION OF BUSINESS BY DOMESTIC FRATERNAL BENEFIT SOCIETY. A domestic fraternal benefit society's certificate of authority becomes void if the society:

- (1) discontinues business for a period of one year; or
- (2) has fewer than 400 members holding benefit certificates.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.502. INITIATION OF PROCEEDINGS FOR TERMINATION OF DOMESTIC FRATERNAL BENEFIT SOCIETY. (a) The commissioner may advise the attorney general of the commissioner's determination if:

- (1) after examining a domestic fraternal benefit society, the commissioner determines that the society:
 - (A) has failed to comply with any provision of this chapter;
 - (B) is exceeding its powers;
 - (C) is not fulfilling its contracts in good faith; or
 - (D) is engaging in business fraudulently; or

(2) the commissioner determines that a domestic fraternal benefit society:

(A) has, after its first year of existence, had fewer than 400 members; or

(B) has discontinued business.

(b) The attorney general shall bring an action in quo warranto against the fraternal benefit society if the attorney general determines that circumstances warrant the action.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.503. ISSUANCE OF INJUNCTION AND APPOINTMENT OF RECEIVER. (a) If it appears on the trial of an action brought under Section 885.502(b) that the fraternal benefit society should be closed, the court shall:

(1) enjoin the society from engaging in further business; and

(2) appoint a receiver for the society.

(b) A receiver appointed under Subsection (a)(2) shall:

(1) immediately take possession of the books, papers, money, and other assets of the fraternal benefit society; and

(2) promptly, under the court's direction, proceed to close the society's affairs and distribute its funds to the persons entitled to those funds.

(c) A court in this state may not hear an application for an injunction against or proceedings for the dissolution of or the appointment of a receiver for a domestic fraternal benefit society or lodge unless the attorney general makes the application or brings the proceedings.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER O. CRIMINAL PENALTIES

Sec. 885.701. FALSE STATEMENTS; CRIMINAL PENALTY. (a) A person commits an offense if the person wilfully makes a false or fraudulent statement or representation:

(1) in or with reference to an application for membership in a fraternal benefit society authorized to engage in business in this state; or

(2) for the purpose of obtaining money from or benefits in a fraternal benefit society transacting business under this chapter.

(b) An offense under this section is a misdemeanor punishable by:

- (1) a fine of not less than \$100 or more than \$500;
- (2) confinement in jail for not less than 30 days or more than one year; or
- (3) both the fine and confinement.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.702. SOLICITING MEMBERSHIP IN UNAUTHORIZED FRATERNAL BENEFIT SOCIETY; CRIMINAL PENALTY. (a) A person commits an offense if the person solicits membership for or in any manner assists in procuring membership in a fraternal benefit society that is not authorized to transact business in this state.

(b) An offense under this section is a misdemeanor punishable by a fine of not less than \$50 or more than \$200.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.703. SOLICITING MEMBERSHIP IN LODGE OF UNAUTHORIZED FRATERNAL BENEFIT SOCIETY; CRIMINAL PENALTY. (a) A person commits an offense if the person solicits for or organizes a lodge of a fraternal benefit society without first obtaining from the commissioner a certificate of authority that entitles the society to engage in business in this state.

(b) An offense under this section is a misdemeanor punishable by:

- (1) a fine of not less than \$100 or more than \$250;
- (2) confinement in jail for not less than three months or more than six months; or
- (3) both a fine and confinement.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.704. EXCEPTION TO SOLICITATION OFFENSES. Sections 885.702 and 885.703 do not:

(1) prohibit a member of an existing lodge from soliciting a person to become a member of the lodge; or

(2) apply to a member of a lodge who participates in, directs, or conducts the organization or establishment of a lodge within the limits of the county in which the person resides or of the person's lodge district.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.705. GENERAL CRIMINAL PENALTY. (a) An officer, agent, or employee of a domestic fraternal benefit society commits an offense if the person neglects, refuses to comply with, or violates any provision of the laws of this state governing domestic fraternal benefit societies.

(b) An offense under this section is a misdemeanor punishable by a fine not to exceed \$200.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 885.706. OTHER PENALTIES. Notwithstanding Section 885.705, if another section of this chapter provides a penalty for a violation of the section, the penalty provided in the other section prevails.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

CHAPTER 886. LOCAL MUTUAL AID ASSOCIATIONS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 886.001. DEFINITION. In this chapter, "local mutual aid association" means an entity, including a society or association of any sort, authorized under this chapter to engage in the business of insurance and pay benefits with money provided by assessments on the members as needed, including a burial association described by Section 888.001.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 886.002. APPLICABILITY OF CHAPTER; EXEMPTIONS. (a) Except as provided by Subsection (b), this chapter and Chapters 887 and 888 apply to local mutual aid associations.

(b) This chapter does not apply to the following entities unless the entity is a burial association described by Section 888.001:

(1) a labor union, domestic order, or association that does not provide a death benefit of more than \$150;

(2) an association described by Section 885.004; or

(3) any society or association operating before March 21, 1929, statewide on an assessment basis under a charter granted under another statute of this state.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 886.003. LIMITED EXEMPTION FROM INSURANCE LAWS. A local mutual aid association is subject only to this chapter and Chapters 887 and 888. Except as otherwise provided by this chapter, a local mutual aid association is exempt from all other insurance laws of this state, unless a local mutual aid association is expressly designated in the law.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 886.004. ORGANIZATION OF NEW ASSOCIATION PROHIBITED. A new local mutual aid association may not be organized under this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER B. AUTHORITY TO ENGAGE IN BUSINESS

Sec. 886.051. OPERATION UNDER CERTIFICATE OF AUTHORITY. A local mutual aid association engages in business under a certificate of authority issued by the department.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 886.052. COMPLIANCE WITH LAW REQUIRED. An individual, firm, or corporation may not engage in business in this state as a local mutual aid society or association that pays a death benefit or other benefit and that pays benefits with money provided by assessments made as necessary unless the individual, firm, or corporation is acting in accordance with this chapter or another law of this state.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER C. POWERS AND DUTIES OF ASSOCIATION

Sec. 886.101. GENERAL POWERS OF ASSOCIATION. A local mutual aid association is a body corporate that may sue and be sued in its own name and exercise the other powers and functions specifically granted in this chapter, but not otherwise.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 886.102. APPLICABILITY OF TEXAS NON-PROFIT CORPORATION ACT. (a) Except to the extent of any conflict with this code, the Texas Non-Profit Corporation Act (Article 1396-1.01 et seq., Vernon's Texas Civil Statutes) applies to a local mutual aid association. The commissioner has each power and duty of, and shall perform each act to be performed by, the secretary of state under that Act with respect to local mutual aid associations.

(b) On advance approval of the commissioner, a local mutual aid association may pay dividends to its members.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 886.103. ARTICLES OF ASSOCIATION, CONSTITUTION, AND BYLAWS. (a) The articles of association of a local mutual aid association must state:

(1) the name of the association, which must be distinctly different from other associations operating in the same area;

(2) the purpose for which the association is created, including the upper and lower age limits of individuals to whom benefit certificates may be issued;

- (3) the location of the principal office of the association;
 - (4) the territory in which the association will engage in business;
 - (5) the titles of the officers of the association; and
 - (6) the number of directors of the association.
- (b) The constitution and bylaws of the association may not violate, and must be in harmony with, this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 886.104. BENEFITS AUTHORIZED. (a) Except as provided by Subsection (b), a local mutual aid association may provide only for the payment of death benefits. An association may not provide for old age benefits or benefits for accidental injury or sickness.

(b) A local mutual aid association organized before March 21, 1929, that provides for the payment of death, old age, and accident benefits may continue to provide those benefits.

(c) The policy issued by the association must clearly state the benefits provided.

(d) A local mutual aid association may not issue a policy providing for:

- (1) a level premium;
- (2) guaranteed benefits; or
- (3) surrender of loan values.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 886.105. TERRITORIAL LIMITATIONS. (a) A local mutual aid association may conduct business in any county in this state.

(b) If the articles of association of an association provide that the association engages in business only in a limited territory, the association may amend the articles to permit statewide business. After the amendment, the association is entitled to receive a certificate of authority permitting statewide business.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 886.106. CONNECTION WITH OTHER ASSOCIATIONS PROHIBITED.

(a) A local mutual aid association may not have any connection with another local mutual aid association.

(b) An association may not contribute any form of salary or compensation to an executive officer of another association.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 886.107. ANNUAL STATEMENT; FILING FEE. (a) For the filing of each annual statement, the department shall charge the appropriate fee. The fee must be:

(1) payable to the department; and

(2) deposited in the Texas Department of Insurance operating account.

(b) Sections 201.001 and 201.002 apply to the fee.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.102, eff. April 1, 2009.

Sec. 886.108. SURETY BOND. (a) A local mutual aid association's officer responsible for the funds of the association shall file with the department a surety bond.

(b) The surety bond must be:

(1) executed by a surety company authorized to do business in this state;

(2) satisfactory to the department; and

(3) payable in an amount and conditioned as specified by Section 887.054.

(c) This section does not apply to a local mutual aid association that:

(1) has a total membership of 1,000 or fewer members;

(2) charges \$1 or less each for annual dues or assessments;

and

(3) charges \$2.50 or less for a membership fee.

(d) An association exempted under Subsection (c) shall file with the department a bond in the amount of \$1,000 and conditioned as provided by Section 887.054.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 886.109. VOLUNTARY DISSOLUTION. A local mutual aid association may dissolve by vote of the majority of the members at:

- (1) a regular meeting called by the secretary; or
- (2) a special meeting called for the purpose of considering dissolution.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 886.110. AUTOMATIC DISSOLUTION. A local mutual aid association is dissolved automatically and forfeits its right to engage in the business of insurance if:

- (1) the association's membership falls below 25 percent of the maximum value of the policy issued; or
- (2) the association's membership falls below 50 percent of the maximum value of the policy issued and the association fails to notify each member of the amount paid on the preceding death claim when assessment is made.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER O. DISCIPLINARY PROCEDURES AND CRIMINAL PENALTY

Sec. 886.701. REVOCATION. Except as otherwise provided by law, the department may revoke the right of a local mutual aid association to engage in the business of insurance in this state only on:

- (1) the judgment of a court;
- (2) the filing of articles of dissolution by the members of the association or by the officers on behalf of the members; or
- (3) a filing showing that the association's membership has been merged and taken over by another association.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 886.702. GROUNDS FOR DISSOLUTION OR FORFEITURE. (a) In addition to any other penalties imposed on a local mutual aid association or on its members or officers, an association is subject

to dissolution and forfeiture of its right to engage in the business of insurance if the association:

- (1) ceases to engage in the business of insurance;
- (2) falls below the requirements of this chapter;
- (3) engages in the business of insurance without a certificate of authority;
- (4) fails to make reports as required by law;
- (5) refuses to submit to examination by the department or pay the cost of an examination;
- (6) engages in the business of insurance in a fraudulent, illegal, or dishonest manner; or
- (7) violates this chapter.

(b) The attorney general shall, at the request of the department, file any action necessary to wind up the affairs of an association to which Subsection (a) applies and provide for the appointment of a receiver if necessary.

(c) An action under this section must be brought in Travis County.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 886.703. CRIMINAL PENALTY. (a) A person commits an offense if the person violates this chapter.

(b) An offense under this section is a misdemeanor punishable by a fine not to exceed \$500.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

CHAPTER 887. PROVISIONS APPLICABLE TO CERTAIN MUTUAL ASSESSMENT COMPANIES

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 887.001. DEFINITIONS. In this chapter:

- (1) "Assessment" means any money or thing of value, including premiums, paid in consideration of insurance provided by an insurance certificate.
- (2) "Association" means an organization subject to this chapter.
- (3) "Insurance certificate" means an insurance policy, contract of insurance, certificate of membership, or other document

through which insurance is effected or evidenced.

(4) "Member" includes a certificate holder or any other insured of an association.

(5) "Membership fee" means the amount of the first assessment or assessments placed in the expense fund of an association and representing the cost of soliciting or procuring a member, as permitted by the department.

(6) "Mortuary fund" includes a mortuary fund, relief fund, claim fund, or similar fund.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.002. PURPOSE. The primary purpose of this chapter and Chapter 888 is to secure to members and the beneficiaries of members the full and prompt payment of all claims, according to the maximum benefit provided under the insurance certificate.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.003. APPLICABILITY OF CHAPTER. (a) This chapter governs:

- (1) local mutual aid associations;
- (2) statewide mutual life associations;
- (3) life, health, and accident associations;
- (4) mutual assessment life, health, and accident associations;
- (5) burial associations; and
- (6) similar entities.

(b) Except as provided by Section 887.004, this chapter applies to insurance companies and associations, whether incorporated or not:

(1) that issue policies or certificates of insurance on the lives of individuals on a mutual assessment plan or that provide health and accident benefits on a mutual assessment plan or whose funds are derived from assessments on certificate holders or members; and

- (2) that are not governed by:
- (A) Chapter 841, 861, 882, 883, 885, 941, or 942; or
 - (B) Chapter 5, Title 78, Revised Statutes, as provided by Section 18, Chapter 40, Acts of the 41st Legislature, 1st Called

Session, 1929, as amended by Section 1, Chapter 60, General Laws, Acts of the 41st Legislature, 2nd Called Session, 1929.

(c) This chapter does not apply to mutual fire insurance companies.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.004. INAPPLICABILITY TO CERTAIN ORGANIZATIONS OF MEMBERS OF RELIGIOUS DENOMINATION. This chapter does not apply to an association that:

- (1) is not operated for profit;
- (2) is composed only of the members of a particular religious denomination;
- (3) does not provide insurance benefits in an amount greater than \$1,000 on any one individual; and
- (4) does not pay any officer of the association a salary greater than \$100 a month.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.005. DEPARTMENT OF PUBLIC SAFETY EMPLOYEE MUTUAL ASSOCIATION. Notwithstanding any other provision of this chapter, a mutual association for employees of the Department of Public Safety may provide coverage and benefits to retired officers and employees of that department.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.006. CONSTRUCTION. (a) This chapter does not:

- (1) enlarge the powers or rights of any association;
- (2) enlarge the scope of an association's legal or corporate existence; or
- (3) authorize the creation of any association or corporation to engage in the business of insurance described by Section 887.003(b) if that creation is not specifically permitted by law.

(b) The laws prohibiting or limiting creation of an association and the exercise of corporate power are not affected by this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.007. DEPOSIT OF FEES. The department shall deposit a fee collected under this chapter to the credit of the Texas Department of Insurance operating account.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.008. INTERPRETATION OF CHAPTER BY COMMISSIONER. If a provision of this chapter appears obscure when applied to health, accident, or disability provisions in an insurance certificate issued by an association authorized to issue health, accident, or disability certificates, the commissioner shall interpret the provision in accordance with the expressed purpose of this chapter and looking to the full payment of claims and preserving to members the benefit of the association's protection.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.009. RULES. The commissioner may adopt reasonable rules to implement the purposes of this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER B. GENERAL POWERS AND DUTIES; OFFICERS AND DIRECTORS

Sec. 887.051. BYLAWS. (a) An association shall submit to the department a copy of the association's bylaws. The department shall examine the bylaws and approve the bylaws if they comply with this chapter. The association shall conform the bylaws to this chapter if they are not in compliance.

(b) On approval of the bylaws under Subsection (a), an association shall file with the department a copy of the bylaws certified by the president or general manager and the secretary of the association.

(c) An association's bylaws must contain all things required by this chapter and may not contain any provision in conflict with this chapter.

(d) An association's bylaws must provide for periodic and special meetings of the membership.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.052. AMENDMENT OF BYLAWS. (a) A majority of an association's members present at a regular meeting or at a meeting called for the purpose may amend the association's bylaws.

(b) An association shall mail to all members notice of any regular or special meeting at which amendments to bylaws will be considered. The notice must contain:

- (1) a complete copy of the proposed amendments; and
- (2) a fair explanation of the intent and effect of the proposed amendments.

(c) An amendment must be ratified by the association's board of directors.

(d) An association shall file with the department, in the same manner provided for filing bylaws under Section 887.051, an amendment adopted by the association. An amendment is not effective unless approved by the department.

(e) An association shall mail to each member a certified copy of any amendment to the association's bylaws at the next assessment after the amendment to the bylaws is made.

(f) On adoption of an amendment to an association's bylaws that might affect the insurance rights of the association's members, the association shall immediately send a copy of the amendment by first class mail to each affected member. The burden of proof is on the association to prove that the association mailed the amendment.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.053. IMMUNITY. An officer, director, or member of an association is not individually liable because of an insurance certificate issued by the association or a claim arising from an insurance certificate.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.054. FINANCIAL OFFICER; BOND. (a) An association, by resolution entered in its minutes, shall designate an officer to be responsible for handling the association's funds. The president, secretary, or general manager of the association must certify a copy of the resolution, and the association shall file the copy with the department.

(b) Except as provided by Subsection (c) or (d), the association shall make and file a surety bond covering the officer designated under Subsection (a). The bond must:

(1) be issued by a corporate surety company authorized to issue surety bonds in this state;

(2) be satisfactory to the department and payable to the department for the use and benefit of the association;

(3) obligate the principal and surety to pay any monetary loss sustained by the association through an act of fraud, dishonesty, forgery, theft, embezzlement, or wilful misapplication by the officer, whether acting alone or with other persons, while employed as or exercising the powers of an officer designated under Subsection (a); and

(4) be in an amount of:

(A) at least \$2,500; or

(B) if the association's mortuary fund exceeds \$2,500, an amount equal to the lesser of:

(i) the amount of the association's mortuary fund;

or

(ii) \$20,000.

(c) Instead of the bond required by Subsection (b), the officer designated under Subsection (a) may deposit with the department cash or securities approved by the department in the amount and subject to the conditions applicable to the bond.

(d) Except as provided by Subsection (e), this section does not apply to a local mutual aid association that was operating on May 12, 1939, and has never:

(1) had a total membership of more than 1,000 members;

(2) charged more than \$1 each for annual dues and assessments; and

(3) charged more than \$2.50 for membership fees.

(e) An association to which Subsection (d) applies must file with the department a bond in the amount of \$1,000, conditioned as provided for a bond under Subsection (b).

(f) Successive recoveries may be made on a bond under this section until the amount of the bond is exhausted.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.055. BOND REQUIREMENTS FOR CERTAIN PERSONS. (a) In addition to the bond required by Section 887.054 and any other bond required by law, an association shall obtain a separate or blanket surety bond covering each other person who may have access to the association's mortuary funds. The bond must:

(1) be issued by a surety authorized by the department to engage in business in this state;

(2) be payable to the department for the use and benefit of the association;

(3) obligate the principal and surety to pay any monetary loss sustained by the association through an act of fraud, dishonesty, forgery, theft, embezzlement, or wilful misapplication by a covered person, whether acting alone or with other persons; and

(4) be in an amount determined by the department of at least \$1,000 but not more than \$5,000.

(b) Successive recoveries may be made on a bond under this section until the amount of the bond is exhausted.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.056. RECOVERY ON BOND. (a) On receipt of information that an officer of an association has violated the terms of a bond under Section 887.054 or 887.055, the department shall demand from the officer a written explanation of the charge.

(b) If after an explanation under Subsection (a) the department is not satisfied regarding the existing facts in controversy, the department shall:

(1) notify the officer to appear in Travis County, not earlier than the 11th day or later than the 16th day after service of notice, with any records and other information the department considers proper; and

(2) conduct an examination into the charge against the officer.

(c) If after an examination under Subsection (b) the department

is satisfied that the officer violated the terms of the bond, the department shall:

- (1) immediately notify the company executing the bond;
- (2) prepare a written statement covering the facts; and
- (3) deliver the statement to the attorney general.

(d) On receipt of a statement under Subsection (c), the attorney general shall investigate the charges. If the attorney general is satisfied that the officer violated the terms of the bond, the attorney general shall:

(1) enforce the liability against the cash or securities provided as surety by the officer; or

(2) in the name of the commissioner, file suit in Travis County on the bond for the benefit of the bond's beneficiaries against the officer as principal and the sureties for the recovery of:

- (A) any amounts due by the officer; and
- (B) all costs of the suit.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.057. DEPOSIT. (a) An association shall, through the department, deposit with the comptroller an amount equal to the largest risk assumed by the association on any one life or individual.

(b) A deposit under this section must be cash or convertible securities subject to approval by the department.

(c) A deposit is liable for the payment of any final judgment against the association and is subject to garnishment after a final judgment against the association.

(d) An association shall immediately replenish a deposit under this section if the deposit is impounded or depleted. If the association fails to immediately replenish the deposit on demand by the department, the department may consider the association insolvent and take appropriate action.

(e) An association may not state in an advertisement, in a letter, in literature, or otherwise that it has made a deposit with the department as required by law, unless the association also states fully:

- (1) the purpose of the deposit;

- (2) the conditions under which the deposit is made; and
- (3) the exact amount and character of the deposit.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.058. CHANGE OF ASSOCIATION'S NAME. An association may change its name by amending the association's charter if:

- (1) the association submits the proposed amendment to the department for approval; and
- (2) the department does not determine that the proposed name is confusing and misleading to the public.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.059. BOOKS AND RECORDS. (a) An association shall keep the association's books and records in a form and manner that:

- (1) accurately reflects the condition of the association or the facts essential to the association's faithful and effective operation; and
- (2) is acceptable to the department.

(b) The association shall adopt forms or systems that are acceptable to the department and will most effectively serve the purpose described by Subsection (a)(1).

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.060. ANNUAL STATEMENT. (a) Not later than April 1 of each year, an association shall file with the department a sworn statement of the association's condition on the preceding December 31.

- (b) A statement under this section must be on a form provided by the department for that purpose and include a complete account of:
- (1) the association's real and contingent assets;
 - (2) the association's liabilities; and
 - (3) income to and disbursements from the association's mortuary and expense funds during the year.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.061. REPORT ON CONDITION OF ASSOCIATION. The department may require from an association written reports on the condition of the association at any time the department considers advisable. The department may require that a report be verified by the oath of a responsible officer of the association.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.062. EXAMINATION. The following provisions apply to an association:

- (1) Subchapter A, Chapter 86; and
- (2) Sections 401.051, 401.052, 401.054-401.062, 401.151, 401.152, 401.155, and 401.156.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 2E.103, eff. April 1, 2009.

Sec. 887.063. ADMITTED ASSETS. An association may include among its admitted assets, within the assets of the expense fund only, any asset designated as a net asset under Section 841.004.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.064. DIVIDENDS. If the amount of an association's mortuary fund exceeds the amount of reserves required by Subchapter I, the association may pay dividends from the fund to its certificate holders. The amount of the dividends and the method of distribution of the dividends must be:

- (1) equitable and nondiscriminatory; and
- (2) approved by the department before payment.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.065. MERGER. (a) An association may not merge with another association without the advance approval of the department.

(b) The department may grant approval under Subsection (a) only after the department:

(1) completely investigates the facts; and

(2) determines that the proposed merger is to the advantage of the members.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER C. AUTHORITY TO ENGAGE IN BUSINESS

Sec. 887.101. CERTIFICATE OF AUTHORITY REQUIRED. (a) Except as provided by Section 887.102, the department shall require an association or person to hold a certificate of authority issued by the department before the association or person may engage in the business of insurance in this state.

(b) If an association or person writes insurance without a certificate of authority issued under Subsection (a), the department shall notify the attorney general. The attorney general shall institute proceedings in the district court of Travis County to restrain the association or person from writing insurance without a certificate of authority.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.102. EXEMPT ASSOCIATION; PERMIT. (a) An association is not required to hold a certificate of authority under Section 887.101 if the association:

(1) limits its membership to:

(A) the employees and the families of employees of a particular designated firm, corporation, or individual; or

(B) borrowers of a federal agency in this state and members of the borrower's immediate family who are living with the borrower and are not engaged in nonfarm work for their chief income;

(2) has been in existence for at least five years;

(3) is not operated for profit; and

(4) does not pay commissions.

(b) An association exempt under this section shall:

(1) make annual reports to the department, on forms

provided for that purpose, showing the financial condition of the association, receipts and expenditures of the association, and any other facts required by the department; and

(2) obtain from the department a permit to engage in the business of insurance.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.103. REFUSAL OF CERTIFICATE OF AUTHORITY OR PERMIT.

(a) An association may not continue to engage in the business of insurance in this state if the commissioner notifies the association in writing of the commissioner's refusal to issue a certificate of authority or a permit.

(b) Not later than the 60th day after the date notice is received under Subsection (a), an association may file suit to review the commissioner's action in accordance with Subchapter D, Chapter 36.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.104. REFUSAL OR REMOVAL FOR UNWORTHINESS OF PUBLIC TRUST. (a) The department may not issue a certificate of authority to an association if the department determines that an officer, employee, or member of the board of directors of the association is unworthy of the trust or confidence of the public.

(b) On issuance of a certificate of authority to an association, the commissioner shall order the removal of an officer, employee, or director of the association if the officer, employee, or director is found unworthy of the trust or confidence of the public.

(c) If the association does not remove an officer, employee, or director as required by an order issued under Subsection (b), the commissioner shall:

- (1) revoke the certificate of authority; and
- (2) treat the association as insolvent.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER D. MEMBERS

Sec. 887.151. CLASSES OF MEMBERS. (a) An association's constitution and bylaws shall state the number of members to be admitted in a class of the association.

(b) An association shall keep the accounts of the classes' mortuary assessments separate. The association may not use the funds of a class to pay claims for any other class.

(c) Not later than six months after the date a class of members is created, an association must build the class up to the required membership to pay claims in full. Until the required membership level is reached, the insurance certificates for the class may not provide for a benefit greater than \$500, unless the association has sufficient funds to lawfully make the full payment of benefits.

(d) Creation of any new class is subject to advance approval of the department.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.152. QUALIFYING MEMBERSHIP IN ASSOCIATION. (a) An individual must qualify under an association's bylaws to become a member of the association.

(b) An association must maintain the qualifying membership at all times. If an association fails to maintain the qualifying membership, the commissioner shall treat the association as insolvent.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.153. VOTING RIGHTS OF MEMBERS. An association shall permit each member of the association to vote at any periodic meeting or special meeting of the members.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.154. MEMBERSHIP RECORDS. An association shall keep:

(1) a complete and correct roster of the association's members, with proper statistical records for determining by age or some other method the proper cost of insurance;

(2) accurate records of classes of memberships; and

(3) records of amounts of assessments paid by each member and by each class that show:

(A) how the funds are distributed between mortuary and expense funds for each class; and

(B) the amounts paid out of the funds of the whole membership or each class in death claims or other benefits.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.155. TRANSFER OF MEMBERSHIP OR MERGER OF CLASSES. (a) Without advance approval of the department, an association may not:

(1) transfer any part or class of membership or all membership to another association; or

(2) merge classes or transfer a member from one class to another in the association.

(b) The department may grant approval under Subsection (a) only after the department:

(1) completely investigates the facts; and

(2) determines that the proposed merger or transfer is to the advantage of the members or classes affected by the merger or transfer.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER E. POWERS AND DUTIES RELATING TO INSURANCE AND COVERAGES

Sec. 887.201. LIMIT ON LIFE INSURANCE. An association may not insure an individual life for more than \$5,000.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.202. STIPULATED PREMIUM PLAN; DEDUCTION OF UNPAID PREMIUM BALANCE. (a) An association may issue an insurance certificate on a stipulated premium plan that provides for the insured to pay regular premiums weekly, monthly, quarterly, semiannually, or annually, as determined by the insured.

(b) An association may issue an insurance certificate that provides that on the maturity of benefits payable under the certificate any balance of premium for the certificate year remaining

unpaid is deducted from the benefits payable.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.203. ISSUANCE OF LIFE INSURANCE POLICY BY CERTAIN ASSOCIATIONS. (a) A local mutual aid association or statewide mutual assessment company that has a mortuary fund and expense fund with a combined value of at least \$100,000 greater than the liabilities of the combined funds may issue a life insurance policy in the same manner as a company organized under Chapter 841.

(b) An insurance policy issued as provided by Subsection (a):

- (1) may not insure an individual life for more than \$5,000;
- (2) must be reserved as required for a company organized under Chapter 841; and
- (3) may be issued only on an endowment or limited pay basis.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.204. RENEWAL OR REINSTATEMENT OF INSURANCE CERTIFICATE. (a) If an insurance certificate terminates for any reason and the association's rules provide that a reinstated certificate is regarded as a new certificate, an application for reinstatement must state in at least 10-point type that:

- (1) the same rules that apply to the original certificate apply to the reinstated certificate; and
- (2) the association may invalidate the certificate within the contestable period for a false statement regarding the applicant's health or physical condition or another matter material to the risk.

(b) On reinstatement of an insurance certificate, an association shall send to the certificate holder by first class mail a copy of the application for reinstatement. The burden of proof is on the association to prove that the association mailed the application.

(c) If a renewal insurance certificate is issued after termination of an insurance certificate, the association shall attach to the renewal insurance certificate a copy of the application for reinstatement. The application is part of the renewal insurance

certificate.

(d) If an association renews or reinstates an insurance certificate after termination of the certificate, the association shall divide the reinstated member's payments between the funds in the same percentage as is required of regular payments in the association's bylaws, except that if the period between termination and reinstatement is nine months or longer, the association may:

- (1) charge a reinstatement fee not greater than the membership fee; and
- (2) place the fee in the expense fund.

(e) A renewal or reinstatement certificate may not be contestable for any cause except nonpayment of assessments for a period longer than six months from the date of renewal or reinstatement, except that if the renewal or reinstatement occurs within the certificate's original two-year contestable period, the contestable period may be extended for six months from the date it would have originally expired.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.205. LIFE INSURANCE CERTIFICATE BENEFICIARIES. (a) An association may pay death benefits only to:

- (1) a member's spouse;
- (2) a member's relative by blood to the fourth degree or by marriage to the third degree;
- (3) a person actually dependent on the member;
- (4) a creditor, estate, or other person with an insurable interest; or
- (5) a purely charitable or religious institution.

(b) A beneficiary of a life insurance certificate forfeits the beneficiary's interest in the certificate if the beneficiary is the principal or an accomplice in wilfully bringing about the death of the insured. The nearest relative of the insured is entitled to the proceeds of an insurance certificate forfeited under this subsection.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.206. PAYMENT OF CLAIM; PROOF OF CLAIM. (a) An association shall pay each claim under an insurance certificate in

full not later than the 60th day after the date of receipt of due proof of claim.

(b) Written notice of a claim given to an association is considered due proof of claim if the association does not provide the claimant with the forms usually provided for filing claims before the 16th day after the date notice is received.

(c) If an association is unable to pay a valid claim in full within the time prescribed by Subsection (a), the commissioner shall treat the association as insolvent.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.207. EXCEPTION TO FULL PAYMENT REQUIREMENT: ASSESSMENT-AS-NEEDED ASSOCIATIONS. (a) Section 887.206 does not apply to a class organized before May 12, 1939, and operating on the postmortem or assessment-as-needed plan on that date.

(b) An association with a postmortem or assessment-as-needed class to which Subsection (a) applies may continue to operate on the plan only if:

(1) the class has a sufficient membership at the assessment rate charged to produce for the mortuary fund at least 50 percent of the maximum value of the largest certificate in the class; and

(2) the association receives the amount required by Subdivision (1).

(c) If the membership of a class is sufficient in number to pay more than 50 percent but less than 100 percent of the maximum value of the largest certificate in the class, an officer of the association shall print on each assessment notice the percentage of the maximum value of the certificate actually paid on the last claim for death benefits in the class.

(d) If the amount realized on an assessment is not sufficient to pay 50 percent of the maximum amount of promised benefits as shown on the certificate, the commissioner shall treat the association as insolvent.

(e) Any benefits paid by an association operating on a postmortem or assessment-as-needed basis are dependent on the amount realized from assessments on the membership. Each of the association's insurance certificates must state:

(1) that any benefits paid are dependent on the amount

realized from assessments on the membership; and

(2) the certificate's maximum payment.

(f) An association or a class in an association organized after May 12, 1939, may not operate on the postmortem or assessment-as-needed plan.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.208. CONTESTED CLAIMS. (a) An association may not contest a claim:

(1) only for delay or for a captious or inconsequential reason; or

(2) to force settlement at less than full payment.

(b) An association shall notify a claimant of the association's intent to deny liability on a claim not later than the 60th day after the date the association receives due proof of claim.

(c) An association that does not notify a claimant as provided by Subsection (b) is presumed as a matter of law to have accepted liability on the claim.

(d) The commissioner shall revoke the certificate of authority of any association the commissioner finds is operating fraudulently or improperly contesting claims.

(e) An association shall report to the department the costs of contests in the annual statement under Section 887.060. The report must be verified by an officer of the association.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.209. VENUE. An action brought against an association that grows out of or is based on any right of claim or loss or proceeds due, arising from or predicated on any claim for benefits under an insurance certificate issued by the association, may be brought in:

(1) the county where the certificate holder or beneficiary instituting the action resides; or

(2) the county of the principal office of the association.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.210. REINSURANCE. (a) An association may enter into a reinsurance agreement with a legal reserve company that:

(1) is authorized to write life, health, and accident insurance in this state; and

(2) has capital or surplus of at least \$100,000.

(b) A reinsurance agreement under this section is subject to the commissioner's approval.

(c) An association may not pay more out from its mortuary fund for reinsurance under this section than is received at the time of reinsurance by the mortuary fund on the insurance certificates or members reinsured.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER F. CONTENTS OF APPLICATIONS AND INSURANCE CERTIFICATES

Sec. 887.251. GENERAL REQUIREMENTS FOR INSURANCE CERTIFICATE AND APPLICATION FORMS; INCONTESTABILITY. (a) An insurance certificate issued by an association must include:

(1) any condition of the certificate, including any portion of the bylaws of the association that affects the insurance rights of the parties in any material way; and

(2) a statement that the certificate is issued subject to:

(A) the association's constitution and bylaws; and

(B) any amendments to the constitution and bylaws

approved by the commissioner.

(b) An insurance certificate must provide that a certificate in force for two years becomes incontestable, except for nonpayment of dues or assessments, on the second anniversary of the date of issuance, if the insured does not die before that date.

(c) An insurance certificate issued by an association or an application for the certificate may not contain language or be in a form that misleads the certificate holder or applicant about the kind of insurance provided under the certificate.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.252. APPLICATION FOR INSURANCE CERTIFICATE. (a) An application for an insurance certificate issued by an association must be signed by the applicant. If the applicant is a minor, the

application may be signed by a parent or guardian.

(b) The application for an insurance certificate that provides that a misstatement relating to the applicant's health or physical condition may void the certificate within the contestable period must state that provision in language approved by the commissioner. The statement must be in at least 10-point type.

(c) An association shall attach to an insurance certificate a copy of the application for the certificate. The application is part of the insurance certificate.

(d) In the absence of fraud, each statement in an application for an insurance certificate is regarded as a representation and not a warranty.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.253. LIFE INSURANCE CERTIFICATE FORMS. (a) A life insurance certificate issued by an association must include:

(1) on the front page of the certificate, a definitive statement of the amount of the death benefit to be paid; and

(2) a plain statement of the circumstances or conditions under which the benefit is to be paid.

(b) A life insurance certificate must provide that if the age of the insured is misstated, the amount of insurance is the amount that the premium paid would have purchased if the age had been stated correctly, based on rates in effect when the insured dies.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.254. HEALTH AND ACCIDENT INSURANCE CERTIFICATE FORMS. An insurance certificate issued by an association must include a plain statement of each health, accident, or other benefit under the certificate and the terms under which each benefit is paid.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.255. LIFE INSURANCE BENEFIT REDUCTIONS AND EXCLUSIONS. (a) An association may, with the commissioner's approval, issue an insurance certificate that provides for:

(1) reduced benefits if the insured:

(A) dies or is injured while engaged in:

(i) military, naval, or aerial service or aerial flight during peace or war; or

(ii) a hazardous occupation specified in the certificate;

(B) dies by the insured's own hand, regardless of whether the insured was sane or insane; or

(C) dies or is injured by mob violence or legal execution; or

(2) reduced or excluded benefits for sickness from certain causes specified in the certificate.

(b) The front page of an insurance certificate must call attention to any reduction or exclusion of benefits provided by the certificate. The circumstances or conditions under which the reduction or exclusion applies must be stated plainly in the certificate.

(c) If an insurance certificate that provides natural death benefits contains a provision for reducing the greatest death benefit provided by the certificate for a specified insured for a reason other than a reason specified by Subsection (a):

(1) the reduced death benefit for the insured must at all times when the reduction is in effect equal or exceed 120 percent of the total premium paid on that certificate by the insured; and

(2) the reduction must end before the fifth anniversary of the date the certificate is issued.

(d) Subsection (c) does not apply to a life insurance certificate on which the reduction of the death benefit does not apply at the time of the death of the specified insured.

(e) If a life insurance certificate provides for an increase of the initial amount of the death benefit for a specified insured one or more times during the first five years of the certificate, the amount of the death benefit for the insured must at all times during the period of the increasing benefit equal at least 120 percent of the premiums paid on that certificate by the insured during the period of the increase.

(f) Subsection (e) does not apply to a life insurance certificate that has been in force for more than five years from the date the certificate was issued.

(g) Subsections (c)-(f) do not apply to a family group life

insurance certificate described by Section 887.402.

(h) This section does not apply to health and accident insurance policies.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.256. FORM APPROVAL. (a) The commissioner shall approve the form and language of an insurance certificate before the certificate is used by an association. The commissioner shall, in cooperation with the several associations, ensure that the certificate forms are as uniform as feasible. Forms for all associations are not required to be uniform.

(b) An insurance certificate form used by an association after May 12, 1939, must comply with this chapter and with any other laws regulating the association.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER G. ASSESSMENTS AND REVENUE

Sec. 887.301. ASSESSMENTS REQUIRED. (a) An association shall levy regular and periodic assessments on its membership in amounts and at intervals necessary to:

(1) meet the reasonable operating expenses of the association; and

(2) allow the association to pay in full any claims arising under its insurance certificates.

(b) An association may also levy an assessment for surplus funds.

(c) An association shall specify the purpose of an assessment.

(d) An assessment on a life insurance certificate issued after May 21, 1965, insuring the life of one or more individuals must be:

(1) in accordance with the reserve standard adopted by the association and approved by the commissioner, except that an association may use the 1956 Chamberlain Reserve Table with interest not to exceed 3-1/2 percent a year; and

(2) in an amount sufficient to deposit in the mortuary fund an amount at least equal to the renewal net premiums computed in accordance with the reserve standard adopted by the association and approved by the commissioner.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.302. AUTHORITY TO INCREASE ASSESSMENT RATES ON CERTAIN INSURANCE CERTIFICATES. (a) An association's board of directors may by resolution increase assessment rates on life insurance certificates in force up to the rate on an attained age basis in accordance with the 1956 Chamberlain Reserve Table, with interest at 3-1/2 percent a year, or any other reasonable, equitable, or necessary increase. The board may also adjust assessment rates on accident, health, and hospitalization insurance certificates in force.

(b) An assessment rate increase or adjustment under this section on insurance certificates in force applies to all classes of the same or similar certificates.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.303. APPROVAL REQUIRED FOR CERTAIN RATE INCREASES. An association may not implement a rate increase on insurance certificates in force before the commissioner approves the rate increase as complying with this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.304. LIMIT ON RATE INCREASES. Notwithstanding any other provision of this chapter, on a life insurance certificate issued after May 21, 1965, an association may not during any consecutive five-year period increase the rate to more than double the rate charged the insured at the time of the rate increase.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.305. EXPENSE LOADING ON CERTAIN INSURANCE CERTIFICATES. If an association increases a life insurance assessment rate at any age other than at age of issue, the expense loading on the new assessments may not, on 50 years of age or greater, exceed 25 percent of the gross assessment charged, unless an

additional expense loading is approved by the commissioner as reasonable and necessary.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.306. ASSESSMENT-AS-NEEDED ASSOCIATIONS: PAYMENTS ON CERTAIN INSURANCE CERTIFICATES. (a) This section applies only to an association operating on an assessment-as-needed basis.

(b) If the members' payments on insurance certificates issued and in force before May 12, 1939, or on the reinsurance or renewals of those certificates, are not sufficient to pay matured death and disability claims in the maximum amount stated in the certificates and to provide for the creation and maintenance of the funds required by the association's bylaws, the association may, with the commissioner's approval and after proper hearing before the commissioner, provide for meeting the deficiency by additional, increased, or extra rates of payment.

(c) The association may give the members the option of agreeing to reduced maximum benefits or making increased payments.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.307. REVENUE OF ASSOCIATION; DEPOSIT. (a) The revenue of an association must be derived from:

- (1) membership fees; and
- (2) assessments.

(b) Not later than the fifth day after the date an association collects revenue, the association shall deposit the revenue in a state or national bank.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.308. SUSPENSION OF MEMBER FOR NONPAYMENT. Before suspending a member from membership for nonpayment of assessments or membership fees, an association shall send notice to the member by first class mail stating the final date of payment.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.309. FAILURE TO COMPLY WITH CERTAIN COMMISSIONER ORDERS. If an association refuses to comply with an order of the commissioner regarding rates or assessments under this chapter, the commissioner shall treat the association as insolvent.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER H. MORTUARY AND EXPENSE FUNDS

Sec. 887.351. MORTUARY AND EXPENSE FUNDS. An association's bylaws must provide for the method and procedure for allocating assessments between the association's mortuary and expense funds.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.352. LIMITS ON USE OF FUNDS. An association may spend or invest money from a mortuary fund or expense fund only as provided for each fund by this subchapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.353. DIVISION OF FUNDS: CERTAIN LIFE INSURANCE CERTIFICATES. (a) This section applies to a life insurance certificate insuring the life of one or more individuals issued:

(1) after December 31, 1965; or

(2) before December 31, 1965, and on which the assessment rate has been increased based on an age other than age on the date the certificate was issued.

(b) To the extent consistent with this subchapter, an association shall divide collected assessments into at least two funds.

(c) An association shall deposit in a mortuary fund a portion of the association's assessments at least equal to the renewal net premium computed at the age of issue or some other advanced age in accordance with the reserve standard adopted by the association. The association may pay from the mortuary fund only:

(1) fund claims under insurance certificates;

(2) dividends to certificate holders as provided by Section 887.064; and

(3) any other expenditures permitted by law.

(d) An association shall deposit in an expense fund the remaining portion of the assessments not deposited under Subsection (c). The association may pay expenses from the expense fund.

(e) This section does not apply to an association operating on an assessment-as-needed basis.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.354. DIVISION OF FUNDS: ACCIDENT AND HEALTH INSURANCE CERTIFICATES AND CERTAIN LIFE INSURANCE CERTIFICATES. (a) This section applies to:

(1) a life insurance certificate in force on December 31, 1965, to which Section 887.353 does not apply; and

(2) an accident, health, or hospitalization insurance certificate.

(b) An association shall deposit in a mortuary fund an amount equal to at least 60 percent of the association's assessments, not including membership fees.

(c) An association shall deposit in an expense fund:

(1) membership fees; and

(2) the remaining portion of the assessments not deposited under Subsection (b).

(d) This section does not apply to an association operating on an assessment-as-needed basis.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.355. DIVISION OF FUNDS: CERTAIN LIFE INSURANCE CERTIFICATES WITH NO RATE INCREASE. (a) This section applies to a life insurance certificate in force on December 31, 1965, on which the assessment rate has not been increased.

(b) An association may:

(1) deposit in a mortuary fund at least the net renewal premium, based on the reserve table adopted by the association; and

(2) deposit in an expense fund the remaining portion of the premium.

(c) This section does not apply to an association operating on an assessment-as-needed basis.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.356. DIVISION OF FUNDS: ASSESSMENT-AS-NEEDED ASSOCIATIONS. (a) An association operating on an assessment-as-needed basis shall divide collected assessments into at least:

- (1) a mortuary fund; and
- (2) an expense fund.

(b) An association under this section shall deposit into a mortuary fund an amount equal to at least 60 percent of the association's assessments, not including membership fees.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.357. INVESTMENT OF FUNDS. (a) An association may invest money from a mortuary fund only in securities and investments that are a legal investment for the reserve funds of a domestic life, accident, and health insurance company operating under Chapter 841.

(b) An association may invest money from an expense fund only in securities and investments that are a legal investment for the surplus funds of a domestic life, accident, and health insurance company operating under Chapter 841.

(c) An association may invest surplus funds belonging to the association only in securities that are a legal investment for the surplus funds of a domestic life, accident, and health insurance company operating under Chapter 841.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.358. PAYMENT OF TAXES ON MORTUARY FUND INCOME. An association may pay from a mortuary fund any taxes that are assessed against income on the fund and required to be paid by the association.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.359. PAYMENT OF REINSURANCE PREMIUM. An association may pay from a mortuary fund the premiums for any reinsurance under Section 887.210.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.360. COST OF DEFENDING CONTESTED CLAIMS. An association authorized to write accident, health, or hospitalization insurance may pay the reasonable costs of defending a contested claim on an accident, health, or hospitalization insurance certificate from the mortuary fund of the association if:

- (1) the expenditure is approved by the commissioner; and
- (2) the association has the reserves required by Subchapter I.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER I. RESERVES

Sec. 887.401. RESERVES ON INDIVIDUAL LIFE INSURANCE CERTIFICATES. (a) An association shall reserve an individual life insurance certificate insuring one or more persons at individual premiums for each person as provided by this section.

(b) An association shall maintain reserves on each of its individual life insurance certificates in accordance with the reserve standard adopted by the association and approved by the commissioner. The standard must provide reserves that in the aggregate are at least equal to the reserve amounts computed using the 1956 Chamberlain Reserve Table with interest not to exceed 3-1/2 percent a year. An association may use the 1956 Chamberlain Reserve Table with interest not to exceed 3-1/2 percent a year.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.402. RESERVES ON FAMILY GROUP LIFE INSURANCE CERTIFICATES. (a) An association shall reserve a family group life insurance certificate on which the association charges a group premium that is not reduced on the death of an insured as provided by this section.

(b) An association shall maintain reserves on each of its family group life insurance certificates using one of the following methods:

(1) the reserves must be equal to the reserves that would be required under Section 887.401 on individual life insurance certificates on the lives of the two oldest living members of the family group, with the amount of insurance for those two members determined assuming that the elder of the two will die first;

(2) the reserves must be equal to the reserves required under Section 887.401 on individual life insurance certificates on the lives of the living members of the family group, with the amount of insurance for each member of the family group determined assuming that each member will die first; or

(3) any other table or method of computing reserves approved in advance by the commissioner.

(c) An association may select the method to be used to compute the reserves under Subsection (b).

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.403. ISSUE YEAR AND ISSUE AGE IN CERTAIN INSURANCE CERTIFICATES. (a) In this section, "gross premium" means the renewal net premium plus any expense loading designated by the association or as otherwise regulated by this chapter.

(b) For an individual or family group life insurance certificate in force on December 31, 1965, or an individual or family group life insurance certificate with a rate increase effective after December 31, 1965, the reserves may be computed as if:

(1) the issue year is the last calendar year that the gross premium computed using the reserve table and interest rate adopted by the association at the insured's age in that calendar year is equal to or less than the premium rate charged by the association on the reserved certificate; and

(2) the issue age is the insured's age in the calendar year under Subdivision (1).

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.404. RESERVES ON ACCIDENT, HEALTH, AND HOSPITALIZATION

INSURANCE CERTIFICATES. An association shall maintain reserves on each of its accident, health, and hospitalization insurance certificates in the manner required of a company authorized to issue that type of coverage under Chapter 841.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.405. COMPUTATION OF RESERVE LIABILITY. (a) Each year, an association shall compute its reserve liability on all outstanding insurance certificates.

(b) To make the computation, an association:

(1) shall use the net premium basis in accordance with the reserve table and interest rate adopted by the association and approved by the commissioner; and

(2) may use group methods and approximate averages for fractions of a year.

(c) The reserve liability may be computed on not more than a one-year preliminary term.

(d) As soon as practical each year, the commissioner shall compute or cause to be computed the reserve liability of each association. To make the computation, the commissioner may use group methods and approximate averages for fractions of a year.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.406. INCREASE OF RESERVES. (a) If an association does not have in its mortuary fund the reserves required by this subchapter, the association's board of directors by appropriate action shall increase assessment rates on insurance certificates in force by advancing the age of each insured from the age at the date the certificate is issued or from the age previously advanced or otherwise equitably or reasonably adjust assessment rates to correct the reserve inadequacy. The board shall take that action not later than the 30th day after the date the reserves are computed.

(b) An association may make an assessment rate adjustment under Subsection (a) at any time if it appears that a reserve inadequacy will exist as of December 31 of the year in which the rate adjustment is made.

(c) The commissioner shall order an association to comply with

this chapter.

(d) If the board of directors does not comply with Subsection (a), the commissioner shall treat the association as insolvent.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.407. NONAPPLICABILITY TO ASSESSMENT-AS-NEEDED ASSOCIATIONS. This subchapter does not apply to an association operating on an assessment-as-needed basis.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER J. CONVERSION TO LEGAL RESERVE INSURANCE COMPANY

Sec. 887.451. AUTHORIZATION TO CONVERT OR REINSURE. Subject to the requirements of this subchapter, an association may convert or reinsure itself to a legal reserve insurance company operating under Chapter 882.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.452. PROPOSAL FOR CONVERSION OR REINSURANCE. An association's board of directors may determine by majority vote to submit a proposed conversion or reinsurance under Section 887.451 to the members of the association. Before the proposed conversion or reinsurance may be submitted to the members, the board must prepare detailed plans for the conversion or reinsurance and submit the plans to the commissioner.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.453. MEMBERS MEETING; NOTICE. (a) On receipt of the commissioner's written approval of proposed plans under Section 887.452 or of the plans as amended to meet the commissioner's requirements in accordance with Chapter 882, an association's board of directors or an officer of the association authorized by its bylaws to call a meeting of its members shall:

- (1) call a meeting of the association's members for voting

on ratification of the proposed conversion or reinsurance; and

(2) mail to each member of the association:

(A) a copy of the proposed plans; and

(B) a notice of the meeting.

(b) The meeting may not be held before the 16th day after the date the notice is mailed under Subsection (a)(2).

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.454. MEMBERS MEETING; PROCEDURES. (a) In a meeting called under Section 887.453, a member may vote in person, by proxy, or by mail.

(b) All votes must be cast by ballot. A majority vote of the members participating in the election is required to ratify the conversion or reinsurance.

(c) The person presiding at the meeting shall supervise and direct the procedure of the meeting and appoint an adequate number of inspectors to conduct the voting.

(d) Under rules adopted by the commissioner, the inspectors may determine all questions concerning the qualifications of the voters and the verification, canvassing, and validity of the ballots. The inspectors shall certify the result of the election to the commissioner and to the association.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.455. COMPLETION AND LEGAL EFFECT OF CONVERSION OR REINSURANCE. (a) An association's conversion or reinsurance is complete when the association has:

(1) complied with all laws regulating the incorporation of a mutual legal reserve insurance company; and

(2) received from the commissioner its charter and certificate of authority to engage in business as a mutual insurance company.

(b) An association that converts or reinsures to a mutual legal reserve insurance company:

(1) is considered by law to have each right, privilege, power, or authority of any other mutual legal reserve company;

(2) is considered by law to be a continuation of the

business of the association; and

(3) succeeds to and is invested with:

(A) each right or privilege of the former association that is not inconsistent with Chapter 882;

(B) each franchise or other interest of the former association; and

(C) all property of the former association, including debts due on any account and all choses in action.

(c) On conversion or reinsurance of an association to a mutual legal reserve insurance company, the title to any real estate by deed or otherwise vested in the former association vests in the company, and the title is not in any way impaired because of the conversion or reinsurance.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.456. CONTINUING OBLIGATIONS OF CONVERTED OR REINSURED ASSOCIATION. (a) The standing of each claim against an association that converts or reinsures under this subchapter must be preserved unimpaired under the reorganized company or the company reinsuring the membership of the association.

(b) Each debt, liability, and duty of a converted or reinsured association attaches to the reorganized company or the company reinsuring the membership of the association and may be enforced against it to the same extent as if the debt or liability had been incurred or contracted by the company, except that a reorganized company or reinsuring company may alter a liability created under the terms of an insurance certificate outstanding at the date of conversion or reinsurance in accordance with the plan approved by the commissioner under this subchapter.

(c) Notwithstanding Subsection (b), the company may not alter the renewability or noncancellability of an insurance certificate issued before the date of conversion or reinsurance.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.457. DISBURSEMENT OF MORTUARY FUND. (a) The mortuary fund belonging to an association that converts or reinsures under this subchapter is the property of the reorganized company or the

company reinsuring the membership of the former association. Money in the mortuary fund may be disbursed to:

(1) pay a valid claim outstanding and arising after the date of conversion or reinsurance from an insurance policy issued by the company to the association's members under an approved plan;

(2) establish the legal reserve on new insurance policies issued by the company to the association's members under an approved plan; or

(3) pay the appropriate actuarial portion of the mortuary fund to a member of the association who refuses to accept a new insurance policy offered by the company.

(b) A member must request payment under Subsection (a)(3) not later than the 60th day after the date of the conversion or reinsurance.

(c) The effective date of a mutual legal reserve company's insurance policy may be the effective date of the reinsurance contract. On conversion, 10 percent of the mortuary fund credit allocated to each policy may be credited to the contingency reserve fund of the company for the benefit of the policyholders. The balance of the mortuary fund credit may be applied as:

(1) a reserve credit to permit the company's policy to be backdated to the earliest date the reserve credit allows; or

(2) an annuity to reduce the required premium either for a given term or for the whole of life.

(d) A company may not change the manner in which a mortuary fund credit is applied under Subsections (c)(1) and (2) without the prior approval of the commissioner.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER K. CONVERSION TO STOCK LEGAL RESERVE LIFE INSURANCE COMPANY

Sec. 887.501. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a local mutual aid association or statewide mutual assessment company or association engaging in business in this state on January 1, 1955.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.502. AUTHORIZATION TO CONVERT. An association may convert to a stock legal reserve life insurance company if the association:

- (1) has at least \$100,000 in the association's mortuary fund at the time of conversion; and
- (2) except as provided by Section 887.508, possesses:
 - (A) capital in an amount equal to at least \$700,000 cash; and
 - (B) surplus in an amount equal to at least \$700,000 cash.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.503. APPROVAL BY MEMBERSHIP. An association may convert under this subchapter only if the association's membership votes to approve the conversion at a meeting called for that purpose.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.504. AMENDMENT OF CHARTER OR ARTICLES OF ASSOCIATION REQUIRED. On authorization under Section 887.503, the board of directors and officers of the association shall amend the association's charter or articles of association to comply with Sections 841.051, 841.052, and 841.053.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.505. EXCHANGE OF INSURANCE CERTIFICATES; RESERVES.

(a) An association that converts to a stock legal reserve life insurance company shall exchange each insurance certificate in force on the date of the conversion for a legal reserve policy as provided by Section 887.457.

(b) On the exchange of mutual assessment insurance certificates for legal reserve policies as provided by Subsection (a), an association shall establish and maintain the reserves required for a company organized under Chapter 841 for legal reserve policies.

(c) After the reserves are established, the association's capital must remain unimpaired and in an amount equal to at least

\$700,000.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.506. COMPLETION OF CONVERSION. An association becomes a stock legal reserve life insurance company on:

- (1) compliance with this subchapter; and
- (2) approval by the commissioner.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.507. LEGAL EFFECT OF CONVERSION. Except as provided by this subchapter, an association that converts to a stock legal reserve life insurance company under this subchapter is subject to Chapter 841.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.508. EXEMPTION FROM CAPITAL AND SURPLUS REQUIREMENTS.

(a) An association is exempt from the capital and surplus requirements of Section 887.502(2) if the association:

- (1) possesses capital in an amount equal to at least \$100,000 and unencumbered surplus in an amount equal to at least \$100,000; and
- (2) converted to a stock legal reserve life insurance company before September 1, 1999.

(b) An association that is exempt under Subsection (a) and that converts on or after September 1, 1989, shall immediately increase its capital and surplus to amounts that satisfy Section 887.502(2) on:

- (1) a change of control of at least 50 percent of the voting securities of the converted company; or
- (2) if the converted company or the holding company that controls the converted company, if any, is not controlled by voting securities, a change of at least 50 percent of the ownership of the converted company or its holding company.

(c) For purposes of Subsection (b), a transfer of ownership because of death, regardless of whether the decedent died testate or

intestate, is not considered a change of control of a converted company or its holding company if ownership is transferred only to one or more individuals, each of whom would have been an heir of the decedent had the decedent died intestate.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.509. LIMITS ON OPERATION OF CONVERTED ASSOCIATION.

Unless the association increases the association's capital and surplus to the minimum capital and surplus required for the organization of a stock legal reserve life insurance company under Chapter 841, an association that converts to a stock legal reserve life insurance company under this subchapter may not:

(1) operate in a territory as to which the association was not authorized under the converted association's previous charter or articles of association;

(2) insure a life for more than \$5,000 in event of death;

or

(3) declare or pay cash dividends.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.510. INCREASE OF CAPITAL AND SURPLUS REQUIRED. (a)

An association that converts to a stock legal reserve life insurance company under this subchapter shall, not later than the 10th anniversary of the date of conversion, increase its capital and surplus to the minimum capital and surplus required for a stock legal reserve life insurance company organized under Chapter 841.

(b) The commissioner shall revoke a converted association's certificate of authority to engage in the business of insurance if the association does not comply with Subsection (a).

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER L. GENERAL FINANCIAL REGULATION

Sec. 887.551. HAZARDOUS FINANCIAL CONDITION, SUPERVISION, CONSERVATORSHIP, AND LIQUIDATION. The following provisions apply to an association engaged in the business of insurance in this state:

- (1) Subchapter A, Chapter 404;
- (2) Chapter 441; and
- (3) Chapter 443.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.104,
eff. April 1, 2009.

SUBCHAPTER O. PENALTIES

Sec. 887.701. UNLAWFUL CONVERSION; CRIMINAL PENALTY. (a) A director, officer, agent, employee, attorney at law, or attorney in fact of an association commits an offense if the person:

(1) fraudulently takes, misapplies, or converts to the person's own use any money, property, or other item of value belonging to the association or coming into the person's custody, control, or possession by virtue of the person's office, agency, or employment;

(2) conceals any item described by Subdivision (1) with the intent to take, misapply, or convert the item to the person's own use; or

(3) pays or delivers any item described by Subdivision (1) to any other person, knowing that the other person is not entitled to receive the item.

(b) An offense under this section is punishable by imprisonment in the Texas Department of Criminal Justice for a term of not more than 10 years or less than 2 years.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by:

Acts 2009, 81st Leg., R.S., Ch. 87 (S.B. 1969), Sec. 25.123, eff. September 1, 2009.

Sec. 887.702. DIVERSION OF SPECIAL FUNDS; CRIMINAL PENALTY.

(a) A director, officer, agent, employee, attorney at law, or attorney in fact of an association commits an offense if the person wilfully borrows, withholds, or diverts from its purpose all or part of a special fund that:

- (1) belongs to or is under the management and control of an

association; and

(2) is designated by law or by rule of the commissioner for a specific use.

(b) An offense under this section is punishable by imprisonment in the Texas Department of Criminal Justice for a term of not more than 10 years or less than 2 years.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 87 (S.B. 1969), Sec. 25.124, eff. September 1, 2009.

Sec. 887.703. APPROPRIATION OF MONEY; CRIMINAL PENALTY. (a) An officer or employee of a mutual accident insurance company commits an offense if the person uses or appropriates, or knowingly permits the use or appropriation by another of, any money belonging to the company in a manner not provided for by the law authorizing the organization of the company.

(b) An offense under this section is punishable by imprisonment in the Texas Department of Criminal Justice for a term of not more than 10 years or less than 2 years.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 87 (S.B. 1969), Sec. 25.125, eff. September 1, 2009.

Sec. 887.704. VIOLATION OF COMMISSIONER ORDER; CRIMINAL PENALTY. (a) A director, officer, agent, employee, attorney at law, or attorney in fact of an association commits an offense if the person wilfully fails to comply with a lawful order of the commissioner.

(b) An offense under this section is punishable by:

(1) a fine not to exceed \$500;

(2) confinement in jail for a term not to exceed six months; or

(3) both the fine and confinement.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 887.705. OTHER VIOLATIONS; CRIMINAL PENALTY. (a) A director, officer, agent, employee, attorney at law, or attorney in fact of an association or other person commits an offense if the person violates a provision of this chapter other than Section 887.701, 887.702, 887.703, or 887.704.

(b) An offense under this section is punishable by:

- (1) a fine not to exceed \$500;
- (2) confinement in jail for a term not to exceed six months; or
- (3) both the fine and confinement.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

CHAPTER 888. BURIAL ASSOCIATIONS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 888.001. DEFINITIONS. In this chapter:

(1) "Burial association" means an individual, firm, partnership, association, or corporation engaged in the business of providing burial or funeral benefits payable partly or wholly in merchandise or services, not to exceed \$150 or the value thereof. The term includes a burial company and a burial society.

(2) "Insurance certificate" and "member" have the meanings assigned by Section 887.001.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 888.002. LIBERAL CONSTRUCTION. Sections 888.051, 888.052, 888.102(b), 888.151, 888.152, 888.153, 888.154, 888.155, 888.156, 888.157, 888.202, 888.203, and 888.204 shall be liberally construed.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 888.003. BYLAWS OF BURIAL ASSOCIATIONS. The bylaws of a burial association may not contain any provision in conflict with this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 888.004. RULES TO IMPLEMENT PURPOSES OF CHAPTER. The commissioner may adopt reasonable rules to implement the purposes of this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 888.005. APPLICABILITY OF TEXAS NON-PROFIT CORPORATION ACT. (a) Except to the extent of any conflict with this code, the Texas Non-Profit Corporation Act (Article 1396-1.01 et seq., Vernon's Texas Civil Statutes) applies to a burial association. The commissioner has each power and duty of, and shall perform each act to be performed by, the secretary of state under that Act with respect to burial associations.

(b) On advance approval of the commissioner, a burial association may pay dividends to its members.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 888.006. APPLICABILITY OF OTHER LAW. A burial association is subject to Chapter 887.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER B. ANNUAL ASSESSMENT

Sec. 888.051. IMPOSITION OF ANNUAL ASSESSMENT; AMOUNT. (a) An annual assessment is imposed on each burial association that holds a certificate of authority to engage in the business of insurance in this state. The assessment is in addition to any other fee that the association is required to pay.

(b) The amount of the assessment is equal to the greater of:

(1) the amount computed by multiplying one-half cent by the number of members in the burial association on December 31 of the applicable year; or

(2) \$5.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 888.052. PAYMENT OF ANNUAL ASSESSMENT. (a) Each burial association shall pay the annual assessment imposed by Section 888.051 to the department between January 1 and March 1 at the same time the association files its annual statement with the department.

(b) Annual assessments collected under this section shall be deposited to the credit of the Texas Department of Insurance operating account. Sections 201.001 and 201.002 apply to the assessments.

(c) All assessments paid to the department under this section are for the use and benefit of the department to:

- (1) obtain advice, information, and knowledge relating to adequate and reasonable rates for burial associations in this state;
- (2) compile records for purposes of Subdivision (1); and
- (3) implement Sections 888.051, 888.052, 888.102(b), 888.151, 888.152, 888.153, 888.154, 888.155, 888.156, 888.157, 888.202, 888.203, and 888.204.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.105, eff. April 1, 2009.

SUBCHAPTER C. INSURANCE CERTIFICATES; PAYMENT OF BENEFITS

Sec. 888.101. INSURANCE CERTIFICATES ISSUED BY BURIAL ASSOCIATION. (a) Except as provided by Subsection (c), an insurance certificate issued by a burial association must provide for the payment of the benefit in specified merchandise or burial services.

(b) The merchandise or services to be provided must be:

- (1) stated in the insurance certificate; and
- (2) approved by the department as being of the reasonable value stated on the face of the certificate.

(c) Subsections (a) and (b) do not apply if, at the time the insurance certificate is issued, the insured elects to have the benefit paid in cash.

(d) An election under this section must be stated in the insurance certificate.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 888.102. PAYMENT INSTEAD OF MERCHANDISE OR SERVICES. (a) If a burial association that issues an insurance certificate fails or refuses to provide the merchandise or services specified by the certificate, the association shall pay the benefit in cash.

(b) If a burial association that issues an insurance certificate is not given the opportunity to provide the merchandise or services specified by the certificate, instead of the specified merchandise or services, the association shall pay the greater of:

(1) the total amount paid into its mortuary fund to the credit of that certificate's account; or

(2) the percentage of the certificate's face value specified by the certificate.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 888.103. INSURANCE CERTIFICATE FORMS. An insurance certificate form used by a burial association on or after May 12, 1939, must comply with this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER D. RATES FOR BURIAL ASSOCIATIONS

Sec. 888.151. DATA COLLECTION RELATED TO RATES. (a) The commissioner shall:

(1) collect data, statistics, and information on the death rates, lapses, experiences, and other information relating to burial association rates in and outside of this state that the commissioner considers useful in determining reasonable and adequate rates for burial associations; and

(2) study the statistics, rates, and experiences of burial associations.

(b) The commissioner may distribute information collected under Subsection (a)(1) to burial associations in this state.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 888.152. ADOPTION OF RATE SCHEDULE. (a) The commissioner shall adopt a schedule of reasonable and adequate rates that a burial association may charge its members. The schedule of rates must be adopted in compliance with Chapter 2001, Government Code.

(b) The schedule must show the maximum and minimum rates that a burial association may charge per week, per month, per quarter, per six months, and per year, for the definite benefits at the definite ages. The commissioner must designate the ages in convenient groups.

(c) To ensure the adequacy and reasonableness of the rates, the commissioner may consider information gathered from an area of this state that is sufficiently large to include the varying conditions of the risks involved and during a period sufficiently long to ensure that the minimum and maximum rates authorized are:

(1) just and reasonable as they apply to members of the public who become insured under this chapter; and

(2) adequate and non-confiscatory as they apply to the burial associations.

(d) The commissioner may require:

(1) sworn statements from any burial association in this state showing its experience in rates collected and claims paid over a reasonable period; and

(2) any other information the commissioner considers necessary or useful in adopting the rate schedule.

(e) The department shall mail a copy of the adopted rate schedule to each burial association that holds a certificate of authority to engage in the business of insurance in this state.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 888.153. NEW OR AMENDED RATE SCHEDULES. (a) At any time the commissioner considers appropriate, the commissioner may adopt:

(1) a new rate schedule for burial associations; or

(2) an amendment to an existing rate schedule.

(b) After the commissioner adopts a new rate schedule or an amendment to an existing rate schedule and sends a copy to the burial associations, each burial association shall use the new or amended rate schedule for individuals who the association subsequently accepts as members.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 888.154. CONTRACTS WITH EXPERTS AND CONSULTANTS. The department may contract with experts and consultants to assist the department in exercising the department's powers and performing the department's duties under this subchapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 888.155. RETENTION OF BURIAL ASSOCIATION'S INITIAL RATE SCHEDULE. Each burial association shall retain, as part of its permanent records, the initial rate schedule adopted by the association under former Article 14.45, Insurance Code, following the amendment of that article by Chapter 593, Acts of the 66th Legislature, Regular Session, 1979.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 888.156. CHANGE OF RATES BY BURIAL ASSOCIATION. (a) With the department's consent, a burial association may change its rates by adopting a new rate schedule and filing that schedule with the department.

(b) The new rate schedule must be similar in all respects to the initial schedule adopted by the burial association and each new rate must be not less than the minimum or more than the maximum rate adopted by the commissioner.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 888.157. CONTINUATION OF FORMER RATES. (a) A burial association that had rates adopted and in use before June 12, 1947, may continue to apply those rates to individuals who were members of the burial association on that date.

(b) With the department's approval, the burial association may:

- (1) change the rates described by Subsection (a); and
- (2) make the new rates correspond to the rate schedule most recently filed by the burial association with the department.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 888.158. FAILURE TO COMPLY WITH COMMISSIONER RATE ORDERS. If a burial association refuses to comply with an order of the commissioner regarding rates under this subchapter, the commissioner shall consider the association insolvent.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER E. PROHIBITIONS

Sec. 888.201. UNAUTHORIZED PROVIDING OF BURIAL OR FUNERAL BENEFITS. An individual, firm, partnership, corporation, or association may not engage in the business of providing burial or funeral benefits payable partly or wholly in merchandise or services unless the individual, firm, partnership, corporation, or association is authorized to engage in that business by this chapter, Chapter 886, Chapter 887, or another law.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 888.202. RATE VIOLATIONS. (a) A burial association or an officer, agent, or employee of a burial association may not charge or collect any rate from a member of the association other than the rate applicable for the age and benefit stated in the association's rate schedule on file with the department and in force at that time.

(b) An officer, agent, or employee of a burial association commits an offense if the officer, agent, or employee violates Subsection (a).

(c) An officer of a burial association commits an offense if the officer knowingly permits a violation of Subsection (a).

(d) An offense under this section is a misdemeanor punishable by a fine of not less than \$50 or more than \$200.

(e) The department may revoke the certificate of authority of a burial association that violates this section.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 888.203. CONNECTION BETWEEN BURIAL ASSOCIATIONS. (a) A burial association may not be directly or indirectly connected with another burial association.

(b) A member, director, or officer of a burial association may not be a member, director, or officer of another burial association.

(c) A person whose spouse or employee is an officer or director of a burial association may not be an officer or director of another burial association.

(d) A funeral director or funeral home directly or indirectly connected with a burial association or designated by a burial association as its funeral director or funeral home may not be:

(1) connected in any manner with another burial association; or

(2) designated by another burial association as its funeral director or funeral home to:

(A) provide its members with services or merchandise; or

(B) service its policies.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 888.204. CERTAIN AFFILIATIONS BETWEEN BURIAL ASSOCIATIONS AND FUNERAL HOMES PROHIBITED. (a) It is against the public policy of this state for a funeral home or an owner of an interest in a funeral home to be directly or indirectly connected or affiliated with more than one burial association.

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

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 888.205. VIOLATION OF CHAPTER; CRIMINAL PENALTY. (a) A director, officer, agent, employee, attorney at law, or attorney in fact of a burial association, or other person commits an offense if the person violates a provision of this chapter other than Section 888.202.

(b) An offense under this section is a misdemeanor punishable by:

(1) a fine not to exceed \$500;

- (2) confinement in jail for a term not to exceed six months; or
- (3) both the fine and confinement.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBTITLE F. FARM AND COUNTY MUTUAL INSURANCE COMPANIES

CHAPTER 911. FARM MUTUAL INSURANCE COMPANIES

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 911.001. LIMITED EXEMPTION FROM INSURANCE LAWS; APPLICABILITY OF CERTAIN LAWS. (a) A provision of this code, other than this chapter, does not apply to a farm mutual insurance company holding a certificate of authority under this chapter unless farm mutual insurance companies are expressly mentioned in the other law.

(b) A law enacted after May 20, 1973, does not apply to a farm mutual insurance company unless the law states that it applies to a farm mutual insurance company.

(c) Except to the extent of any conflict with this chapter, the following provisions apply to a farm mutual insurance company:

- (1) Subchapter A, Chapter 32;
- (2) Subchapter D, Chapter 36;
- (3) Sections 31.002(2), 32.021(c), 32.023, 32.041, 33.002, 38.001, 81.001-81.004, 201.005, 201.055, 401.051, 401.052, 401.054-401.062, 401.103-401.106, 401.151, 401.152, 401.155, 401.156, 421.001, 801.051-801.055, 801.057, 801.101, 801.102, 822.204, 841.004, 841.251, 841.252, 862.101, 1806.001, 1806.101, 1806.103(b), and 1806.104-1806.107;
- (4) Chapter 86;
- (5) Subchapter A, Chapter 401;
- (6) Subchapter B, Chapter 404;
- (7) Chapter 422;
- (8) Subchapter B, Chapter 424, other than Section 424.052, 424.072, or 424.073;
- (9) Chapter 441;
- (10) Chapter 443;
- (11) Chapter 462;
- (12) Chapter 481;
- (13) Chapter 541;
- (14) Chapter 802;

- (15) Subchapter A, Chapter 805;
- (16) Chapter 824; and
- (17) Article 1.09-1.

(d) After hearing, the commissioner may adopt rules regarding the application of a law referred to in Subsection (c) to farm mutual insurance companies. The department may enforce rules adopted under this subsection.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2005, 79th Leg., Ch. 631 (H.B. 2565), Sec. 3, eff. September 1, 2005.

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.106, eff. April 1, 2009.

Sec. 911.002. GENERAL RULEMAKING AUTHORITY; ENFORCEMENT. After hearing, the commissioner may adopt rules to clarify and augment this chapter as determined by the commissioner to be necessary to accomplish the purposes of this chapter. The department may enforce rules adopted under this section.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 911.003. FEES. (a) The department shall charge and collect the following fees:

- (1) \$10 for an amendment to a farm mutual insurance company's charter; and
- (2) \$1 for the issuance of a company's certificate of authority.

(b) The department shall charge and the comptroller shall collect a fee of \$20 for the filing of an annual statement required by the department.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

**SUBCHAPTER B. ORGANIZATION OF FARM MUTUAL INSURANCE COMPANY;
DIRECTORS**

Sec. 911.051. APPLICABILITY OF TEXAS NON-PROFIT CORPORATION

ACT. Except to the extent of any conflict with this chapter, the Texas Non-Profit Corporation Act (Article 1396-1.01 et seq., Vernon's Texas Civil Statutes) applies to a farm mutual insurance company. The commissioner has each power and duty of, and shall perform each act to be performed by, the secretary of state under that Act with respect to farm mutual insurance companies.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 911.052. FORMATION OF COMPANY: INCORPORATION REQUIRED. To form a farm mutual insurance company, an association of individuals that does not hold a certificate of authority issued by the department must obtain a charter as required by this subchapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 911.053. INCORPORATION REQUIREMENTS. (a) In this section, "separate risk" means one or more items of real property and the property's contents, if any, that is not exposed to any other property on which insurance is applied for in the association seeking the charter.

(b) To be granted a charter as a farm mutual insurance company, an association must:

(1) demonstrate that the association:

(A) has existed as an association of individuals for at least three years;

(B) has at least 100 individual members;

(C) operates for the purpose of membership recreation or welfare under a system of subordinate lodges, locals, or districts;

(D) does not have capital stock;

(E) is organized and operates solely for the mutual benefit of its members and not for profit;

(F) has a representative form of government; and

(G) has decided by a majority vote of the association's members to apply for a charter as a farm mutual insurance company under this chapter; and

(2) have:

(A) at least 100 written applications for insurance on

at least 400 separate risks; and

(B) an unencumbered surplus as required by Section 911.308(b).

(c) Coverage for a risk described by Subsection (b)(2)(A) may not be in an amount that exceeds one percent of the total amount of insurance coverage to be issued by the association as stated in its application for a charter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 911.054. CHARTER AND ARTICLES OF INCORPORATION. (a) The charter and articles of incorporation of an association that wants to form a farm mutual insurance company must state the names and post office addresses of at least 25 charter members of the company, all of whom are residents of one or more adjoining counties in this state and each of whom must:

(1) be a member of the association;

(2) own at least \$5,000 of insurable property for which the member has applied in writing for insurance coverage from the company to be formed; and

(3) sign the charter and articles of incorporation.

(b) In addition to the requirements of Subsection (a), the charter must:

(1) be acknowledged before a notary public by at least five of the charter members described by Subsection (a);

(2) state:

(A) the name of the company, which must include the words "Farm Mutual" or "Farmers Mutual";

(B) the location of the company's principal office;

(C) the number, names, and post office addresses of each of the company's first directors, of which there must be at least five; and

(D) the type of property the company will insure and the risk to be insured against; and

(3) include any other provision the incorporators want consistent with this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 911.055. APPLICATION FOR PERMIT TO SOLICIT INSURANCE. (a) At least 10 residents described by Section 911.054(a) that want to form a farm mutual insurance company may apply to the department for a permit to solicit insurance on the mutual or cooperative plan.

(b) The application for a permit to solicit insurance must:

(1) state:

(A) that at least 100 individuals are members of an association described by Section 911.053(b)(1);

(B) that the association has indicated, by majority vote, that the association wants to:

(i) insure property of the association's members under this chapter; and

(ii) be chartered as a farm mutual insurance company;

(C) the name of the company, which must include the words "Farm Mutual" or "Farmers Mutual";

(D) the location of the company's principal office;

(E) the risks the company proposes to insure; and

(F) the names and places of residence of at least 10 of the applicants; and

(2) be accompanied by:

(A) affidavits of at least two of the applicants, each of whom must:

(i) state the applicant's name and residence; and

(ii) verify the facts stated in the application;

and

(B) a filing fee in the amount of \$25.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 911.056. ISSUANCE OF PERMIT TO SOLICIT INSURANCE; TERM.

(a) The department shall approve or deny an application for a permit to solicit insurance under Section 911.055. If the department finds that the application complies with this chapter, the department shall issue to the applicants a permit to solicit insurance.

(a-1) If the department finds that the application does not comply with this chapter, the department shall deny the application. On the applicant's request, the commissioner shall hold a hearing on a denial. Not later than the 30th day after the date of the

applicant's request for a hearing, the commissioner shall request a hearing date.

(b) A permit issued under this section authorizes the permit holders to solicit insurance on the mutual or cooperative plan in accordance with the terms of the application. The permit does not authorize the permit holders to:

- (1) issue insurance policies; or
- (2) pay losses.

(c) A permit issued under this section is valid for six months. On receipt of an application for renewal and a fee in the amount of \$10, the department may renew a permit issued under Section 911.055 as frequently and for the period as the department determines necessary.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1022 (H.B. [4291](#)), Sec. 16, eff. June 19, 2009.

Sec. 911.057. COLLECTION AND REFUND OF MONEY FROM CERTAIN INDIVIDUALS APPLYING FOR INSURANCE. An association described by Section 911.053(b)(1) of which the applicants for a permit to solicit insurance are members shall hold in trust money collected from an individual applying for insurance in the association until the association is incorporated. If the association's incorporation is not perfected, the association shall refund the money to the individual applying for the insurance.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 911.058. MEMBERSHIP CONTROL OF COMPANY. (a) The control of a farm mutual insurance company must be ultimately vested as provided by this chapter in the company's members through a supreme legislative or governing body, the members of which must be elected directly by the company's members or by delegates elected by the company's members.

(b) Through the company's governing body, the company's members may establish local chapters, branches, lodges, or similar organizations.

(c) The methods provided by this section for the control of a farm mutual insurance company are exclusive.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 911.059. ELIGIBILITY OF BOARD OF DIRECTORS; TERM. (a) An individual is eligible to serve as a director of a farm mutual insurance company if the individual is a policyholder who maintains insurance coverage in the amount of at least \$3,000 written by the company on the individual's property.

(b) Except as otherwise provided by the company's bylaws or constitution, a director serves for a term of one year or until the director's successor qualifies for office.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 911.060. GENERAL POWERS OF BOARD OF DIRECTORS. The board of directors of a farm mutual insurance company has the powers provided by:

(1) this chapter; and

(2) the company's charter, constitution, and bylaws to the extent those powers do not conflict with this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 911.061. AUTHORITY TO BORROW MONEY. (a) The board of directors of a farm mutual insurance company, acting through its authorized officers, may borrow money in an amount determined to be necessary to pay the company's accrued or unaccrued losses.

(b) The board may pledge as security for a loan the assets of the company, including the contingent liability of its policyholders.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 911.062. REMOVAL OF OFFICER OR DIRECTOR. (a) The board of directors of a farm mutual insurance company, at a meeting, may remove an officer or director of the company if, by a two-thirds

majority vote of all the company's directors, the board determines that the removal of the individual is in the best interest of the company. The board may remove an officer or director under this subsection without stating a reason for the removal.

(b) The board may appoint one or more individuals to assume the duties and serve the unexpired term of an officer or director removed under this section.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 911.063. CREATION OF LOCAL CHAPTERS AND DISTRICTS. (a) A farm mutual insurance company's bylaws may provide for:

(1) the organization of local chapters to transact the company's business; and

(2) the creation of districts in and for which directors may be elected.

(b) The bylaws may also provide that delegates from the company's local chapters are the company's supreme governing body.

(c) The company may consider the hazards against which the company insures and the company's classes of risks and territory of operation in organizing the local chapters and creating the districts.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 911.064. POLICYHOLDER MEETINGS. (a) A farm mutual insurance company shall hold a policyholder meeting to elect directors and transact business at the time and place and in the manner prescribed by the company's bylaws.

(b) A special meeting of a company's policyholders may be called by:

(1) the president, the general manager, or one-third of the company's directors; or

(2) the commissioner.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 911.065. VOTING BY POLICYHOLDER. (a) Each policyholder

of a farm mutual insurance company is entitled to only one vote at a policyholders' meeting.

(b) A policyholder may not vote by proxy.

(c) A farm mutual insurance company may provide in its constitution or bylaws that a policyholder may vote electronically or by mail without making a personal appearance at a policyholders' meeting.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 1083 (H.B. 3496), Sec. 3, eff. September 1, 2017.

Sec. 911.066. AUTHORITY TO PROHIBIT WAIVER OF BYLAWS. A farm mutual insurance company may provide in its bylaws that a company adjuster, representative appointed by the company, or local chapter or officer or agent elected by the local chapter may not waive a provision in the company's constitution or bylaws or in a policy issued by the company.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 911.067. APPLICATION FOR EXTENSION OF CHARTER FOR CERTAIN COMPANIES; TERM. (a) Before a farm mutual insurance company's charter expires, the company may apply to the department for an extension of the company's charter if:

(1) the company was chartered, holding a certificate of authority, and operating before May 21, 1973, under Chapter 16, Insurance Code, as it existed on that date; or

(2) the company was organized and engaging in business before April 6, 1937, and the company continues to engage in business.

(b) A farm mutual insurance company described by Subsection (a) and whose charter has expired may apply to the department to have the charter extended perpetually if the company is engaged in business in this state.

(c) The term of the charter begins on the date that the charter is extended or, if the original charter expired before the charter is extended, the date the original charter expired.

(d) An application for an extension must be authorized by either a two-thirds majority vote of the company's directors or by a simple majority vote of those voting at a policyholders' meeting and must:

- (1) state in full the charter to be extended;
- (2) state the period for which the charter is to be extended; and
- (3) be signed and acknowledged by the president and secretary of the company.

(e) A company whose charter is extended retains the rights, privileges, and immunities granted the company under the company's original charter.

(f) The department shall charge and collect a fee of \$10 for the extension of a farm mutual insurance company's charter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER C. AUTHORITY TO ENGAGE IN BUSINESS IN THIS STATE

Sec. 911.101. AUTHORITY TO ENGAGE IN BUSINESS. Except to the extent of any conflict with this chapter, a farm mutual insurance company must hold a certificate of authority under Section 801.051 to engage in the business of insurance in this state under this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER D. POLICIES AND COVERAGE

Sec. 911.151. KINDS OF INSURANCE AUTHORIZED. (a) A farm mutual insurance company may insure property against loss or damage by:

- (1) fire, lightning, explosion, theft, windstorm, hurricane, hail, riot, civil commotion, smoke, aircraft, or land vehicles; or
- (2) any other hazard against which any other fire or windstorm insurance company operating in this state under Chapter 862 may write insurance on property described by Subsection (b).

(b) The company may write insurance against the hazards described by Subsection (a) on:

- (1) a rural or urban dwelling and attendant outhouses and yard buildings and all their contents for home and personal use,

musical instruments and libraries, barns and ranch buildings of any description and vehicles and implements used on or about barns or ranch buildings;

(2) agricultural products that are produced or kept on farms or ranches;

(3) a church building, fraternal lodge hall, private or church school, or nonindustrial use building owned by a nonprofit organization, regardless of the location;

(4) a trailer or mobile home; and

(5) growing crops if the insurance is reinsured by:

(A) the Federal Crop Insurance Corporation under Section 508, Federal Crop Insurance Act (7 U.S.C. Section 1508); or

(B) a property and casualty insurance company that:

(i) is authorized to write insurance in this state; and

(ii) has a rating by the A.M. Best Company of A- or better.

(c) An insurance policy written by a farm mutual insurance company against loss or damage by windstorm, hurricane, or hail, as described by Subsection (a), may include coverage for:

(1) a building or other structure that is built wholly or partially over water; and

(2) the corporeal movable property contained in a building or structure described by Subdivision (1).

(d) The farm mutual insurance company may impose appropriate limits of coverage and deductibles for coverage described by Subsection (c).

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by:

Acts 2005, 79th Leg., Ch. 1153 (H.B. 3048), Sec. 4, eff. September 1, 2005.

Sec. 911.152. PROPERTY AND HAZARDS AGAINST WHICH COMPANY MAY NOT INSURE. (a) A farm mutual insurance company may not insure:

(1) a building, or the building's contents, with more than 40 percent of the building's floor space or more than 500 square feet of floor space, whichever is less, used for business purposes, except as provided by Section 911.151(b)(3); or

(2) any type of commercial or private passenger motor vehicle, except as provided by Section 911.151(b)(4).

(b) A farm mutual insurance company may not assume or issue an insurance policy that:

(1) indemnifies an insured for liability to a third party the insured incurs in committing a tortious act; or

(2) covers an insured for liability the insured incurs under a contract to maintain, hold, or store property belonging to another.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 911.153. CONTRACT TERMS: INCORPORATION OF BYLAWS. (a) A farm mutual insurance company's bylaws are part of each contract between the company and an insured.

(b) Each policy issued by the company must state that the company's bylaws are part of the contract.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 911.154. CONTRACT TERMS: ADOPTION OF ADDITIONAL PROVISIONS. (a) A farm mutual insurance company may adopt as part of the company's bylaws and insurance policies any provision contained in the standard policies of companies writing fire or windstorm insurance as adopted by the commissioner to the extent the provision applies to a farm mutual insurance company.

(b) A company that adopts a provision as provided by Subsection (a) shall state in the company's bylaws or in each policy issued by the company that the provision has been adopted as provided by Subsection (a).

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 911.155. REPAIR OR REPLACEMENT OF INSURED PROPERTY. The company's bylaws may authorize the company to require, at its option, that all or a percentage of the money paid for a loss be used to replace or repair the damaged or destroyed property. The requirement may apply equally to personal and real property, including personal

and real property exempt from execution, such as a homestead or a building on the homestead. The company may provide in its bylaws that the requirements of Section 862.053 do not apply to its insurance policies.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER E. CHARGES, PREMIUMS, AND ASSESSMENTS

Sec. 911.201. PAYMENT OF PREMIUM OR ASSESSMENT. (a) A farm mutual insurance company's bylaws must:

(1) state the time and manner of the levy and payment of a premium or assessment for policies written by the company;

(2) in addition to the regular premium or assessment under Subdivision (1), establish the contingent liability of a policyholder for all losses accrued while a policy is in force in the amount of at least \$1 for each \$100 of insurance coverage, except as provided by Subsection (b); and

(3) state the time and manner of payment of a policyholder's contingent liability established under Subdivision (2).

(b) A company's bylaws may provide for the issuance of policies without contingent liability as required by Subsection (a)(2) if the company has policyholder surplus in the amount of at least \$1,000,000.

(c) As required by its bylaws, a farm mutual insurance company shall establish and levy premiums and assessments, including the contingent liability of a policyholder, for all insurance written by the company.

(d) A policyholder shall pay premiums and assessments as required by the company's bylaws.

(e) The premium or assessment for a policy shall be secured by a lien on each item of real or personal property, other than a homestead, covered by the policy, including the land on which an insured building is located. The lien remains on the property while the insured owns the property.

(f) A conservator, receiver, or liquidator of a farm mutual insurance company may not make an assessment against a policyholder for the contingent liability established under Subsection (a)(2).

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 911.202. NONPAYMENT OF PREMIUMS OR ASSESSMENTS: FILING OF ACTION. (a) A farm mutual insurance company may bring an action in the county in which the company's home office is located against a policyholder who defaults on the payment of a premium or an assessment.

(b) The company is entitled to judgment against the policyholder for:

- (1) delinquent premiums or assessments;
- (2) foreclosure of the lien described by Section 911.201;

and

(3) the costs of an action, including a reasonable attorney's fee.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 911.203. POLICYHOLDER LIABILITY. A policyholder is liable for the losses of a farm mutual insurance company only as provided by the company's constitution and bylaws, and only in proportion to the amount that the premium or assessment for the policyholder's policy bears to the total amount of premiums or assessments for all policies written by the company in the class to which the policyholder's policy belongs.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER F. AGENTS

Sec. 911.251. LICENSING AND APPOINTMENT OF CERTAIN AGENTS. (a) An individual or firm may not solicit, write, sign, execute, or deliver insurance policies, bind insurance risks, collect premiums, or otherwise act on behalf of a farm mutual insurance company in the capacity of an insurance agent in the solicitation or sale of crop insurance unless the individual or firm holds a license issued under Title 13.

(b) A farm mutual insurance company may not appoint and act through an agent under Subchapter F, Chapter 4051.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.223(a), eff. Sept. 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.107, eff. April 1, 2009.

SUBCHAPTER G. REGULATION OF FARM MUTUAL INSURANCE COMPANY; FINANCIAL REQUIREMENTS

Sec. 911.301. GENERAL OPERATING REQUIREMENTS. (a) In this section:

(1) "Census year" means a year in which the United States Census Bureau conducts a federal decennial census.

(2) "Rural property" means property located outside an area of land subject to the taxing authority of a municipality with a population of more than 6,500, adjusted in accordance with Subsection (e).

(b) A farm mutual insurance company shall:

(1) maintain a majority of the company's total insurance in force on rural property at all times the insurance is written; and
(2) operate on a regular and special assessment basis.

(c) Except as otherwise approved by the commissioner, a farm mutual insurance company may not use more than 33 percent of the company's gross income for expenses.

(d) Property that is rural property at the time the property is originally insured continues to be classified as rural property if:

(1) the policy or policies that insure the property are written by the same farm mutual insurance company; and

(2) the coverage continues in effect without lapse of coverage for more than 60 days.

(e) On January 1 of the second year following a census year, the population limit described by Subsection (a)(2) increases or decreases by a percentage that is equal to the percentage increase or decrease in the population of this state from the previous decennial census.

(f) Not later than November 1 of the year following a census year, the commissioner shall:

(1) compute the new population limit in accordance with Subsection (e); and

(2) publish the limit on the department's Internet website.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by:

Acts 2023, 88th Leg., R.S., Ch. 958 (S.B. 2008), Sec. 1, eff.
September 1, 2023.

Sec. 911.302. LOCATION OF BUSINESS. (a) Except as provided by Subsection (b), a farm mutual insurance company may write insurance in:

(1) the county in which the company's home office is located at the time of incorporation and in any county adjoining the county in and for which the company is organized;

(2) any county in which another farm mutual insurance company is not organized; and

(3) any county in this state if the company's reserve fund exceeds \$200,000 in cash or securities in which the reserve fund of a stock fire insurance company may be invested.

(b) This section does not apply to a farm mutual insurance company organized and operating in this state under a certificate of authority issued before May 21, 1973, under former Chapter 16 of this code.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 911.303. REINSURANCE. (a) A farm mutual insurance company may reinsure the company's risks with another company against any hazard against which the farm mutual insurance company is permitted to insure.

(b) The farm mutual insurance company may contract for mutual or reciprocal reinsurance with another company on the mutual or cooperative plan subject to the following conditions:

(1) the farm mutual company may assume the reinsurance on the risks of the other company only if the other company reinsures the risks of the farm mutual insurance company; and

(2) the farm mutual company may write or assume the reinsurance only on property that the company is authorized to insure and that is located in this state.

(c) A farm mutual insurance company that reinsures another company's property is liable for the losses of the other company only

as specified in the reinsurance contract. The farm mutual insurance company does not become a member or partner of the other company as a result of the reinsurance.

(d) A farm mutual insurance company may pay or collect additional assessments or premiums for the purpose of a contract described by Subsection (b).

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 911.304. ANNUAL REPORTS REQUIRED. (a) A farm mutual insurance company shall annually prepare a written report as required by this section and submit the report to the company's policyholders.

(b) The annual report must show:

- (1) the total amount of premiums paid during the year for the policyholders' insurance;
- (2) the company's operating expenses; and
- (3) the total amount of claims paid and the amount paid for each covered peril.

(c) Repealed by Acts 2007, 80th Leg., R.S., Ch. 47, Sec. 2, eff. May 8, 2007.

(d) The company shall make available to each policyholder a copy of the annual report at the time and in the manner prescribed by the company's bylaws.

(e) A farm mutual insurance company shall make annual reports to the department as required by the commissioner or by law.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 47 (S.B. 849), Sec. 1, eff. May 8, 2007.

Acts 2007, 80th Leg., R.S., Ch. 47 (S.B. 849), Sec. 2, eff. May 8, 2007.

Sec. 911.305. EXAMINATION OF COMPANY. The department shall examine each farm mutual insurance company as often as the department determines necessary.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 911.306. SOLVENCY REQUIREMENTS. (a) A farm mutual insurance company is solvent if:

(1) the company's assets, including the policyholders' contingent liability for the company's losses, are reasonably sufficient to pay the company's losses according to the terms of the policies; and

(2) the company's required unencumbered surplus, if any, has not been impaired in excess of 16-2/3 percent of the required unencumbered surplus.

(b) A company that is solvent as provided by this section may continue to engage in the business of insurance.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 911.307. RESERVE REQUIREMENTS. (a) A farm mutual insurance company's board of directors may provide for the accumulation of reserve funds.

(b) The company shall invest the reserve funds in the same type of securities in which the reserve funds of other fire insurance companies are required to be invested by law.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 911.308. SURPLUS REQUIREMENTS. (a) A farm mutual insurance company organized between January 1, 1955, and May 21, 1973, shall maintain an unencumbered surplus of \$2 for each \$100 of insurance in force or an unencumbered surplus of \$200,000, whichever amount is less.

(b) A farm mutual insurance company organized under this chapter on or after May 21, 1973, shall maintain an unencumbered surplus in cash of \$2 for each \$100 of insurance in force or an unencumbered surplus of \$200,000, whichever amount is greater.

(c) A company described by Subsection (b) shall invest the minimum unencumbered surplus as provided by Section 822.204. The company may invest funds in excess of the minimum unencumbered surplus as provided by the provisions of Subchapter B, Chapter 424, other than Sections 424.052, 424.072, and 424.073.

(d) A company described by Subsection (b) shall, without delay, restore the minimum unencumbered surplus if the surplus is impaired.

The department shall proceed as provided by Subchapter B, Chapter 404.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.108, eff. April 1, 2009.

CHAPTER 912. COUNTY MUTUAL INSURANCE COMPANIES

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 912.001. DEFINITIONS. In this chapter:

- (1) "Member" includes a policyholder or another person who is insured by a county mutual insurance company.
- (2) "Policy" includes a certificate or contract of insurance, certificate of membership, or other document through which insurance is effected or evidenced.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 912.002. LIMITED EXEMPTION FROM INSURANCE LAWS; APPLICABILITY OF CERTAIN LAWS. (a) A county mutual insurance company is exempt from the operation of all insurance laws of this state except laws that are made applicable by their specific terms or except as specifically provided by this chapter.

(b) A county mutual insurance company is subject to:

- (1) Sections 38.001, 401.051, 401.052, 401.054-401.062, 401.151, 401.152, 401.155, 401.156, 501.159, 501.202, 501.203, 822.204, 1806.001, 1806.101, 1806.103(b), 1806.104-1806.107, 1953.051(b), 2002.002, and 2002.005;
- (2) Subchapter A, Chapter 86;
- (3) Subchapter A, Chapter 401;
- (4) the provisions of Subchapter B, Chapter 424, other than Sections 424.052, 424.072, and 424.073;
- (5) Chapters 221, 251, 252, 254, 541, and 2210; and
- (6) Articles 5.39 and 5.40.

(c) Rate regulation for a residential fire and allied lines insurance policy written by a county mutual insurance company is subject to Chapter 2253. On and after December 1, 2004, rate regulation for a personal automobile insurance policy and a

residential fire and allied lines insurance policy written by a county mutual insurance company is subject to Article 5.13-2 and Chapter 2251. A county mutual insurance company is subject to Chapter 2253. The commissioner may adopt rules as necessary to implement this subsection.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 206, Sec. 21.40(a), (b), eff. June 11, 2003; Acts 2003, 78th Leg., ch. 209, Sec. 10, eff. Oct. 1, 2003.

Amended by:

Acts 2005, 79th Leg., Ch. 631 (H.B. 2565), Sec. 4, eff. September 1, 2005.

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.109, eff. April 1, 2009.

Acts 2015, 84th Leg., R.S., Ch. 1137 (S.B. 189), Sec. 3, eff. September 1, 2015.

Sec. 912.003. FEES. The department shall charge and collect a fee in the amount of \$1 for the issuance of a county mutual insurer's certificate of authority.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 912.004. FORMATION OF NEW COUNTY MUTUAL COMPANY PROHIBITED. A new county mutual insurance company may not be formed under this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 912.005. LIMITATION ON TRANSFER OF BUSINESS TO COUNTY MUTUAL INSURANCE COMPANY. An insurer may not transfer more than 10 percent of the insurer's insurance policies to a county mutual insurance company without the prior approval of the commissioner.

Added by Acts 2003, 78th Leg., ch. 206, Sec. 21.405, eff. June 11, 2003.

**SUBCHAPTER B. ORGANIZATION OF COUNTY MUTUAL INSURANCE COMPANY;
DIRECTORS**

Sec. 912.051. APPLICABILITY OF TEXAS NON-PROFIT CORPORATION ACT. (a) Except to the extent of any conflict with this code, the Texas Non-Profit Corporation Act (Article 1396-1.01 et seq., Vernon's Texas Civil Statutes) applies to a county mutual insurance company. The commissioner has each power and duty of, and shall perform each act to be performed by, the secretary of state under that Act with respect to county mutual insurance companies.

(b) On advance approval of the commissioner, a county mutual insurance company may pay dividends to its members.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 912.052. ELIGIBILITY OF BOARD OF DIRECTORS; TERM. (a) An individual is eligible to serve as a director of a county mutual insurance company if the individual is a policyholder who maintains insurance coverage in the amount of at least \$1,000 written by the company on the individual's property.

(b) Except as otherwise provided by the company's bylaws, a director serves for a term of one year or until the director's successor qualifies for office.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 912.053. GENERAL POWERS OF BOARD OF DIRECTORS. The board of directors of a county mutual insurance company has the powers provided by the company's charter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 912.054. AUTHORITY TO BORROW MONEY. (a) The board of directors of a county mutual insurance company may borrow money in an amount determined to be necessary to pay the company's accrued or unaccrued losses.

(b) The board may pledge as security for a loan the assets of the company, including the contingent liability of its policyholders.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 912.055. CHARTER AND ARTICLES OF INCORPORATION. The charter and articles of incorporation of a county mutual insurance company must state:

- (1) the name of the company, which must include the words "County Mutual Insurance Company";
 - (2) the location of the principal office of the company;
- and
- (3) the number of the directors, which must be at least five.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 912.056. CREATION OF LOCAL CHAPTERS AND DISTRICTS. (a) A county mutual insurance company's bylaws may provide for:

- (1) the organization of local chapters to transact the company's business; and
- (2) the creation of districts in and for which directors may be elected.

(b) The bylaws may also provide that delegates from the company's local chapters are the company's supreme governing body.

(c) The company may consider the hazards against which the company insures and the company's classes of risks and territory of operation in organizing the local chapters and creating the districts.

(d) A company organized and operating under this chapter that, as of September 1, 2001, and continuously thereafter, appointed managing general agents, created districts, or organized local chapters to manage a portion of the company's business independent of all other business of the company may continue to operate in that manner and may appoint and contract with one or more managing general agents in accordance with this code only if the company:

- (1) cedes 85 percent or more of the company's direct and assumed risks to one or more reinsurers; and
- (2) has a private passenger automobile insurance business:
 - (A) with a market share of not greater than five percent; or

(B) that is predominantly nonstandard.

(e) A company described by Subsection (d) shall file, for each managing general agent, district, or local chapter program, the rating information required by the commissioner by rule. Each managing general agent, district, or local chapter program shall be treated as a separate insurer for the purposes of Chapters 544, 2251, 2253, and 2254.

(f) Notwithstanding any other provision of this code, a company operating under Subsection (d) that cedes 85 percent or more of the company's direct and assumed risks to one or more nonaffiliated reinsurers shall maintain unencumbered surplus, or guaranty fund and unencumbered surplus, equal to the greater of \$2 million or five percent of the company's recoverable for reinsurance after taking full credit against the recoverable as otherwise permitted for:

(1) premium payable to ceding insurers, net of any ceding commission due the company;

(2) collateral held as required by Section 493.104, letters of credit, and security trusts that secure the collection of the reinsurance; and

(3) reinsurance through reinsurers whose financial strength is rated "A" or better by the A. M. Best Company, Incorporated, or another nationally recognized statistical rating organization acceptable to the commissioner.

(g) The commissioner by rule shall adopt a transition period for insurance companies subject to Subsection (f) to meet the requirements of that subsection and for the pro rata elimination of any deficiencies in the amounts required under that subsection. The transition period adopted under this subsection must be for a period of not less than five years.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 677 (H.B. [2449](#)), Sec. 3, eff. September 1, 2009.

Sec. 912.057. POLICYHOLDER MEETINGS. (a) A county mutual insurance company shall hold a policyholder meeting to elect directors and transact business at the time and place and in the manner prescribed by the company's bylaws.

(b) A special meeting of a company's policyholders may be called by:

- (1) the president, the general manager, or one-third of the company's directors; or
- (2) the commissioner.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 912.058. VOTING BY POLICYHOLDERS. (a) Each policyholder of a county mutual insurance company is entitled to only one vote at a policyholders' meeting.

(b) A policyholder may not vote by proxy unless the company's bylaws specifically authorize voting in that manner.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 912.059. AMENDMENT TO BYLAWS. (a) A majority of the members of a county mutual insurance company, either in person or by proxy when ratified by the board of directors, may amend the company's bylaws at a regular meeting or at a special meeting called for that purpose.

(b) Notice of a regular or special meeting at which an amendment to the bylaws will be considered must be mailed or delivered personally to each member.

(c) An amendment to the bylaws is not effective until approved by the commissioner as meeting the requirements of this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 912.060. AUTHORITY TO PROHIBIT WAIVER OF BYLAWS. A county mutual insurance company may provide in its bylaws that a local chapter or an officer or agent elected by the local chapter may not waive a provision of the bylaws.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 912.061. APPLICATION FOR EXTENSION OF CHARTER; TERM. (a)

Before a county mutual insurance company's charter or extension of the charter expires, the company may apply to the department for an extension of the charter for a term of 50 years from the date the charter would otherwise expire.

(b) The application for an extension must:

(1) demonstrate that the application was authorized either by a two-thirds vote of the company's directors or by a majority vote at a policyholders' meeting;

(2) state in full the charter to be extended;

(3) state the period for which the charter is to be extended;

(4) be signed and acknowledged by the president and secretary of the company; and

(5) be accompanied by a fee of \$50.

(c) A company whose charter is extended retains the rights, privileges, and immunities granted a county mutual insurance company by this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER C. AUTHORITY TO ENGAGE IN BUSINESS IN THIS STATE

Sec. 912.101. OPERATION UNDER CERTIFICATE OF AUTHORITY. A county mutual insurance company engages in the business of insurance under a certificate of authority issued by the department.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 912.102. AUTHORITY TO ENGAGE IN BUSINESS. A county mutual insurance company may engage in the business of insurance in accordance with this chapter and other applicable laws only if:

(1) the company was formed before September 6, 1955, and was actively engaged in the business of insurance on that date; or

(2) the company was formed under a permit to solicit insurance issued before September 6, 1955.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER D. POLICIES AND COVERAGE

Sec. 912.151. KINDS OF INSURANCE AUTHORIZED. (a) A county mutual insurance company that qualifies to write casualty lines for statewide operation may write all lines of automobile insurance. The company may not assume a risk on any one hazard that is greater than five percent of its assets, unless the company promptly reinsures the excess amount of risk.

(b) A county mutual insurance company may insure property against loss or damage by:

(1) fire, lightning, gas explosion, theft, windstorm, and hail or for any combination of these hazards; or

(2) any other hazard against which any other fire or windstorm insurance company operating in this state may write insurance on property described by Subsection (c).

(c) Unless restricted by its charter, the company may write insurance against the hazards described by Subsection (b) on:

(1) a rural or urban dwelling and attendant outhouses and yard buildings;

(2) the contents, for home and personal use, of a rural or urban dwelling, an attendant outhouse, or a yard building, including a family vehicle, musical instrument, and library;

(3) a barn or other farm, dairy, truck garden, hennery, or ranch building and any other improvement;

(4) a vehicle, harness, implement, tool, or machinery of any description used on and about a farm, truck garden, dairy, hennery, or ranch;

(5) fruit and products, other than growing crops, and any fowl, livestock, or domestic animals that are produced, raised, grown, kept, or used on a farm, truck garden, dairy, hennery, or ranch;

(6) a church house, country school house, country lodge room, or country recreation hall, other than a road house or public dance hall; and

(7) the contents of a church house, country school house, country lodge room, or country recreation hall.

(d) An insurance policy written by a county mutual insurance company against loss or damage by windstorm or hail, as described by Subsection (a), may include coverage for:

(1) a building or other structure that is built wholly or partially over water; and

(2) the corporeal movable property contained in a building

or structure described by Subdivision (1).

(e) The county mutual insurance company may impose appropriate limits of coverage and deductibles for coverage described by Subsection (d).

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2005, 79th Leg., Ch. 1153 (H.B. 3048), Sec. 5, eff. September 1, 2005.

Sec. 912.152. POLICY FORMS. (a) A county mutual insurance company is subject to:

- (1) Sections 1952.051-1952.055;
- (2) Subchapter H, Chapter 1952;
- (3) Subchapter B, Chapter 2002;
- (4) Chapter 2301; and
- (5) Articles 5.06 and 5.35.

(b) County mutual insurance companies shall file policy forms under Subchapter B, Chapter 2301, or continue to use the standard policy forms and endorsements promulgated under former Articles 5.06 and 5.35 on notification to the commissioner in writing in the manner prescribed by those articles that those forms will continue to be used.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by Acts 2003, 78th Leg., ch. 206, Sec. 21.41, eff. June 11, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.110, eff. April 1, 2009.

Acts 2019, 86th Leg., R.S., Ch. 455 (H.B. 259), Sec. 2, eff. September 1, 2019.

Sec. 912.153. CONTRACT TERMS: INCORPORATION OF BYLAWS. (a) A county mutual insurance company's bylaws are part of each contract between the company and an insured.

(b) Each policy issued by the company must state that the company's bylaws are part of the contract.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 912.154. AMOUNT OF INSURANCE UNDER MULTIPLE HAZARDS POLICY. The amount of risk or insurance coverage in a policy that insures a risk against more than one hazard is the maximum loss the county mutual insurance company may sustain under the policy at any one time, regardless of the number of hazards against which the company insures.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 912.155. REPAIR OR REPLACEMENT OF INSURED PROPERTY. (a) The county mutual insurance company's bylaws may authorize the company to require, at its option, that all or a percentage of the money paid for a loss be used to replace or repair the damaged or destroyed property. The requirement may apply equally to personal and real property, including personal and real property exempt from execution, such as a homestead or a building on the homestead. The company may provide in its bylaws that the requirements of Section 862.053 do not apply to its insurance policies.

(b) This section does not apply to a company that meets the requirements of Section 912.308(a)(3), but such a company is subject to Sections 883.154, 883.155, and 883.156.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 912.156. CONTESTING CLAIM FOR CERTAIN PURPOSES PROHIBITED. (a) In this section, "full payment" means payment of the full amount of a loss actually sustained on the occurrence of the contingency against which the insurance coverage is obtained, not to exceed the maximum amount stated in the policy.

(b) A county mutual insurance company may not contest a claim:

(1) only for delay or a captious or inconsequential reason;

or

(2) to force a settlement for less than full payment.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 912.157. DENIAL OF CLAIM: NOTICE REQUIRED. (a) A county mutual insurance company shall notify a claimant of the company's intent to deny liability on a claim not later than the 60th day after the date the company receives due proofs that the claim will not be paid.

(b) A company that does not notify a claimant as required by Subsection (a) is presumed as a matter of law to have accepted liability on the claim.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER E. CHARGES, PREMIUMS, AND ASSESSMENTS

Sec. 912.201. SCHEDULE OF CHARGES. A county mutual insurance company shall file with the department a schedule of the amounts the company charges a policyholder or an applicant for a policy, regardless of the term the company uses to refer to those charges, including "rate," "policy fee," "inspection fee," "membership fee," or "initial charge." A county mutual insurance company shall file premium, expense, and loss experience data with the department in the manner prescribed by the commissioner. An insurer shall file the schedules and data required under this section according to rules promulgated by the commissioner.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 206, Sec. 21.42, eff. June 11, 2003.

Sec. 912.202. PAYMENT OF PREMIUM OR ASSESSMENT. (a) A county mutual insurance company's bylaws must:

(1) state the time and manner of the levy and payment of a premium or assessment for policies written by the company;

(2) in addition to the regular premium or assessment under Subdivision (1), establish the contingent liability of a policyholder for all losses accrued while a policy is in force in the amount of \$2 for each \$100 of insurance coverage; and

(3) state the time and manner of payment of a policyholder's contingent liability established under Subdivision (2).

(b) As required by its bylaws, a county mutual insurance

company shall establish and levy premiums and assessments, including the contingent liability of a policyholder, for all insurance written by the company.

(c) A policyholder shall pay premiums and assessments as required by the company's bylaws.

(d) The premium or assessment for a policy shall be secured by a lien on each item of real or personal property, other than a homestead, covered by the policy, including the land on which an insured building is located. The lien remains on the property while the insured owns the property.

(e) Subsection (a) does not apply to a company that meets the requirements of Section 912.308(a)(3), but such a company is subject to Sections 883.154, 883.155, and 883.156.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 912.203. NONPAYMENT OF PREMIUM OR ASSESSMENT: FILING OF ACTION. (a) A county mutual insurance company may bring an action in the home county of the company against a policyholder who defaults on the payment of an assessment or premium.

(b) The company is entitled to judgment against the policyholder for:

- (1) delinquent premiums or assessments;
- (2) foreclosure of the lien described by Section 912.202;

and

(3) the costs of an action, including a reasonable attorney's fee in the amount of at least \$5.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 912.204. POLICYHOLDER LIABILITY. A policyholder is liable for the losses of a county mutual insurance company only as provided by Section 912.202 and the company's bylaws, and only in proportion to the amount that the premium or assessment for the policyholder's policy bears to the total amount of premiums or assessments for all policies written by the company in the class to which the policyholder's policy belongs.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER F. AGENTS

Sec. 912.251. LICENSING AND APPOINTMENT OF AGENTS. An agent for a county mutual insurance company must be licensed and appointed as provided by Title 13.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.224(a), eff. Sept. 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.111, eff. April 1, 2009.

**SUBCHAPTER G. REGULATION OF COUNTY MUTUAL INSURANCE COMPANY;
FINANCIAL REQUIREMENTS**

Sec. 912.301. REPORT REGARDING CONDITION OF COMPANY. (a) The commissioner may, at any time the commissioner determines advisable, compel written reports from a county mutual insurance company regarding the company's condition.

(b) The commissioner may require that the report be verified under oath by a responsible officer of the company.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 912.302. ANNUAL STATEMENT FEE. The department shall charge and the comptroller shall collect a fee of \$20 for the filing of an annual statement by a county mutual insurance company.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 912.303. BOOKS AND RECORDS. (a) A county mutual insurance company shall maintain the company's books and records in a form and manner that accurately reflects the condition of the company or the facts essential to the company's faithful and effective operation.

(b) The company shall use forms or systems that most effectively serve the purposes of this section.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 912.304. REINSURANCE. (a) A county mutual insurance company may reinsure any or all of the company's risks with another company against any hazard against which the county mutual insurance company is permitted to insure.

(b) The county mutual insurance company may contract for mutual or reciprocal reinsurance with another company on the mutual or cooperative plan subject to the following conditions:

(1) the county mutual insurance company may assume the reinsurance on the risks of the other company only if the other company reinsures the risks of the county mutual insurance company; and

(2) the county mutual insurance company may write or assume the reinsurance only on property that the company is authorized to insure and that is located in this state.

(c) A county mutual insurance company that reinsures another company's property is liable for the losses of the other company only as specified in the reinsurance contract. The county mutual insurance company does not become a member or partner of the other company as a result of the reinsurance.

(d) A county mutual insurance company may pay or collect additional assessments or premiums for the purpose of a contract described by Subsection (b).

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 912.305. SECURITY DEPOSIT. (a) A county mutual insurance company shall maintain with the comptroller through the department a deposit in cash or, subject to the commissioner's approval, convertible securities. The deposit must be equal to:

(1) the largest amount assumed by the company on any one risk; or

(2) on a demonstration of reinsurance acceptable to the commissioner, the largest amount retained by the company on any one risk after reinsurance.

(b) The deposit is liable for the payment of all judgments against the company and is subject to garnishment after final

judgment against the company. The company, on the commissioner's demand, must immediately replenish the deposit when the deposit is impounded or depleted. If the company does not immediately replenish the deposit, the company may be regarded as insolvent.

(c) If a county mutual insurance company makes a statement, including a statement contained in an advertisement, letter, or literature, that the company deposited cash or securities as required by this section, the company must also state in full:

- (1) the purpose, exact amount, and character of the deposit; and
- (2) the conditions under which the deposit was made.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 912.306. REQUIRED BONDS. (a) A county mutual insurance company shall obtain a bond for:

- (1) the officer responsible for handling the funds of the company's members; and
- (2) all other office employees who may have access to the company's funds.

(b) The bonds required under this section must:

- (1) be with a surety authorized by the department to engage in business in this state;
- (2) be made payable to the department for the use and benefit of the company's members; and
- (3) obligate the principal and surety to pay pecuniary losses that the company sustains through an act of fraud, dishonesty, forgery, theft, embezzlement, wrongful abstraction, or wilful misapplication, regardless of whether the act is committed by the officer or employee directly and alone, or in cooperation with another person.

(c) A bond under this section must:

- (1) be in an amount that is at least the greater of \$1,000 or the amount of cash assets on hand, but not more than \$20,000, if the bond covers the officer; or
- (2) be in an amount established by the department that is at least \$1,000 but not more than \$5,000, if the bond covers office employees.

(d) One or more persons may recover on a bond under this

section until the bond is exhausted.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 912.307. RESERVE REQUIREMENTS. (a) A county mutual insurance company shall maintain unearned premium reserves as provided by Section 862.102.

(b) The company shall invest the unearned premium reserves and any other type of reserves authorized by the company's board of directors in the same type of securities in which the reserve funds of insurance companies engaged in the same kind of business are required to be invested by law.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 912.308. AMOUNT AND INVESTMENT OF SURPLUS. (a) A county mutual insurance company shall maintain an unencumbered surplus which may be invested only in items listed in Section 822.204. The unencumbered surplus must be at least:

(1) \$25,000, if the company is organized to write insurance coverage locally in only the county of its domicile;

(2) \$50,000, if the company is organized to write insurance coverage in only the county of its domicile and any adjacent county;
or

(3) an amount equal to the aggregate of the minimum capital and minimum surplus required under Sections 822.054, 822.202, 822.210, and 822.211, for a fire insurance company if the county mutual insurance company is organized to write insurance coverage statewide.

(b) Except as provided by Section 912.056, a county mutual insurance company is subject to Subchapter B, Chapter 404, and Sections 822.203, 822.210, and 822.212.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.112, eff. April 1, 2009.

Acts 2009, 81st Leg., R.S., Ch. 677 (H.B. 2449), Sec. 2, eff. September 1, 2009.

Sec. 912.309. POLICYHOLDER LOANS TO COMPANY. (a) A policyholder may loan to a county mutual insurance company money as necessary:

(1) for the company to engage in the company's business; or

(2) to enable the company to comply with a requirement of this chapter, including the unencumbered surplus requirement under Section 912.308.

(b) Subject to the approval of the commissioner, the county mutual insurance company may repay a loan and agreed interest, at an annual rate not to exceed 10 percent, only from the surplus remaining after the company provides for the company's reserves, other liabilities, and required surplus.

(c) A loan under this section or interest on a loan is not otherwise a liability or claim against the company or any of its assets.

(d) A county mutual insurance company may not pay a commission, promotion expense, or other bonus in connection with a loan made to the company.

(e) A county mutual insurance company shall report in its annual statement the amount of each loan made to the company.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 912.310. CERTAIN COMPANIES EXEMPT. (a) Chapter 196, Acts of the 53rd Legislature, Regular Session, 1953, and Chapter 117, Acts of the 54th Legislature, Regular Session, 1955, do not apply to a county mutual insurance company:

(1) that was organized and operating as a county mutual fire insurance company on May 22, 1953; and

(2) the business of which is devoted exclusively to the writing of industrial fire insurance policies covering dwellings, household goods and wearing apparel on a weekly, monthly, or quarterly basis on a continuous premium payment plan.

(b) The exemption established by this section applies only so long as the company is engaged exclusively in the writing of industrial fire insurance policies described by Subsection (a).

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER O. GENERAL FINANCIAL REGULATION

Sec. 912.701. HAZARDOUS FINANCIAL CONDITION, SUPERVISION, CONSERVATORSHIP, AND LIQUIDATION. Subchapter A, Chapter 404, and Chapters 441 and 443 apply to a county mutual insurance company engaged in the business of insurance in this state.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.113, eff. April 1, 2009.

SUBCHAPTER P. DISCIPLINARY ACTION AND PROCEDURES IN GENERAL

Sec. 912.751. OFFICER OR DIRECTOR UNWORTHY OF TRUST: REMOVAL AND REVOCATION OF CERTIFICATE OF AUTHORITY. (a) After notice and hearing, the commissioner shall order the removal of an officer or director of a county mutual insurance company holding a certificate of authority if the officer or director is found unworthy of the trust or confidence of the public.

(b) If a county mutual insurance company does not remove an officer or director as required by an order issued under Subsection (a), the commissioner shall:

- (1) revoke the company's certificate of authority; and
- (2) treat the company as insolvent.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 912.752. FRAUDULENT OPERATION OR IMPROPER CONTESTS: REVOCATION OF CERTIFICATE OF AUTHORITY. After notice and hearing, the commissioner shall revoke the certificate of authority of a county mutual insurance company that is:

- (1) operating fraudulently; or
- (2) improperly contesting the company's claims.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 912.753. TIME LIMIT TO APPEAL. An individual or a county mutual insurance company may appeal an order or a ruling of the commissioner under this chapter not later than the 60th day after the date of the order or ruling, in accordance with Subchapter D, Chapter 36.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER Q. GENERAL CRIMINAL PENALTIES

Sec. 912.801. VIOLATION OF CHAPTER; CRIMINAL PENALTY. (a) Except as otherwise provided by this subchapter, a person, including a director, officer, agent, employee, attorney at law, or attorney in fact of a county mutual insurance company, commits an offense if the person violates this chapter.

(b) An offense under this section is punishable by:

- (1) a fine of not more than \$500;
- (2) confinement in jail for a term of not more than 180

days; or

- (3) both a fine and confinement as provided by Subdivisions (1) and (2).

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 912.802. CONVERSION; CRIMINAL PENALTY. (a) A director, officer, agent, employee, attorney at law, or attorney in fact of a county mutual insurance company commits an offense if the person fraudulently takes or converts to the person's own use or secretes with the intent to take or convert to the person's own use, and with knowledge that the person is not entitled to receive it, any property or other thing of value of the company that is in the person's custody, control, or possession as a result of the person's office, directorship, agency, or employment or in any other manner.

(b) A director, officer, agent, employee, attorney at law, or attorney in fact of a county mutual insurance company commits an offense if the person pays or delivers property or another thing of value described by Subsection (a) to another person knowing that the person is not entitled to receive it.

(c) An offense under this section is punishable by imprisonment in the Texas Department of Criminal Justice for a term of not more

than 10 years or less than 2 years.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 87 (S.B. 1969), Sec. 25.126, eff. September 1, 2009.

Sec. 912.803. UNLAWFUL DIVERSION OF FUNDS; CRIMINAL PENALTY.

(a) A director, officer, agent, employee, attorney at law, or attorney in fact of a county mutual insurance company commits an offense if the person wilfully borrows, withholds, or diverts from its purpose in any manner all or part of a special fund that:

(1) belongs to or is under the control and management of the company; and

(2) is designated by law for that purpose.

(b) An offense under this section is punishable by imprisonment in the Texas Department of Criminal Justice for a term of not more than 10 years or less than 2 years.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 87 (S.B. 1969), Sec. 25.127, eff. September 1, 2009.

Sec. 912.804. FALSE AFFIDAVIT; CRIMINAL PENALTY. (a) An officer, director, agent, employee, attorney at law, or attorney in fact of a county mutual insurance company commits an offense if the person wilfully makes a false affidavit in connection with the requirements of this chapter.

(b) An offense under this section is punishable by:

(1) a fine of not more than \$500; or

(2) confinement in jail or imprisonment in the Texas Department of Criminal Justice for a term of not more than two years.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 87 (S.B. 1969), Sec. 25.128, eff. September 1, 2009.

SUBTITLE G. LLOYD'S PLAN AND RECIPROCAL AND INTERINSURANCE EXCHANGES
CHAPTER 941. LLOYD'S PLAN
SUBCHAPTER A. GENERAL PROVISIONS

Sec. 941.001. DEFINITIONS. In this chapter:

- (1) "Affiliate" has the meaning described by Section 823.003.
- (2) "Attorney in fact" means an attorney in fact authorized under a power of attorney to act for the underwriters of a Lloyd's plan.
- (3) "Lloyd's plan" means an entity engaged in the business of writing insurance on the Lloyd's plan.
- (4) "Underwriter" means an individual, partnership, or association of individuals that writes insurance on the Lloyd's plan.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 941.002. LLOYD'S PLAN INSURANCE AUTHORIZED; LIFE INSURANCE PROHIBITED. (a) Except as provided by Subsection (b), a Lloyd's plan may write any kind of insurance that may be lawfully written in this state, including:

- (1) fire insurance, including tornado, hail, crop, and floater insurance;
- (2) automobile insurance, including fire, theft, transportation, property damage, collision liability, and tornado insurance;
- (3) liability insurance;
- (4) marine insurance;
- (5) accident and health insurance;
- (6) burglary insurance;
- (7) plate glass insurance; and
- (8) fidelity and surety bonds insurance.

(b) A Lloyd's plan may not write life insurance.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 941.003. LIMITED EXEMPTION FROM INSURANCE LAWS; APPLICATION OF CERTAIN LAWS. (a) A Lloyd's plan is exempt from the operation of all insurance laws of this state except as specifically provided in this chapter or unless it is specifically provided in the

other law that the law is applicable.

(b) A Lloyd's plan is subject to:

(1) Subchapter A, Chapter 5, Chapter 254, Subchapters A and B, Chapter 1806, and Subtitle C, Title 10;

(2) Articles 5.35, 5.39, and 5.40;

(3) Article 5.13-2, as provided by that article, Chapter 2251, as provided by that chapter, and Chapter 2301, as provided by that chapter;

(4) Chapters 251, 252, 402, 541, and 2253;

(5) Subchapter A, Chapter 401;

(6) Subchapter B, Chapter 404;

(7) Subchapter C, Chapter 1806; and

(8) Sections 38.001, 501.159, 822.203, 822.205, 822.210, 822.212, 2002.005, 2002.051, and 2002.052.

(c) Chapter 2007 applies to rates for motor vehicle insurance written by a Lloyd's plan.

(d) Underwriters and their attorney in fact are subject to Sections 822.051, 822.057, 822.058, 822.059, 822.060, and 822.201, except that:

(1) the articles of agreement executed by the underwriters are instead of the articles of incorporation; and

(2) the aggregate of the guaranty fund and unencumbered surplus of the Lloyd's plan constitutes capital structure for purposes of Section 822.060.

(e) A Lloyd's plan is subject to Chapter 2210, as provided by that chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 206, Sec. 21.43(a), (b), eff. June 11, 2003.

Amended by:

Acts 2005, 79th Leg., Ch. 631 (H.B. [2565](#)), Sec. 5, eff. September 1, 2005.

Acts 2005, 79th Leg., Ch. 1295 (H.B. [2614](#)), Sec. 2, eff. September 1, 2005.

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 2E.114, eff. April 1, 2009.

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 3B.026, eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. [3167](#)), Sec. 9.026, eff.

September 1, 2007.

Acts 2009, 81st Leg., R.S., Ch. 1408 (H.B. 4409), Sec. 42, eff. June 19, 2009.

Sec. 941.004. WITHDRAWAL FROM THE BUSINESS OF INSURANCE. (a) A Lloyd's plan may withdraw from the business of insurance only if the department determines that adequate provision has been made, through reinsurance or other means, for:

(1) payment of all unadjusted losses of the Lloyd's plan;
and

(2) reinsurance of all outstanding risks in favor of residents of this state or covering property located in this state.

(b) On compliance with the requirements of Subsection (a):

(1) any bond of the attorney in fact shall be released;
and

(2) the department shall release to the underwriters any net assets over which the department has joint control.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER B. FORMATION AND STRUCTURE OF LLOYD'S PLAN

Sec. 941.051. FORMATION OF LLOYD'S PLAN. (a) To write insurance on the Lloyd's plan, underwriters must:

(1) execute articles of agreement expressing the intent to write insurance; and

(2) comply with the requirements of this chapter.

(b) A Lloyd's plan must have at least 10 underwriters.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 941.052. ATTORNEY IN FACT. (a) The attorney in fact may execute insurance policies for the Lloyd's plan.

(b) The principal office of the attorney in fact must be maintained at the place designated by the underwriters in the articles of agreement.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 941.053. DEPUTY OR SUBSTITUTE ATTORNEY IN FACT. An appointed deputy attorney in fact or substitute attorney in fact for an attorney in fact holding a certificate of authority under this chapter and accepting powers of attorney from underwriters is authorized by the certificate of authority to:

- (1) issue or make a policy or contract of insurance; and
- (2) perform any other act incident to issuing or making a policy or contract of insurance.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 941.054. NAME OF LLOYD'S PLAN. The name under which a Lloyd's plan engages in business:

- (1) must contain the word "Lloyd's"; and
- (2) may not be so similar to any name in use in this state as to be likely to confuse or deceive.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER C. AUTHORITY TO ENGAGE IN BUSINESS

Sec. 941.101. CERTIFICATE OF AUTHORITY REQUIRED. (a) An attorney in fact may not write insurance in this state or for residents of this state or covering property located in this state unless the attorney in fact holds a certificate of authority issued under this chapter.

(b) Except as otherwise provided by this chapter, an attorney in fact must:

- (1) be a resident of this state; and
- (2) maintain the attorney in fact's office in this state.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 941.102. APPLICATION FOR CERTIFICATE OF AUTHORITY. (a) The attorney in fact shall file with the department a verified application for a certificate of authority that states:

- (1) the name of the attorney in fact;
- (2) the name under which the Lloyd's plan will engage in the business of insurance;

- (3) the names and addresses of the underwriters;
- (4) the location of the principal office; and
- (5) the kinds of insurance to be written.

(b) The application must be accompanied by:

- (1) a copy of each form of policy or contract under which insurance will be written;
- (2) a copy of the form of the power of attorney under which the attorney in fact will act for and bind the underwriters;
- (3) a copy of the articles of agreement executed by the underwriters and the attorney in fact;
- (4) a financial statement showing in detail:
 - (A) assets held by the attorneys in fact, committee of underwriters, trustees, or other officers of the Lloyd's plan;
 - (B) liabilities incurred and outstanding; and
 - (C) income received and disbursements made by the attorney in fact;
- (5) an instrument executed by each underwriter authorizing the attorney in fact to accept service of process for each underwriter in any action on a policy or contract of insurance; and
- (6) an instrument from the attorney in fact that delegates to the department the power of the attorney in fact to accept service of process.

(c) On filing the application, the attorney in fact shall pay to the department a fee of \$10. A fee collected under this subsection shall be deposited to the credit of the Texas Department of Insurance operating account.

(d) Sections 201.001 and 201.002 apply to a fee collected under Subsection (c).

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 2E.115, eff. April 1, 2009.

Sec. 941.103. ISSUANCE OF CERTIFICATE OF AUTHORITY. On determination by the department that the underwriters and attorney in fact have complied with the law, the department shall, in accordance with Sections 801.001, 801.002, 801.051-801.055, 801.057, and 801.101, issue a certificate of authority to the attorney in fact.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER D. OPERATION, POWERS, AND DUTIES OF LLOYD'S PLAN

Sec. 941.151. LIABILITY OF UNDERWRITER. (a) Subject to Subsection (c), an underwriter by contract with the persons insured may limit the underwriter's liability to the percentage of the loss that equals the ratio of the underwriter's subscription paid in cash or securities allowed by this chapter to the total guaranty fund contributed by all the underwriters.

(b) Subject to Subsection (c), an underwriter's total liability on all risks may be limited to the amount of the underwriter's subscription, as expressed in the underwriter's power of attorney and agreement with the attorney in fact.

(c) At least half of an underwriter's subscription must be paid or contributed to the guaranty fund in cash or admissible securities.

(d) An underwriter is responsible solely for the underwriter's liability as provided by the insurance contract. An underwriter is not liable as a partner.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 941.152. LIABILITY OF ADDITIONAL OR SUBSTITUTED UNDERWRITER. An additional or substituted underwriter is liable in the same manner and to the same extent as an original subscriber to the articles of agreement and power of attorney on file with the department.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 941.153. ACCRUAL OF PROFITS. The profits of a Lloyd's plan may accrue to an underwriter only on the basis of the underwriter's actual investment in cash or convertible securities, without regard to any obligation or subscription of the underwriter to pay additional cash or securities in the future.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 941.154. ASSUMPTION OF RISK BY CERTAIN AFFILIATED INSURERS. An insurer who is subject to Article 5.26 may not directly or indirectly assume all or a substantial part of a risk covered by a policy written by a Lloyd's plan that is an affiliate of the insurer if the risk is written at a rate less than the rate that may be lawfully charged by:

(1) the insurer; or

(2) one of the insurer's affiliates that is subject to Article 5.26.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 941.155. PROMOTION OF LLOYD'S PLAN. (a) An individual, firm, or corporation may not be instrumental in organizing a Lloyd's plan if, in the organization of the Lloyd's plan, compensation is paid to the individual, firm, or corporation or to a representative of the individual, firm, or corporation for procuring underwriters or a guaranty fund for the Lloyd's plan unless the individual, firm, or corporation holds a permit issued by the department that authorizes the charging of a commission in connection with organizing the Lloyd's plan.

(b) Not more than 10 percent of the total amount of an underwriter's subscription to a Lloyd's plan may be paid to any person as a commission for the sale of units of or an interest in the Lloyd's plan or for procuring underwriters for the Lloyd's plan.

(c) This section applies to the continued organization or extension of a Lloyd's plan, if a commission is to be paid in connection with the organization or extension. With respect to a continued organization or extension of a Lloyd's plan, the commissioner may not refuse the permit because of the contemplated size or amount of the guaranty fund of the Lloyd's plan.

(d) After the permit has been granted, securities may not be accepted as contributions to the guaranty fund unless the securities have been approved in advance by the department as complying with this chapter with respect to the investment of the funds of a Lloyd's plan.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 941.156. REINSURANCE PERMITTED. This chapter does not prevent a domestic Lloyd's plan from reinsuring:

(1) the Lloyd's plan's excess lines with a solvent foreign Lloyd's plan acceptable to the department that does not hold a certificate of authority to engage in the business of insurance in this state; or

(2) any business from a foreign Lloyd's plan described by Subdivision (1).

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER E. FINANCIAL REQUIREMENTS

Sec. 941.201. REQUIRED NET ASSETS. The department may not issue a certificate of authority to an attorney in fact unless the net assets contributed to the attorney in fact, a committee of underwriters, a trustee, or other officers as provided for in the articles of agreement constitute a guaranty fund and surplus over and above all of the Lloyd's plan's liabilities that is at least equal to the minimum capital stock and surplus required of a stock insurance company engaging in the same kinds of business.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 941.202. LIMITATION OF BUSINESS. (a) Except as provided by Subsection (c), a Lloyd's plan may not assume or write insurance risks in this state, for residents of this state, or covering property located in this state that produce an amount of net premium income that exceeds 10 times the value of the net assets of the underwriters.

(b) If the insurance risks written or assumed by a Lloyd's plan produce a net premium income that exceeds the limit specified by Subsection (a), the Lloyd's plan may not write or assume an additional insurance risk until the net assets have been increased to a level that brings the net premium income produced by the additional insurance risk within that limit.

(c) The limit imposed by Subsection (a) does not apply to a Lloyd's plan if:

(1) the Lloyd's plan's net assets equal at least the amount of money required of a stock insurance company engaged in the same

kind of business in this state; or

(2) the department determines that the Lloyd's plan, through reinsurance or other contracts with other responsible and solvent insurers, has reduced the net lines at risk carried by the Lloyd's plan so that its operations are safe and its solvency is not in danger.

(d) An attorney in fact for a Lloyd's plan may not assume an insurance risk that exceeds one-tenth of the sum of the amount of the net assets of the underwriters as described in this subchapter and the amount of the additional liability assumed by the individual underwriters in the articles of agreement and in policies or contracts of insurance, unless the excess insurance risk is promptly reinsured.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 941.203. COMPUTATION OF RESERVE. A Lloyd's plan shall compute reserve liabilities for outstanding business and incurred losses on the same basis required for a stock insurance company engaged in the same kinds of business in this state.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 941.204. AUTHORIZED INVESTMENTS. (a) The minimum guaranty fund and surplus required of a Lloyd's plan under Sections 822.054, 822.202, 822.210, 822.211, and 941.201 must be:

- (1) in cash; or
- (2) invested as provided by:
 - (A) Section 822.204; or
 - (B) any other law governing the investment of the

capital stock and minimum surplus of a capital stock insurance company engaged in the same kind of business.

(b) Funds of a Lloyd's plan other than the minimum guaranty fund and surplus described by Subsection (a) must, if invested, be invested as provided by:

- (1) the provisions of Subchapter B, Chapter 424, other than Sections 424.052, 424.072, and 424.073; or
- (2) any other law governing the investment of the funds of a capital stock insurance company engaged in the same kind of

business.

(c) A Lloyd's plan may purchase, hold, or convey real property in accordance with Section 862.002.

(d) A Lloyd's plan organized before August 10, 1943, and engaging in business under a certificate of authority issued by the former Board of Insurance Commissioners is not required to comply with this section except as to securities acquired on or after August 10, 1943, regardless of whether those securities were substituted for securities held before that date or were acquired from additional, successor, or substituted underwriters.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.116, eff. April 1, 2009.

Sec. 941.205. JOINT CONTROL OF MINIMUM ASSETS. (a) To the extent of the minimum required under this subchapter, the assets of a Lloyd's plan must be made subject to the joint control of the attorney in fact and the department, in a manner satisfactory to the department, so that the assets may not be withdrawn, diverted, or spent without the approval of the department or for a purpose not permitted under this chapter.

(b) The underwriters are entitled to the interest or income accruing from property or securities placed under joint control under Subsection (a) as the interest or income becomes payable.

(c) As an alternative to submitting assets to joint control under Subsection (a), an attorney in fact for a Lloyd's plan engaged in business before August 20, 1929, may execute a bond in the amount of \$25,000 for the safekeeping of assets, to be released only on approval of the department. The corporate surety and the form of the bond must be approved by the department.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 941.206. HAZARDOUS FINANCIAL CONDITION, SUPERVISION, CONSERVATORSHIP, AND LIQUIDATION; IMPAIRMENT OF SURPLUS. (a) Subchapter A, Chapter 404, and Chapters 441 and 443 apply to a Lloyd's plan engaged in the business of insurance in this state.

(b) Subchapter B, Chapter 404, applies to a Lloyd's plan.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.117, eff. April 1, 2009.

SUBCHAPTER F. REGULATION OF LLOYD'S PLAN

Sec. 941.251. EXAMINATIONS. (a) The provisions of Sections 86.001, 86.002, 401.051, 401.052, 401.054-401.062, 401.151, 401.152, 401.155, and 401.156 that relate to the examination of insurers apply to a Lloyd's plan.

(b) The department may examine the books and affairs of an attorney in fact for a Lloyd's plan. The attorney in fact and each deputy attorney in fact shall facilitate the examination and furnish any information reasonably required by the department.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.118, eff. April 1, 2009.

Sec. 941.252. ANNUAL REPORT. (a) An attorney in fact shall annually file with the department a verified report on a form prepared by the department of:

- (1) the business conducted by the attorney in fact on behalf of the Lloyd's plan during the preceding year;
- (2) the condition of the affairs of the Lloyd's plan; and
- (3) any other information required by the department.

(b) The report must cover all of the business conducted by the attorney in fact on behalf of the Lloyd's plan, without regard to the place where the business was conducted.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER G. FOREIGN LLOYD'S PLAN

Sec. 941.301. FOREIGN LLOYD'S PLAN; BOND OR MINIMUM NET ASSETS REQUIRED. (a) Except as provided by Subsection (b), the

commissioner may not issue a certificate of authority to an attorney in fact if:

- (1) the underwriters are not residents of this state; or
- (2) the underwriters maintain their principal office outside of this state.

(b) The department may issue a certificate of authority to an attorney in fact in circumstances described by Subsection (a) if the underwriters, at their option:

- (1) file a bond with the department that complies with Section 941.302; or
- (2) maintain net assets in this state that:
 - (A) are subject to the joint control of the attorney in fact and the commissioner; and
 - (B) meet the requirements of Subchapter E regarding the minimum amount of net assets of a Lloyd's plan.

(c) A deposit of securities made under Subsection (b)(2) is considered to have been made on the same terms and conditions as a bond executed in accordance with Section 941.302.

(d) If there is recovery on a deposit or bond made under this section, the commissioner shall immediately demand that additional security be provided to increase the amount of the bonds to the minimum amount required by this section. The additional bond must be posted not later than the 30th day after the date the commissioner makes the demand. Successive recoveries may be made on a bond made under this section until the principal amount of the bond is exhausted.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 941.302. BOND OF FOREIGN LLOYD'S PLAN. (a) A bond filed under Section 941.301 must:

- (1) be executed by corporate sureties that:
 - (A) meet the requirements imposed by the department;
 and
 - (B) are authorized to engage in guaranty, fidelity, and surety business in this state;
- (2) be in a principal amount that equals the minimum amount of net assets of a Lloyd's plan under this subchapter;
- (3) be payable to the department;

(4) be conditioned for the payment of all claims arising under insurance policies or contracts:

- (A) issued in this state;
- (B) issued to residents of this state; or
- (C) covering property located in this state; and

(5) be held by the department for the benefit of any person with a valid claim arising under an insurance policy or contract described by Subdivision (4).

(b) The bond must also provide that if a Lloyd's plan with outstanding insurance policies in favor of residents of this state or covering property located in this state becomes insolvent or ceases to engage in the business of insurance in this state, the department, after 10 days' notice to the attorney in fact for the Lloyd's plan or any receiver in charge of the Lloyd's plan's property and affairs, may contract with another insurer engaging in the business of insurance in this state for the assumption of and reinsurance by that insurer of:

(1) all of the Lloyd's plan's insurance risks outstanding in this state; and

(2) all unsatisfied lawful claims outstanding against the Lloyd's plan.

(c) If the department enters into a contract described by Subsection (b) and the attorney general approves the contract as reasonable, the assuming insurer is entitled to recover from the makers of the bond filed under Section 941.301 the amount of the premium or compensation for reinsurance that is specified in the contract.

(d) A bond filed under Section 941.301 binds any additional or substitute underwriters of the Lloyd's plan.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER H. CONVERSION TO CAPITAL STOCK INSURANCE COMPANY

Sec. 941.351. CONVERSION AUTHORIZED. The underwriters may convert a Lloyd's plan to a capital stock insurance company governed by Chapter 822 by complying with this subchapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 941.352. ADOPTION OF CONVERSION PLAN. The underwriters by a two-thirds vote may adopt a plan to convert the Lloyd's plan to a capital stock insurance company.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 941.353. REQUIREMENTS OF CONVERSION PLAN. The conversion plan must provide that a capital stock insurance company will be formed in accordance with Chapter 822, except that:

(1) the company's required minimum capital and surplus must equal the required minimum guaranty fund and surplus of the Lloyd's plan;

(2) the company's assets may be in cash or in the form of an investment lawfully held by the Lloyd's plan; and

(3) an original examination under Section 822.058(b) is not required unless directed by the commissioner.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 941.354. COMMISSIONER APPROVAL OF CONVERSION PLAN. On the commissioner's approval of the conversion plan and the formation of the capital stock insurance company, all assets, interests, obligations, and liabilities of the Lloyd's plan, including all outstanding policies and insurance obligations, are transferred to the capital stock insurance company, except as otherwise provided by this subchapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 941.355. CONVERSION OF MEMBER OF HOLDING COMPANY SYSTEM. If the Lloyd's plan is a member of a holding company system identified in registration information that the Lloyd's plan filed with the department in accordance with Chapter 823, the rights and interests of the underwriters in the capital stock insurance company may be assigned at the time of conversion to any affiliated person in that holding company system. An assignment under this subsection is not:

(1) a change in control for the purposes of Section

822.212; or

(2) an acquisition of control for the purposes of Chapter 823.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER O. PENALTIES

Sec. 941.701. REVOCATION OF CERTIFICATE OF AUTHORITY. The commissioner shall revoke a certificate of authority issued to an attorney in fact if the attorney in fact or an underwriter violates this chapter or any other law of this state.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 941.702. CRIMINAL PENALTY. (a) A person commits an offense if the person, as a principal, attorney in fact, agent, broker, or other representative, engages in the business of writing insurance on the Lloyd's plan in violation of this chapter.

(b) An offense under this section is punishable by a fine of not more than \$500.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

CHAPTER 942. RECIPROCAL AND INTERINSURANCE EXCHANGES

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 942.001. DEFINITIONS. In this chapter:

(1) "Attorney in fact" means an individual, firm, or corporation who, under a power of attorney or other appropriate authorization of the attorney in fact, acts for subscribers of an exchange by issuing reciprocal or interinsurance contracts.

(2) "Exchange" means a reciprocal or interinsurance exchange and includes the office through which a reciprocal or interinsurance contract is exchanged.

(3) "Reciprocal or interinsurance contract" means an insurance policy or other contract that provides indemnity among a group of subscribers for certain losses.

(4) "Subscriber" means an individual, partnership, or corporation who, through an attorney in fact, enters into a

reciprocal or interinsurance contract.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 942.002. SUBSCRIBER INSURANCE COVERAGE THROUGH EXCHANGE AUTHORIZED; LIFE INSURANCE PROHIBITED. (a) Except as provided by Subsection (c), subscribers of this state may exchange reciprocal or interinsurance contracts with other subscribers of this state or of another state or country to provide indemnity among those subscribers for a loss for which insurance coverage may be obtained under other law.

(b) A public, private, or municipal corporation organized under the laws of this state may act as a subscriber, and the right to exchange a reciprocal or interinsurance contract is:

(1) incidental to the purpose for which the corporation is organized; and

(2) in addition to the corporate rights and powers expressly conferred in the corporation's articles of incorporation.

(c) An exchange may not engage in the business of life insurance.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 942.003. LIMITED EXEMPTION FROM INSURANCE LAWS; APPLICABILITY OF CERTAIN LAWS. (a) An exchange is exempt from the operation of all insurance laws of this state except as specifically provided in this chapter or unless exchanges are specifically mentioned in the other law.

(b) An exchange is subject to:

(1) Subchapter A, Chapter 5, Chapter 254, Subchapters A and B, Chapter 1806, and Subtitle C, Title 10;

(2) Articles 5.35, 5.39, and 5.40;

(3) Article 5.13-2, as provided by that article, Chapter 2251, as provided by that chapter, and Chapter 2301, as provided by that chapter;

(4) Chapters 402, 541, and 2253;

(5) Subchapter A, Chapter 401, and Sections 401.051, 401.052, 401.054, 401.055, 401.056, 401.057, 401.058, 401.059, 401.060, 401.061, 401.062, 401.151, 401.152, 401.155, and 401.156;

(6) Subchapter B, Chapter 404;

(7) Subchapter C, Chapter 1806; and

(8) Sections 38.001, 501.159, 822.203, 822.205, 822.210, 822.212, 861.254(a)-(f), 861.255, 862.001(b), 862.003, 2002.002, 2002.005, 2002.051, and 2002.052.

(c) Chapter 2007 applies to rates for motor vehicle insurance written by an exchange.

(d) The provisions of the Texas Business Corporation Act that relate to the indemnification of officers and directors apply to an exchange.

(e) Subscribers and their attorney in fact are subject to Sections 822.051, 822.057-822.060, and 822.201, except that:

(1) the declaration of the subscribers prescribed by Section 942.053 replaces the articles of incorporation; and

(2) the unencumbered surplus of the exchange constitutes capital structure for purposes of Section 822.060.

(f) An exchange is subject to Chapter 2210, as provided by that chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 206, Sec. 21.44(a), (b), eff. June 11, 2003.

Amended by:

Acts 2005, 79th Leg., Ch. 631 (H.B. [2565](#)), Sec. 6, eff. September 1, 2005.

Acts 2005, 79th Leg., Ch. 1295 (H.B. [2614](#)), Sec. 3, eff. September 1, 2005.

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 2E.119, eff. April 1, 2009.

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 3B.027, eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. [3167](#)), Sec. 9.027, eff. September 1, 2007.

Acts 2009, 81st Leg., R.S., Ch. 1408 (H.B. [4409](#)), Sec. 43, eff. June 19, 2009.

SUBCHAPTER B. FORMATION AND STRUCTURE OF EXCHANGE

Sec. 942.051. APPOINTMENT OF ATTORNEY IN FACT; APPROVAL BY DEPARTMENT OF POWER OF ATTORNEY OR OTHER AUTHORIZATION REQUIRED. (a)

A reciprocal or interinsurance contract may be executed by an attorney in fact appointed by the subscribers of an exchange.

(b) A corporation may be organized in this state to act as attorney in fact for an exchange. The general laws regarding incorporation supplement this chapter to the extent consistent with this chapter. A corporation organized in this state to act as attorney in fact for an exchange may be organized under the Texas Business Corporation Act, notwithstanding any conflicting provision of that Act.

(c) The form of the power of attorney or other document granting authority to the attorney in fact and under which the insurance is to be exchanged is subject to approval by the department. This subsection may not be construed to permit the department to require the filing or use of uniform forms of those documents except as otherwise provided by this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 942.052. SECURITY REQUIREMENTS. (a) Except as provided by Subsection (d), to act as an attorney in fact, an individual, firm, or corporation must execute a good and sufficient fidelity bond that obligates the principal and surety to pay a pecuniary loss of money or property, not exceeding the amount of the bond, that is sustained by the exchange through fraud, dishonesty, forgery, theft, embezzlement, wrongful abstraction, or wilful misapplication on the part of the attorney in fact, directly or through connivance with others.

(b) The bond must:

- (1) be acceptable to the department;
- (2) be payable to the subscribers or the department; and
- (3) be in the amount of:
 - (A) \$25,000 for an individual or firm; or
 - (B) \$50,000 for a corporation.

(c) If the conditions of the bond are violated, the insurance supervisory authority of any state in which the attorney in fact is authorized to engage in the business of the exchange may bring an action to enforce the bond on behalf of the subscribers.

(d) Instead of a bond, an attorney in fact may deposit with the appropriate official of the exchange's state of domicile cash or

securities of the kind in which a general casualty company is authorized to invest its funds. The deposit must be made in the same amount, and must be conditioned, approved, and payable in the same manner, as a bond required under this section.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 942.053. SUBSCRIBER DECLARATION. (a) On entering into a reciprocal or interinsurance contract, the subscribers, through the attorney in fact, shall file with the department a declaration verified by the oath of the attorney in fact.

(b) The declaration must include:

- (1) the name of the proposed exchange;
- (2) the kinds of insurance to be provided under the reciprocal or interinsurance contract;
- (3) a copy of the form of the power of attorney or other authorization of the attorney in fact under which the insurance is to be provided;
- (4) the location of each office from which the reciprocal or interinsurance contracts are to be issued; and
- (5) any other information prescribed by the department, including an affidavit comparable to the affidavit prescribed by Section 822.057(a)(3).

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 942.054. NAME OF EXCHANGE. (a) The name of an exchange must contain the term "reciprocal," "inter-insurance exchange," "underwriters," "association," "exchange," "underwriting," "inter-insurers," or "inter-insurors."

(b) The name selected for an exchange may not be so similar to the name of a similar organization or an insurer that, in the opinion of the department, the name is calculated to confuse or deceive.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 942.055. OFFICE LOCATIONS. The attorney in fact shall maintain the offices of the exchange at the places designated by the

subscribers in the power of attorney or other authorization.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER C. AUTHORITY TO ENGAGE IN BUSINESS

Sec. 942.101. CERTIFICATE OF AUTHORITY REQUIRED; EFFECT ON FOREIGN CORPORATIONS. (a) An attorney in fact must hold a certificate of authority issued by the department under Sections 801.001, 801.002, 801.051-801.055, 801.057, 801.101, and 801.102. A certificate of authority obtained in accordance with this section authorizes the attorney in fact named in the certificate to exercise all powers and perform all duties of an attorney in fact.

(b) A corporation required to obtain a certificate of authority from the department under this section is not considered to be engaging in business in this state within the meaning of any law applying to foreign corporations.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER D. OPERATION, POWERS, AND DUTIES OF EXCHANGE

Sec. 942.151. SUBSCRIBER LIABILITY FOR CERTAIN CONTINGENT PREMIUMS. (a) Except as provided by Section 942.152 and Subsection (b), if a certificate of authority is issued as provided by Subchapter C, the power of attorney or other authorization executed by the subscribers must provide that, in addition to the premium or premium deposit specified in the reciprocal or interinsurance contract, the subscribers are liable for a contingent premium equal to one additional annual premium or premium deposit.

(b) If the subscribers and their attorney in fact are authorized to issue reciprocal or interinsurance contracts for cash premiums only, the power of attorney or other authorization may waive all contingent premiums.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 942.152. SUBSCRIBER LIMITED LIABILITY BASED ON CERTAIN MINIMUM CAPITAL AND SURPLUS. If the unencumbered surplus of an exchange is at least equal to the minimum capital stock and minimum

surplus required of a stock insurance company engaged in the same kinds of business, the subscribers of the exchange may provide by agreement that the premium or premium deposit specified in the reciprocal or interinsurance contract constitutes the entire liability of the subscribers through the exchange.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 942.153. PRIOR AUTHORITY NOT AFFECTED. This chapter does not affect any authority that existed before September 6, 1955, that allowed the subscribers of an exchange and their attorney in fact to write non-assessable policies in this state, subject to any prerequisite imposed by law on that authority.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 942.154. STATEMENTS RELATING TO INDEMNITY AMOUNTS. (a) The attorney in fact for an exchange shall file with the department a sworn statement that shows the maximum amount of indemnity on any single risk.

(b) The attorney in fact for an exchange shall, as required by the department, file with the department a sworn statement that:

(1) the attorney has examined the commercial rating of each subscriber, as established by the reference book of a commercial agency with at least 100,000 subscribers; and

(2) based on the examination or other information in the attorney's possession, it appears that no subscriber has assumed on any single risk an amount greater than 10 percent of that subscriber's net worth.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 942.155. FINANCIAL REQUIREMENTS. (a) An exchange shall maintain at all times an unencumbered surplus over and above all liabilities that is at least equal to the minimum capital stock and surplus required of a stock insurance company engaged in the same kinds of business.

(b) An exchange shall maintain at all times the reserves

required by the laws of this state or by rules adopted by the commissioner to be maintained by stock insurance companies engaged in the same kinds of business.

(c) An exchange shall maintain the required assets as to:

(1) minimum surplus requirements, as provided by Section 822.204; and

(2) other funds, as provided by the provisions of Subchapter B, Chapter 424, other than Sections 424.052, 424.072, and 424.073.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.120, eff. April 1, 2009.

Sec. 942.156. ISSUANCE OF FIDELITY AND SURETY BOND INSURANCE; DEPOSIT REQUIRED. (a) If a domestic exchange writes fidelity or surety bond insurance in this state, the exchange shall keep on deposit with the comptroller money, bonds, or other securities in an amount of not less than \$50,000. The department shall approve for the deposit securities described by the provisions of Subchapter B, Chapter 424, other than Sections 424.052, 424.072, and 424.073, and the exchange shall maintain the approved securities intact at all times.

(b) A foreign exchange that writes fidelity or surety bond insurance in this state shall file with the department evidence satisfactory to the department that the exchange has, for the protection of its subscribers, at least \$100,000 in money, bonds, or other securities as described by the provisions of Subchapter B, Chapter 424, other than Sections 424.052, 424.072, and 424.073, on deposit with the comptroller or other appropriate official of its state of domicile or in escrow under that official's supervision and control in a reliable bank or trust company. If those bonds or other securities are not acceptable to and approved by the department, the department may deny the attorney in fact for the exchange a certificate of authority.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.121,

eff. April 1, 2009.

Sec. 942.157. TRANSACTIONS BETWEEN CERTAIN INSURERS AND AFFILIATED EXCHANGES. (a) In this section, "affiliate" has the meaning assigned by Section 823.003.

(b) An insurer subject to Article 5.26 may not directly or indirectly assume all or a substantial part of any risk covered by a reciprocal or interinsurance contract written by an exchange that is an affiliate of that insurer if the risk is written at a rate less than the rate that may be lawfully charged by the insurer or any affiliate of the insurer that is subject to Article 5.26.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 942.158. ADVANCES OF MONEY BY ATTORNEY IN FACT. (a) The attorney in fact for an exchange may advance to the exchange any amount of money necessary to conduct the business of the exchange, including any amount necessary to enable the exchange to comply with a legal requirement.

(b) Subject to the approval of the department, the advanced amount and any agreed interest on that amount, not exceeding 10 percent a year:

(1) is payable only from the surplus of the exchange remaining after providing for all reserves, other liabilities, and required surplus; and

(2) may not otherwise be a liability or claim against the exchange or any of the exchange's assets.

(c) A commission, promotion expense, or other bonus may not be paid in connection with the advance of money to the exchange.

(d) The amount of each advance must be reported in the exchange's annual report.

(e) The department may not arbitrarily refuse approval under Subsection (b).

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 942.159. VIOLATION BY ATTORNEY IN FACT OF REQUIREMENTS REGARDING INDEMNITY CONTRACTS; CRIMINAL PENALTY. (a) An attorney

in fact commits an offense if the attorney in fact:

(1) exchanges a reciprocal or interinsurance contract without first complying with the law governing the contract; or

(2) directly or indirectly solicits or negotiates an application for the contract without first complying with the law governing the contract.

(b) Subsection (a) does not apply to an action taken by an attorney in fact for the purpose of applying for a certificate of authority from the commissioner as provided by this chapter.

(c) An offense under this section is punishable by a fine of not less than \$100 or more than \$1,000.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER E. REGULATION OF EXCHANGES

Sec. 942.201. ANNUAL REPORT. (a) Not later than March 1 of each year, the attorney in fact for an exchange shall submit to the commissioner a report covering the previous year ending December 31.

(b) The report must:

(1) demonstrate that the financial condition of affairs at the exchange is in accordance with the financial requirements of this chapter under Section 942.155; and

(2) provide any additional information and reports as required to show:

(A) the total amount of premiums or deposits collected;

(B) the total amount of losses paid;

(C) the total amounts returned to subscribers; and

(D) the amounts retained for expenses.

(c) The attorney in fact is not required to provide in the report the name and address of any subscriber.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 942.202. EXAMINATION BY DEPARTMENT. The business affairs and assets of an exchange, as shown at the office of the attorney in fact, are subject to examination by the department.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 942.203. FEES; TAXES; FILING FEE. (a) To the extent applicable, the schedule of fees established under Chapter 202 applies to an exchange and the exchange's attorney in fact.

(b) An exchange is subject to:

- (1) Chapters 221 and 222; and
- (2) Chapters 251-255.

(c) The comptroller shall collect the taxes and the filing fee for the annual report.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.122, eff. April 1, 2009.

SUBTITLE H. OTHER ENTITIES

CHAPTER 961. NONPROFIT LEGAL SERVICES CORPORATIONS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 961.001. DEFINITIONS. In this chapter:

(1) "Applicant" means a person applying for a contract for legal services to be performed through a nonprofit legal services corporation.

(2) "Benefit certificate" means a document issued to a participant that states the benefits and other required matters under a group contract for legal services or an individual contract for legal services issued to a participant.

(3) "Contracting attorney" means an attorney who has entered into a contract under Section 961.301.

(4) "Nonprofit legal services corporation" means a corporation created for the sole purpose of establishing, maintaining, and operating a nonprofit legal services plan under which the corporation contracts for and obtains legal services for participants through contracting attorneys in consideration of each participant's payment of a definite amount to fund the payment of the contracting attorneys' fees.

(5) "Participant" means a person entitled to performance of legal services under contract with a nonprofit legal services corporation.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 961.002. APPLICABILITY OF OTHER LAWS. (a) The Texas Nonprofit Corporation Law as described by Section 1.008, Business Organizations Code, applies to a nonprofit legal services corporation to the extent provided by this chapter.

(b) Repealed by Acts 2019, 86th Leg., R.S., Ch. 643 (S.B. 1623), Sec. 17(2), eff. September 1, 2019.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.123, eff. April 1, 2009.

Acts 2019, 86th Leg., R.S., Ch. 643 (S.B. 1623), Sec. 2, eff. September 1, 2019.

Acts 2019, 86th Leg., R.S., Ch. 643 (S.B. 1623), Sec. 17(2), eff. September 1, 2019.

Sec. 961.003. CORPORATION NOT SUBJECT TO DEPARTMENT REGULATION. A nonprofit legal services corporation is not subject to regulation by the department.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 643 (S.B. 1623), Sec. 3, eff. September 1, 2019.

Sec. 961.004. CORPORATION NOT ENGAGED IN BUSINESS OF INSURANCE. A nonprofit legal services corporation is not engaged in the business of insurance and is not subject to laws relating to insurers.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 643 (S.B. 1623), Sec. 4, eff. September 1, 2019.

SUBCHAPTER B. FORMATION AND STRUCTURE OF NONPROFIT LEGAL SERVICES CORPORATIONS

Sec. 961.051. FILING OF CERTIFICATE OF FORMATION; NONPROFIT STATUS REQUIRED. (a) Seven or more persons may file with the

secretary of state a certificate of formation in accordance with Title 1, Business Organizations Code, to form a nonprofit legal services corporation.

(a-1) Notwithstanding Subsection (a), a nonprofit legal services corporation that on or before September 1, 2019, was organized under the former Texas Non-Profit Corporation Act (Article 1396-1.01 et seq., Vernon's Texas Civil Statutes) or was formed under the Texas Nonprofit Corporation Law, as described by Section 1.008, Business Organizations Code, is a nonprofit legal services corporation for purposes of this chapter.

(b) A nonprofit legal services corporation must be governed and operated as a nonprofit organization.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by:

Acts 2019, 86th Leg., R.S., Ch. 643 (S.B. 1623), Sec. 5, eff. September 1, 2019.

Acts 2019, 86th Leg., R.S., Ch. 643 (S.B. 1623), Sec. 6, eff. September 1, 2019.

SUBCHAPTER D. OFFICERS

Sec. 961.152. FINANCIAL OFFICER. A nonprofit legal services corporation, by resolution entered in its minutes, shall designate one or more officers to be responsible for handling the corporation's funds.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by:

Acts 2019, 86th Leg., R.S., Ch. 643 (S.B. 1623), Sec. 8, eff. September 1, 2019.

SUBCHAPTER E. OPERATION OF NONPROFIT LEGAL SERVICES CORPORATIONS

Sec. 961.206. ADVANCE TO CORPORATION. Any person may advance to a nonprofit legal services corporation, on a contingent liability basis, money necessary for the purposes of the corporation's business or to comply with this chapter. The advance may be made in an amount and at a rate of interest agreed to by the person and the corporation.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by:

Acts 2019, 86th Leg., R.S., Ch. 643 (S.B. 1623), Sec. 10, eff. September 1, 2019.

Sec. 961.207. PARTICIPATION AGREEMENTS. A nonprofit legal services corporation may:

(1) contract with another nonprofit legal services corporation or an insurer authorized to engage in business in this state for joint participation through:

(A) a mutualization contract agreement; or

(B) a guaranty treaty; and

(2) cede or accept a legal services obligation from such a corporation or insurer on all or part of a legal services obligation.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by:

Acts 2019, 86th Leg., R.S., Ch. 643 (S.B. 1623), Sec. 11, eff. September 1, 2019.

Sec. 961.211. BOOKS AND RECORDS. (a) A nonprofit legal services corporation shall keep complete books and records of all money collected and disbursed.

(b) Repealed by Acts 2019, 86th Leg., R.S., Ch. 643 (S.B. 1623), Sec. 17(6), eff. September 1, 2019.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by:

Acts 2019, 86th Leg., R.S., Ch. 643 (S.B. 1623), Sec. 17(6), eff. September 1, 2019.

SUBCHAPTER F. BENEFITS PROVIDED BY NONPROFIT LEGAL SERVICES CORPORATIONS

Sec. 961.251. APPLICANTS; BENEFIT CERTIFICATE. (a) A nonprofit legal services corporation may accept applicants and shall issue a benefit certificate to each applicant that becomes a participant under a legal services contract. Before issuance of the certificate, the applicant must pay the application fee, which does

not apply as part of the cost of receiving benefits under the certificate.

(b) On issuance of the benefit certificate, the participant is entitled to the legal services stated in the certificate for the period provided by the certificate.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 961.253. TYPES OF LEGAL SERVICES CONTRACTS. A nonprofit legal services corporation may issue legal services contracts on an individual, group, or franchise basis.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 961.254. INDEMNITY CONTRACTS. (a) A nonprofit legal services corporation may issue a contract for legal services providing for indemnity for costs of services of an attorney who is not a contracting attorney.

(b) A contract under Subsection (a) may be issued without the guarantee provided by Section 961.302(1).

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 643 (S.B. [1623](#)), Sec. 12, eff. September 1, 2019.

Sec. 961.255. LIMITATIONS ON BENEFITS. A contract for legal services and a benefit certificate issued by a nonprofit legal services corporation may limit:

- (1) the types and extent of benefits; and
- (2) the circumstances under which legal services are provided.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 961.256. CLAIMS. (a) A nonprofit legal services corporation shall pay a lawful claim for payment under a benefit

certificate not later than the 120th day after the date of receipt of due proof of claim.

(b) Written notice of a claim given to the corporation is considered due proof of claim under this section if the corporation does not provide to the claimant before the 16th day after the date notice is received the forms usually provided by the corporation for filing a claim.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER G. CONTRACTS WITH ATTORNEYS

Sec. 961.301. CONTRACTS WITH ATTORNEYS. A nonprofit legal services corporation may contract with qualified attorneys to ensure to each participant legal services performed by the attorneys under the contract for legal services between the corporation and the participant. A contracting attorney must be licensed to practice law in the jurisdiction in which legal services are to be provided.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 643 (S.B. 1623), Sec. 13, eff. September 1, 2019.

Sec. 961.302. AGREEMENT OF CONTRACTING ATTORNEYS. The contracting attorneys shall:

(1) guarantee to the participants the services stated under the participants' benefit certificates, except as provided by Section 961.254; and

(2) agree to perform without cost to the participants, other than the money of the nonprofit legal services corporation held for the participants' benefit under the corporation's plan of operation, services described by the benefit certificates.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 961.303. LIMITATIONS ON CORPORATION'S RELATIONSHIP WITH ATTORNEYS AND PARTICIPANTS. (a) A nonprofit legal services corporation may not:

(1) contract to practice law; or

(2) control or attempt to control the relationship existing between a participant and the participant's attorney.

(b) The corporation may act only as an agent on behalf of its participants for legal services and, except as provided by Section 961.254, those services may be provided only by and through contracting attorneys. A contracting attorney must be an independent contractor maintaining a direct lawyer and client relationship with a participant and may not be an employee of the corporation.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 961.305. ATTORNEY INSURANCE REQUIRED. (a) Each contracting attorney shall maintain professional liability and errors and omissions insurance as required by the nonprofit legal services corporation with which the attorney contracts.

(b) Repealed by Acts 2019, 86th Leg., R.S., Ch. 643 (S.B. 1623), Sec. 17(8), eff. September 1, 2019.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 643 (S.B. 1623), Sec. 17(8), eff. September 1, 2019.

Sec. 961.306. PAYMENT ONLY FOR SERVICES PROVIDED. A nonprofit legal services corporation may not pay any of the claim funds collected from participants to an attorney except for legal services that the attorney provided to participants.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 961.307. COMPLAINT REGARDING ATTORNEY. If a nonprofit legal services corporation receives a complaint concerning the performance of an attorney connected with the corporation, the corporation shall refer the complaint to:

(1) the supreme court of this state or a person that the supreme court designates to receive attorney grievances from the public, if the attorney is licensed by this state; or

(2) the appropriate licensing agency of another jurisdiction where the attorney is licensed, if the attorney is not licensed by this state.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by:

Acts 2019, 86th Leg., R.S., Ch. 643 (S.B. 1623), Sec. 14, eff. September 1, 2019.

SUBCHAPTER I. DISSOLUTION AND LIQUIDATION OF CORPORATION

Sec. 961.402. VOLUNTARY DISSOLUTION. (a) The board of directors of a nonprofit legal services corporation may vote to dissolve the corporation at any time.

(b) In a dissolution under this section, the officers of the corporation shall settle all outstanding obligations to participants and otherwise dispose of the corporation's affairs. After the officers have completed the corporation's liquidation, the corporation shall be dissolved as provided by:

(1) the provisions relating to winding up and termination under Subchapter G, Chapter 22, Business Organizations Code; or

(2) if the corporation was organized under the former Texas Non-Profit Corporation Act (Article 1396-1.01 et seq., Vernon's Texas Civil Statutes), the provisions relating to voluntary dissolution under that former law.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by:

Acts 2019, 86th Leg., R.S., Ch. 643 (S.B. 1623), Sec. 15, eff. September 1, 2019.

CHAPTER 962. JOB PROTECTION INSURANCE

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 962.001. GENERAL DEFINITIONS. In this chapter:

(1) "Insured" means an individual whose indemnification against income loss is provided because of the individual's membership in a company or association that offers a job protection insurance plan.

(2) "Insurer" has the meaning assigned by Section 801.001.

(3) "Person" means an individual, corporation, association,

or other legal entity.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 16, eff. April 1, 2007.

Sec. 962.002. JOB PROTECTION INSURANCE DEFINED. (a) In this chapter, "job protection insurance" means insurance providing indemnity that is:

(1) paid for loss of position arising from discharge or suspension;

(2) payable in installments that do not exceed the average monthly wage of the insured; and

(3) provided to:

(A) conductors, engineers, motormen, brakemen, switchmen, firemen, dispatchers, clerks, operators, trackmen, signalmen, and maintenance-of-way personnel of steam and electric railways; and

(B) bus drivers and truck drivers employed by common carriers.

(b) The term "job protection insurance" does not include a job benefit fund administered by and through a labor union only for the union's members.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 16, eff. April 1, 2007.

Sec. 962.003. COMPLIANCE WITH CHAPTER REQUIRED. An insurer must comply with this chapter to write the insurance coverages authorized by Section 962.101.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 16, eff. April 1, 2007.

Sec. 962.004. APPLICABILITY OF OTHER LAW. An insurer operating under this chapter is subject to the following provisions, if not in conflict with this chapter:

(1) the other chapters of this code, including:

(A) Chapter 221;

(B) Chapter 281, other than any minimum capital and surplus requirements specified in that chapter;

(C) Chapter 822, including Sections 822.203, 822.205, 822.210, and 822.212;

(D) Chapter 861; and

(E) Chapter 402; and

(2) Section 171.0525, Tax Code.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 16, eff. April 1, 2007.

Sec. 962.005. AGENTS. Title 13 applies to the licensing and regulation of an agent authorized to solicit job protection insurance for an insurer operating under this chapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 16, eff. April 1, 2007.

SUBCHAPTER B. AUTHORITY TO ENGAGE IN BUSINESS

Sec. 962.051. QUALIFICATIONS FOR CERTIFICATE OF AUTHORITY. An insurer may not be issued a certificate of authority to operate under this chapter unless:

(1) it or a predecessor was writing the insurance coverages authorized by Section 962.101 on or before January 1, 1920, in at least one state; and

(2) it had policyholders in this state on August 29, 1983, and provides proof of that fact to the department.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 16, eff. April 1, 2007.

Sec. 962.052. ISSUANCE OF CERTIFICATE OF AUTHORITY. (a) The commissioner shall issue a certificate of authority to a domestic or foreign insurer that applies for a certificate if:

(1) the applicant has:

(A) complied with the requirements of this chapter and all other requirements imposed on the applicant by law; and

(B) paid any deposit imposed by law; and

(2) the operational history of the applicant indicates a condition such that the expanded operation of the applicant in this state or the applicant's operations outside this state will not create a condition that might be hazardous to the applicant's policyholders or creditors or to the public, when that operational history is reviewed in conjunction with:

- (A) the applicant's loss experience;
- (B) the kinds and nature of risks insured;
- (C) the financial condition of the applicant and the applicant's ownership;
- (D) the applicant's proposed method of operation;
- (E) the applicant's affiliations;
- (F) the applicant's investments;
- (G) any contracts leading to contingent liability or agreements relating to guaranty and surety, other than insurance; and
- (H) the ratio of the applicant's total annual premium and net investment income to commission expenses, general insurance expenses, policy benefits paid, and required policy reserve increases.

(b) The commissioner shall file in the department's offices any documents delivered to the commissioner under this section.

(c) The certificate of authority authorizes the insurer to engage in the kind or kinds of business in this state specified in the certificate.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 16, eff. April 1, 2007.

Sec. 962.053. COMPLIANCE WITH STATE LAW REQUIRED. A certificate of authority issued under this chapter continues in effect on the condition that the insurer continue to comply with the laws of this state.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 16, eff. April 1, 2007.

Sec. 962.054. INSURERS NOT MEETING CERTAIN REQUIREMENTS. To write the insurance coverages authorized by Section 962.101, a domestic or foreign insurer that does not meet the requirements of

Sections 962.051 and 962.052 must comply with Chapters 822 and 861.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 16, eff. April 1, 2007.

Sec. 962.055. CAPITAL AND SURPLUS REQUIREMENTS. A domestic or foreign insurer operating under this chapter shall maintain the minimum capital and surplus required by Sections 822.054, 822.210, and 822.211.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 16, eff. April 1, 2007.

SUBCHAPTER C. COVERAGE

Sec. 962.101. AUTHORIZED COVERAGES. A domestic or foreign insurer operating under this chapter may write:

- (1) job protection insurance; and
- (2) insurance that:

(A) insures an individual described by Section 962.002(a) against bodily injury or death by accident or against disability on account of sickness or accident;

(B) grants specific hospital benefits and medical, surgical, and sick-care benefits to an individual and the individual's family; and

(C) provides reimbursement of funeral expenses in an amount not to exceed \$200 to any person in connection with the coverage.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 16, eff. April 1, 2007.

Sec. 962.102. OTHER COVERAGES PROHIBITED. A domestic or foreign insurer operating under this chapter may not write coverage that is not authorized by Section 962.101.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 16, eff. April 1, 2007.

Sec. 962.103. APPLICABILITY OF GUARANTY FUND LAW. A guaranty fund established under this code does not provide coverage for insurance written under this chapter except as specifically provided by a law governing the fund.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 16, eff. April 1, 2007.

SUBCHAPTER O. ENFORCEMENT PROVISIONS

Sec. 962.701. PROHIBITED ACTS; OFFENSE. (a) A person may not:

(1) provide coverage described by Section 962.101 unless the person holds a certificate of authority to provide that coverage; or

(2) solicit insurance for an insurer authorized to provide insurance coverage under this chapter unless the person holds an insurance agent's license.

(b) A person commits an offense if the person knowingly violates Subsection (a). An offense under this subsection is a Class B misdemeanor.

(c) Venue for prosecution of an offense under this section is in Travis County.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 16, eff. April 1, 2007.

Sec. 962.702. REFUSAL TO ISSUE OR RENEW CERTIFICATE OF AUTHORITY OR LICENSE; SUSPENSION OR REVOCATION. If, after notice and hearing, the commissioner finds that the applicant, certificate holder, or license holder has violated this chapter or another provision of this code, the commissioner may refuse to issue or renew a certificate of authority or a license, or may suspend or revoke a certificate of authority or a license.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 16, eff. April 1, 2007.

CHAPTER 963. AUTOMOBILE CLUBS

Sec. 963.001. DEFINITION. In this chapter, "automobile club"

has the meaning assigned by Section 722.002, Transportation Code.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1E.001, eff. April 1, 2009.

Sec. 963.002. PROVISION OF CERTAIN INSURANCE SERVICES BY AUTOMOBILE CLUB. (a) An automobile club may provide insurance services only as provided by this chapter.

(b) An automobile club may provide accidental injury and death benefit insurance coverage to a member through purchase of a group policy of insurance issued to the automobile club for the benefit of its members. The coverage must be purchased from an insurance company authorized to engage in the business of that type of coverage in this state.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1E.001, eff. April 1, 2009.

Sec. 963.003. CERTIFICATE OF PARTICIPATION. (a) The automobile club shall provide each member covered by insurance described by Section 963.002 a certificate of participation.

(b) The certificate of participation must state on its face in at least 14-point black boldfaced type that the certificate is only a certificate of participation in a group accidental injury and death policy and is not automobile liability insurance coverage.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1E.001, eff. April 1, 2009.

Sec. 963.004. CERTAIN ACTIVITIES PROHIBITED. An automobile club may endorse insurance products and refer members to agents or insurers authorized to provide the insurance products in this state. The automobile club or an agent of the automobile club may not receive consideration for the referral.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1E.001, eff. April 1, 2009.

Sec. 963.005. CERTAIN TRANSPORTATION-RELATED SERVICES. In addition to reimbursement services described by Section 722.002(2), Transportation Code, an automobile club may contract with a member to:

- (1) reimburse the member for expenses the member incurs for towing, emergency road service, and lockout or lost key services; and
- (2) provide immediate destination assistance and trip interruption service.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1E.001, eff. April 1, 2009.

Sec. 963.006. APPLICABILITY OF INSURANCE LAWS. (a) Except as provided by Subsection (b), an automobile club performing services permitted by this chapter is not subject to regulation under the insurance laws of this state because of the performance of those services.

(b) An automobile club may sell insurance products to a member for a consideration separate from the amount that the member pays for membership in the automobile club if the automobile club is properly licensed as an agent under the applicable provisions of this code.

(c) The insurance laws of this state do not apply to reimbursement provided under Section 963.005.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1E.001, eff. April 1, 2009.

CHAPTER 964. CAPTIVE INSURANCE COMPANIES

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 964.001. DEFINITIONS. (a) In this chapter:

(1) "Affiliated company" or "affiliate" has the meaning assigned by Section 823.003 and includes a parent entity that controls a captive insurance company.

(1-a) "Attorney in fact" means a firm or corporation that, under a power of attorney or other appropriate authorization of the attorney in fact, acts for subscribers of a captive exchange by issuing reciprocal or interinsurance contracts.

(1-b) "Captive exchange" means a reciprocal or interinsurance exchange formed under this chapter. The term includes

the attorney in fact through which a reciprocal or interinsurance contract, as defined by Section 942.001, is exchanged.

(2) "Captive insurance company" means a company that holds a certificate of authority under this chapter to insure the operational risks of the company's affiliates or risks of a controlled unaffiliated business. The term includes a captive exchange.

(3) "Captive management company" means an entity providing administrative services to a captive insurance company.

(4) "Control" means the power to direct, or cause the direction of, the management and policies of an entity, other than the power that results from an official position with or corporate office held in the entity. The power may be possessed directly or indirectly by any means, including through the ownership of voting securities or by contract, other than a commercial contract for goods or nonmanagement services.

(5) "Controlled unaffiliated business" means a person:

(A) that is not an affiliate;

(B) that has an existing contractual relationship with an affiliate under which the affiliate bears a potential financial loss; and

(C) the risks of which are managed by a captive insurance company under Section 964.066.

(6) "Operational risk" means any potential financial loss of an affiliate, except for a loss arising from an insurance policy issued by a captive or insurance affiliate.

(7) "Redomestication" means the transfer to or from this state of the insurance domicile of an authorized captive insurer.

(8) "Subscriber" means an affiliated company or controlled unaffiliated business that enters into a reciprocal contract of insurance with an attorney in fact as a subscriber of a captive exchange.

(b) Notwithstanding Section 30.003, in this chapter, "person" has the meaning assigned by Section 311.005, Government Code.

Added by Acts 2013, 83rd Leg., R.S., Ch. 569 (S.B. 734), Sec. 2, eff. June 14, 2013.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 1050 (H.B. 1944), Sec. 1.01, eff. June 15, 2017.

Sec. 964.002. APPLICABILITY OF OTHER LAWS. (a) Except as otherwise provided by this chapter, this code does not apply to a captive insurance company except:

- (1) Title 2;
- (2) Chapter 223A and Subtitles A and C, Title 3;
- (3) Chapter 401;
- (4) Chapter 441;
- (5) Chapter 443; and
- (6) Chapter 803.

(b) A captive insurance company operating under this chapter is subject to the Business Organizations Code, including the requirement to be authorized by the secretary of state, to the extent those laws do not conflict with this chapter.

(c) Chapter 823 applies to a captive insurance company only if the company is affiliated with another insurer that is subject to Chapter 823.

Added by Acts 2013, 83rd Leg., R.S., Ch. 569 (S.B. 734), Sec. 2, eff. June 14, 2013.

SUBCHAPTER B. CAPTIVE INSURANCE COMPANIES

Sec. 964.051. AUTHORITY TO WRITE DIRECT BUSINESS. (a) Except as provided by this section, a captive insurance company may write any type of insurance, but may only insure the operational risks of the company's affiliates and risks of a controlled unaffiliated business.

(b) A captive insurance company may not issue:

- (1) life insurance, except to insure employee benefits that are subject to the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.);
- (2) annuities;
- (3) accident and health insurance for the company's parent and affiliates, except to insure employee benefits that are subject to the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.);
- (4) title insurance;
- (5) mortgage guaranty insurance;

- (6) financial guaranty insurance;
- (7) residential property insurance;
- (8) personal automobile insurance; or
- (9) workers' compensation insurance.

(c) A captive insurance company may not issue a type of insurance, including automobile liability insurance, that is required, under the laws of this state or a political subdivision of this state, as a prerequisite for obtaining a license or permit if the law requires that the liability insurance be issued by an insurer authorized to engage in the business of insurance in this state.

(d) A captive insurance company is authorized to issue a contractual reimbursement policy to:

- (1) an affiliated certified self-insurer authorized under Chapter 407, Labor Code, or a similar affiliated entity expressly authorized by analogous laws of another state; or
- (2) an affiliate that is insured by a workers' compensation insurance policy with a negotiated deductible endorsement.

Added by Acts 2013, 83rd Leg., R.S., Ch. 569 (S.B. 734), Sec. 2, eff. June 14, 2013.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 1050 (H.B. 1944), Sec. 1.02, eff. June 15, 2017.

Sec. 964.052. REINSURANCE. (a) A captive insurance company may provide reinsurance to an insurer covering the operational risks of the captive insurance company's affiliates, or risks of a controlled unaffiliated business, that the captive insurance company may insure directly under Section 964.051 and:

- (1) employee benefit plans offered by affiliates;
- (2) liability insurance an affiliate must maintain as a prerequisite for obtaining a license or permit if the law requires maintenance of the liability insurance;
- (3) credit life insurance and credit disability insurance offered as a part of, or directly relating to, the operational risks of an affiliate; and
- (4) workers' compensation insurance and employer liability policies issued to affiliates if the insurer that directly issues workers' compensation insurance and employer's liability policies or

its licensed, if required by law, administrator or adjuster:

(A) services all claims incurred during the policy period; and

(B) complies with all requirements for an insurer under this code, including Chapter 462, and under Title 5, Labor Code.

(b) A captive insurance company shall provide notice to the commissioner of a reinsurance agreement that the company becomes a party to not later than the 30th day after the date of the execution of the agreement.

(c) A captive insurance company shall provide notice of a termination of a previously filed reinsurance agreement to the commissioner not later than the 30th day after the date of termination.

(d) A captive insurance company may take credit for reserves on risks or portions of risks ceded to reinsurers under Subchapter C, Chapter 493.

(e) Notwithstanding Section 964.064, a captive insurance company, with the commissioner's approval, may accept risks from and cede risks to or take credit for reserves on risks ceded to:

(1) a captive reinsurance pool composed only of other captive insurance companies holding a certificate of authority under this chapter or a similar law of another jurisdiction; or

(2) an affiliated captive insurance company holding a certificate of authority under this chapter or a similar law of another jurisdiction.

(f) A captive insurance company may cede risks to or take credit for reserves on risks ceded to a nonaffiliated reinsurer if the reinsurer:

(1) holds a certificate of authority to transact insurance or reinsurance in a jurisdiction that is:

(A) on the list of qualified jurisdictions of the National Association of Insurance Commissioners; and

(B) acceptable to the commissioner;

(2) maintains minimum capital and surplus, or the equivalent, of \$250 million as of the end of the preceding year; and

(3) maintains a financial strength rating of B+ or its equivalent from a national or international rating agency that:

(A) has registered with the Securities and Exchange Commission;

(B) is designated as a nationally recognized

statistical rating organization;

(C) is on the list of Credit Rating Providers by the Securities Valuation Office of the National Association of Insurance Commissioners; and

(D) is acceptable to the commissioner.

Added by Acts 2013, 83rd Leg., R.S., Ch. 569 (S.B. 734), Sec. 2, eff. June 14, 2013.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 469 (S.B. 667), Sec. 1, eff. June 15, 2015.

Acts 2015, 84th Leg., R.S., Ch. 469 (S.B. 667), Sec. 2, eff. June 15, 2015.

Acts 2017, 85th Leg., R.S., Ch. 252 (H.B. 1187), Sec. 1, eff. September 1, 2017.

Acts 2017, 85th Leg., R.S., Ch. 594 (S.B. 1070), Sec. 3.12, eff. September 1, 2017.

Acts 2017, 85th Leg., R.S., Ch. 1050 (H.B. 1944), Sec. 1.03, eff. June 15, 2017.

Sec. 964.053. FORMATION. (a) A captive insurance company, other than a captive exchange, or an attorney in fact must be formed for the purpose of engaging in the business of insurance under this chapter by filing an appropriate application with the secretary of state.

(b) A captive insurance company may be formed and operated in any form of business organization authorized under the Business Organizations Code except a risk retention group or general partnership. A captive insurance company may only be formed as a nonprofit corporation if it is controlled by a nonprofit corporation.

(c) The certificate of formation of a captive insurance company, other than a captive exchange, or an attorney in fact must comply with the applicable requirements of the Business Organizations Code. The name of the company or attorney in fact in the certificate of formation may include the words "insurance," "company," or similar words indicating that the purpose of the company or attorney in fact is to operate as an insurance company or attorney in fact under this chapter.

(d) The board of directors or governing body of a captive

insurance company formed in this state must have at least three members, and at least one of the members must be a resident of this state. If the captive insurance company is a captive exchange, the principal office of the attorney in fact must be in this state.

(e) The certificate of formation, bylaws, or governing document of a captive insurance company must authorize a quorum of the board of directors or governing body to consist of not fewer than one-third of the fixed number of directors or members of the governing body.

Added by Acts 2013, 83rd Leg., R.S., Ch. 569 (S.B. 734), Sec. 2, eff. June 14, 2013.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 1050 (H.B. 1944), Sec. 1.04, eff. June 15, 2017.

Sec. 964.054. RESERVES AND ACCOUNTING BASIS. (a) A captive insurance company shall maintain reserves in an amount stated in the aggregate to provide for the payment of all losses or claims for which the captive insurance company may be liable and that are:

(1) incurred on or before the date of the annual report under Section 964.060, whether reported or unreported; and

(2) unpaid as of the date of the annual report under Section 964.060.

(b) In addition to the reserves required by Subsection (a), a captive insurance company shall maintain reserves in an amount estimated to provide for the expenses of adjustment or settlement of the losses or claims described by Subsection (a).

(c) The captive insurance company shall use generally accepted accounting principles as an accounting basis except that a captive insurance company that is required to hold a certificate of authority under another jurisdiction's insurance laws shall use statutory accounting principles.

Added by Acts 2013, 83rd Leg., R.S., Ch. 569 (S.B. 734), Sec. 2, eff. June 14, 2013.

Sec. 964.055. CERTIFICATE OF AUTHORITY REQUIRED. (a) An entity may not engage in business as a captive insurance company domiciled in this state unless it holds a certificate of authority

issued by the department to act as a captive insurance company. A captive insurance company, when permitted by its certificate of formation or governing document, may apply for a certificate of authority under this chapter.

(b) An entity does not qualify for a certificate of authority under this chapter unless:

(1) its affiliates have significant operations in this state, as determined by the commissioner;

(2) its board of directors or governing body holds at least one meeting each year in this state;

(3) it maintains its principal office and books and records in this state, unless the commissioner grants an application to relocate the entity's books and records under Chapter 803; and

(4) it complies with Section 804.101 or 804.102.

Added by Acts 2013, 83rd Leg., R.S., Ch. 569 (S.B. 734), Sec. 2, eff. June 14, 2013.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 1050 (H.B. 1944), Sec. 1.05, eff. June 15, 2017.

Sec. 964.056. CAPITAL AND SURPLUS OR EQUIVALENT REQUIREMENTS.

(a) The department may not issue a certificate of authority to a captive insurance company unless the company possesses and maintains unencumbered capital and surplus, or the equivalent, in an amount determined by the commissioner after considering:

(1) the amount of premium written by the captive insurance company;

(2) the characteristics of the assets held by the captive insurance company;

(3) the terms of reinsurance arrangements entered into by the captive insurance company;

(4) the type of business covered in policies issued by the captive insurance company;

(5) the underwriting practices and procedures of the captive insurance company; and

(6) any other criteria that has an impact on the operations of the captive insurance company determined to be significant by the commissioner.

(b) The amount of capital and surplus, or the equivalent, determined by the commissioner under Subsection (a) may not be less than \$250,000.

(c) The capital and surplus, or the equivalent, required by Subsection (a) must be in the form of:

(1) United States currency;

(2) an irrevocable letter of credit, in a form approved by the commissioner and not secured by a guarantee from an affiliate, naming the commissioner as beneficiary for the security of the captive insurance company's policyholders and issued by a bank approved by the commissioner;

(3) bonds of this state or a county or municipality of this state; or

(4) bonds or other evidences of indebtedness of the United States, the principal and interest of which are guaranteed by the United States.

Added by Acts 2013, 83rd Leg., R.S., Ch. 569 (S.B. 734), Sec. 2, eff. June 14, 2013.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 1050 (H.B. 1944), Sec. 1.06, eff. June 15, 2017.

Sec. 964.057. APPLICATION FOR CERTIFICATE OF AUTHORITY. (a) After forming a captive insurance company, other than a captive exchange, or an attorney in fact, the incorporators or organizers must pay to the commissioner an application fee and file with the commissioner an application for a certificate of authority for a captive insurance company, which must include:

(1) a financial statement certified by two principal officers;

(2) a plan of operation and projections, which must include an actuarial report prepared by a qualified independent actuary;

(3) the captive insurance company's certificate of formation or other documentation demonstrating the valid formation of the captive insurance company, other than a captive exchange, or the attorney in fact;

(4) an affidavit by the incorporators, organizers, or officers of the captive insurance company stating that:

(A) the capital and surplus, or the equivalent, are the bona fide property of the company; and

(B) the certificate of formation or other documentation demonstrating the captive insurance company's or attorney in fact's valid formation is true and correct; and

(5) if the application provides for the issuance of shares of stock or other type of equity instrument without par value, a certificate authenticated by the incorporators or officers stating:

(A) the number of shares or other type of equity instrument without par value that are subscribed; and

(B) the actual consideration received by the captive insurance company for those shares or other type of equity instrument.

(b) If the commissioner is not satisfied with the affidavit filed under Subsection (a)(4), the commissioner may require that the incorporators, organizers, or officers provide at their expense additional evidence as described by Subsection (a) before the commissioner takes action on the application.

(c) The application fee required under this section is \$1,500 or a greater amount set by the commissioner by rule as necessary to recover the cost of administering this section.

(e) Fees collected under this section shall be deposited to the credit of the Texas Department of Insurance operating account.

Added by Acts 2013, 83rd Leg., R.S., Ch. 569 (S.B. 734), Sec. 2, eff. June 14, 2013.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 1050 (H.B. 1944), Sec. 1.07, eff. June 15, 2017.

Sec. 964.058. EXAMINATION BY COMMISSIONER. (a) After the application and application fee for a certificate of authority under Section 964.057 are filed with the department and the applicant has complied with all legal requirements, the commissioner shall conduct an examination of the applicant to determine whether:

(1) the minimum capital and surplus, or the equivalent, requirements of Section 964.056 are satisfied;

(2) the capital and surplus, or the equivalent, are the bona fide property of the applicant; and

(3) the applicant has fully complied with applicable insurance laws.

(b) The commissioner may appoint a competent and disinterested person to conduct the examination required by this section. The examiner shall file an affidavit of the examiner's findings with the commissioner. The commissioner shall record the affidavit.

Added by Acts 2013, 83rd Leg., R.S., Ch. 569 (S.B. 734), Sec. 2, eff. June 14, 2013.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 1050 (H.B. 1944), Sec. 1.08, eff. June 15, 2017.

Sec. 964.059. ACTION ON APPLICATION. (a) The commissioner shall determine whether:

(1) the capital and surplus, or the equivalent, of the applicant meet the requirements of this chapter;

(2) the officers or members of the applicant's governing body have sufficient insurance experience, ability, standing, and good record to make success of the captive insurance company probable;

(3) the applicant is acting in good faith; and

(4) the applicant otherwise satisfies the requirements of this chapter.

(b) In evaluating the application, the commissioner shall consider:

(1) the amount and liquidity of the applicant's assets relative to the risks to be assumed;

(2) the adequacy of the expertise, experience, and character of each individual who will manage the applicant;

(3) the overall soundness of the applicant's plan of operations and the projections contained in that plan;

(4) whether the applicant's affiliates have significant operations located in this state; and

(5) any other factors the commissioner considers relevant to determine whether the applicant will be able to meet its policy obligations.

(c) If the commissioner determines that the applicant has not met the standards set out by Subsection (a), the commissioner shall

deny the application in writing, giving the reason for the denial. On the applicant's request, the commissioner shall hold a hearing on a denial. Not later than the 30th day after the date the commissioner receives the applicant's request for a hearing, the commissioner shall set a hearing date.

(d) If the commissioner does not deny the application under Subsection (c), the commissioner shall approve the application and:

(1) issue to the applicant a certificate of authority to engage in business as provided for in the applicant's certificate of formation or other governing document;

(2) certify and file the approved document with the department; and

(3) issue a certified copy of the certificate of authority to the applicant's incorporators or officers.

(e) A certificate of authority issued to a captive insurance company under this section may not be sold.

Added by Acts 2013, 83rd Leg., R.S., Ch. 569 (S.B. 734), Sec. 2, eff. June 14, 2013.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 1050 (H.B. 1944), Sec. 1.09, eff. June 15, 2017.

Sec. 964.060. ANNUAL REPORT. (a) A captive insurance company holding a certificate of authority under this chapter is not required to file a report, except as provided by this section, Chapter 223A, and Subtitle C, Title 3.

(b) A captive insurance company that holds a certificate of authority to engage in captive insurance business in this state shall file with the commissioner:

(1) on or before March 1 of each year, a statement of the company's financial condition, verified by two of its executive officers and filed in a format prescribed by the commissioner; and

(2) on or before June 1 of each year, a report of its financial condition at last year-end with an independent certified public accountant's opinion of the company's financial condition.

(c) A captive insurance company may make a written application to the commissioner for filing its annual report required under this section on a fiscal year-end. If an alternative filing date is

granted, the company shall file:

(1) the annual report not later than the 60th day after the date of the company's fiscal year-end;

(2) the report of its financial condition at last year-end with an independent certified public accountant's opinion of the company's financial condition not later than the 150th day after the date the annual report is due; and

(3) its balance sheet, income statement, and statement of cash flows, verified by two of its executive officers, before March 1 of each year to provide sufficient detail to support a premium tax return.

(d) The commissioner may waive the requirement for a captive insurance company to file an actuarial report with the company's annual report if the commissioner determines that the company:

(1) has less than \$1 million of net written premium or reinsurance assumed; or

(2) has been in operation for less than six months as of the end of the previous calendar year.

Added by Acts 2013, 83rd Leg., R.S., Ch. 569 (S.B. 734), Sec. 2, eff. June 14, 2013.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 1050 (H.B. 1944), Sec. 1.10, eff. June 15, 2017.

Sec. 964.061. INVESTMENTS. (a) A captive insurance company is not subject to a restriction on allowable investments, except as provided by this section.

(b) A captive insurance company may make loans to its affiliates with the prior approval of the commissioner. Each loan must be evidenced by a note approved by the commissioner. A captive insurance company may not make a loan of the minimum capital and surplus funds, or the equivalent, required by this chapter.

(c) The commissioner may prohibit or limit an investment that threatens the solvency or liquidity of a captive insurance company.

Added by Acts 2013, 83rd Leg., R.S., Ch. 569 (S.B. 734), Sec. 2, eff. June 14, 2013.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 1050 (H.B. 1944), Sec. 1.11, eff.

June 15, 2017.

Sec. 964.062. AMENDMENTS TO CERTIFICATE OF FORMATION OR GOVERNING DOCUMENT. A captive insurance company may not amend its certificate of formation or other governing document unless the amendment has been filed with and approved by the commissioner.

Added by Acts 2013, 83rd Leg., R.S., Ch. 569 (S.B. 734), Sec. 2, eff. June 14, 2013.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 1050 (H.B. 1944), Sec. 1.12, eff. June 15, 2017.

Sec. 964.063. DIVIDENDS AND DISTRIBUTIONS. (a) A captive insurance company shall notify the commissioner in writing when issuing policyholder dividends or distributions to policyholders.

(b) A captive insurance company, with the commissioner's approval, may issue dividends or distributions to the holders of an equity interest in the captive insurance company. The commissioner shall adopt rules to implement this subsection.

Added by Acts 2013, 83rd Leg., R.S., Ch. 569 (S.B. 734), Sec. 2, eff. June 14, 2013.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 469 (S.B. 667), Sec. 3, eff. June 15, 2015.

Acts 2017, 85th Leg., R.S., Ch. 1050 (H.B. 1944), Sec. 1.13, eff. June 15, 2017.

Acts 2017, 85th Leg., R.S., Ch. 1050 (H.B. 1944), Sec. 1.14, eff. June 15, 2017.

Sec. 964.064. PROHIBITION ON JOINING OR CONTRIBUTING TO CERTAIN ENTITIES AND FUNDS. A captive insurance company may not join or contribute financially to any plan, pool, association, or guaranty or insolvency fund in this state, and a captive insurance company, its insured, or any affiliate is not entitled to receive any benefit from a plan, pool, association, or guaranty or insolvency fund for claims arising out of the operations of the company.

Added by Acts 2013, 83rd Leg., R.S., Ch. 569 (S.B. 734), Sec. 2, eff. June 14, 2013.

Sec. 964.065. SUSPENSION OR REVOCATION OF CERTIFICATE OF AUTHORITY. The commissioner, after notice and an opportunity for hearing, may revoke or suspend the certificate of authority of a captive insurance company for:

- (1) insolvency or impairment of required capital or surplus, or the equivalent, to policyholders;
- (2) failure to submit an annual report, as required by Section 964.060;
- (3) failure to comply with the provisions of its own charter, bylaws, rules, or other governing document;
- (4) failure to submit to examination, as required by Chapter 401;
- (5) failure to pay the cost of examination, as required by Chapter 401;
- (6) failure to pay any tax or fee required by this code;
- (7) removal of its principal office or books and records from this state without prior approval of the commissioner;
- (8) use of practices that render its operation detrimental to the public or its condition unsound; or
- (9) failure to otherwise comply with the laws of this state.

Added by Acts 2013, 83rd Leg., R.S., Ch. 569 (S.B. 734), Sec. 2, eff. June 14, 2013.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 1050 (H.B. 1944), Sec. 1.15, eff. June 15, 2017.

Sec. 964.066. STANDARDS FOR RISK MANAGEMENT OF CONTROLLED UNAFFILIATED BUSINESS. The commissioner may adopt rules establishing standards to ensure that an affiliated company is able to exercise control of the risk management function of any controlled unaffiliated business to be insured by the captive insurance company. Until rules under this section are adopted, the commissioner may approve the coverage of these risks by a captive insurance company.

Added by Acts 2013, 83rd Leg., R.S., Ch. 569 (S.B. 734), Sec. 2, eff. June 14, 2013.

Sec. 964.067. CAPTIVE MANAGERS. Before providing captive management services to a licensed captive insurance company, a captive management company shall register with the commissioner by providing the information required on a form adopted by the commissioner.

Added by Acts 2013, 83rd Leg., R.S., Ch. 569 (S.B. 734), Sec. 2, eff. June 14, 2013.

Sec. 964.068. MAINTENANCE TAX. A captive insurance company is subject to maintenance tax under Subtitle C, Title 3, on the correctly reported gross premiums from writing insurance on risks located in this state as applicable to the individual lines of business written by the captive insurance company.

Added by Acts 2013, 83rd Leg., R.S., Ch. 569 (S.B. 734), Sec. 2, eff. June 14, 2013.

Sec. 964.069. RULEMAKING AUTHORITY. The commissioner may adopt reasonable rules as necessary to implement the purposes and provisions of this chapter.

Added by Acts 2013, 83rd Leg., R.S., Ch. 569 (S.B. 734), Sec. 2, eff. June 14, 2013.

Sec. 964.070. CONFIDENTIALITY. (a) Any information filed with the commissioner by an applicant or captive insurance company under this chapter is confidential and privileged for all purposes, including for purposes of Chapter 552, Government Code, a response to a subpoena, or evidence in a civil action. Except as provided by Subsections (b) and (c), the information may not be disclosed without the prior written consent of the applicant or captive insurance company to which the information pertains.

(b) If the recipient of the information described by Subsection

(a) has the legal authority to maintain the confidential or privileged status of the information and verifies that authority in writing, the commissioner or another person may disclose the information to any of the following entities functioning in an official capacity:

- (1) a commissioner of insurance or an insurance department of another state;
- (2) an authorized law enforcement official;
- (3) a district attorney of this state;
- (4) the attorney general;
- (5) a grand jury;
- (6) the National Association of Insurance Commissioners if the captive insurance company is affiliated with an insurance company that is part of an insurance holding company system as described in Chapter 823;
- (7) another state or federal regulator if the applicant or captive insurance company to which the information relates operates in the entity's jurisdiction;
- (8) an international insurance regulator or analogous financial agency if the captive insurance company is affiliated with an insurance company that is part of an insurance holding company system as described in Chapter 823 and the holding company system operates in the entity's jurisdiction; or
- (9) members of a supervisory college described by Section 823.0145, if the captive insurance company is affiliated with an insurance company that is part of an insurance holding company system as described in Chapter 823.

(c) The commissioner may use information described by Subsection (a) in the furtherance of a legal or regulatory action relating to the administration of this code.

(d) The secretary of state may index in the public record any document filed with the secretary by an applicant or captive insurance company.

Added by Acts 2013, 83rd Leg., R.S., Ch. 569 (S.B. [734](#)), Sec. 2, eff. June 14, 2013.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 1050 (H.B. [1944](#)), Sec. 1.16, eff. June 15, 2017.

Sec. 964.071. REDOMESTICATION. (a) An authorized foreign or alien captive insurance company licensed under laws of any jurisdiction may become a domestic captive insurance company in this state on a determination by the commissioner that the authorized foreign or alien captive insurance company has complied with all of the requirements of this chapter for the issuance of a certificate of authority to, and the Business Organizations Code for converting to an entity of this state for, a domestic captive insurance company of the same type.

(b) A domestic captive insurance company, on the approval of the commissioner, may transfer its domicile. On the transfer, the captive insurance company ceases to be a domestic captive insurance company. The commissioner shall approve any proposed transfer unless the commissioner determines the transfer is not in the best interest of the policyholders.

(c) The commissioner may postpone or waive the imposition of any fees or taxes under this code for a period not to exceed two years for any foreign or alien captive insurance company redomesticating to this state.

Added by Acts 2013, 83rd Leg., R.S., Ch. 569 (S.B. 734), Sec. 2, eff. June 14, 2013.

Sec. 964.072. APPROVAL OF CAPTIVE REINSURANCE POOLS. Before determining whether to approve a captive insurance company's participation in a captive reinsurance pool under Section 964.052, the commissioner may:

(1) require the captive insurance company provide to the commissioner evidence that the captive reinsurance pool:

(A) is composed only of other captive insurance companies holding a certificate of authority under this chapter or a similar law of another jurisdiction; and

(B) will be able to meet the pool's financial obligations; and

(2) impose any other limitation or requirement on the captive insurance company that is necessary and proper to provide adequate security for the captive insurance company.

Added by Acts 2015, 84th Leg., R.S., Ch. 469 (S.B. 667), Sec. 4, eff. June 15, 2015.

Sec. 964.073. ADJUSTER LICENSE NOT REQUIRED; EXCEPTION. (a) Except as provided by Subsection (b), a captive insurance company is not required to use a person licensed as an adjuster under Chapter 4101 to adjust losses.

(b) A captive insurance company shall use a person licensed as an adjuster under Chapter 4101 to adjust a claim that a person that is not an affiliated company or an insured controlled unaffiliated business makes against an affiliated company insured by the captive insurance company.

Added by Acts 2017, 85th Leg., R.S., Ch. 1050 (H.B. 1944), Sec. 1.17, eff. June 15, 2017.

SUBCHAPTER C. CAPTIVE EXCHANGES

Sec. 964.101. APPLICABILITY OF OTHER LAW. (a) A captive exchange is subject to:

- (1) this chapter; and
- (2) Sections 942.051, 942.053, and 942.054.

(b) To the extent of a conflict, this chapter controls over other law applicable to a captive exchange under this section.

Added by Acts 2017, 85th Leg., R.S., Ch. 1050 (H.B. 1944), Sec. 2.01, eff. June 15, 2017.

Sec. 964.102. STATUS OF CAPTIVE EXCHANGES. A captive exchange is formed as an exchange as provided by this subchapter and, except as provided by this subchapter, shall operate as a captive insurance company as provided by this chapter.

Added by Acts 2017, 85th Leg., R.S., Ch. 1050 (H.B. 1944), Sec. 2.01, eff. June 15, 2017.

Sec. 964.103. SUBSCRIBER REQUIREMENTS. On and after the date of the captive exchange's formation, each subscriber of the captive exchange must:

- (1) have an existing affiliation with each other

subscriber; or

(2) satisfy the definition of a controlled unaffiliated business regardless of any affiliation relationship created by the captive exchange.

Added by Acts 2017, 85th Leg., R.S., Ch. 1050 (H.B. 1944), Sec. 2.01, eff. June 15, 2017.

Sec. 964.104. ATTORNEY IN FACT REQUIREMENTS. The attorney in fact of a captive exchange must:

(1) be:

(A) a corporation organized in this state; or

(B) a limited liability company organized in this state;

(2) on the date of the captive exchange's formation, have and maintain a power of attorney with all subscribers of the captive exchange;

(3) have its principal office in this state; and

(4) have at least three members in the governing body of the attorney in fact, and at least one of those members must be a resident of this state.

Added by Acts 2017, 85th Leg., R.S., Ch. 1050 (H.B. 1944), Sec. 2.01, eff. June 15, 2017.

Sec. 964.105. ATTORNEY IN FACT POWERS AND DUTIES. (a) The attorney in fact of a captive exchange shall:

(1) supervise the finances of the captive exchange;

(2) supervise the captive exchange's operations to ensure the captive exchange's conformity with the captive exchange's subscriber declaration and power of attorney; and

(3) obtain, as necessary, an audit of the account and records of the attorney in fact at the expense of the captive exchange.

(b) The attorney in fact of a captive exchange has any additional powers and duties conferred by the captive exchange's subscriber declaration and power of attorney.

Added by Acts 2017, 85th Leg., R.S., Ch. 1050 (H.B. 1944), Sec. 2.01,

eff. June 15, 2017.

Sec. 964.106. SUBSCRIBER DECLARATION. A captive exchange shall file with the department a subscriber declaration that includes:

- (1) the information described by Section 942.053;
- (2) the amount of the captive exchange's initial surplus;

and

(3) a provision to authorize a quorum of the governing body of the captive exchange's attorney in fact to consist of not fewer than one-third of the fixed number of members of the governing body.

Added by Acts 2017, 85th Leg., R.S., Ch. 1050 (H.B. 1944), Sec. 2.01, eff. June 15, 2017.

SUBTITLE I. SURPLUS LINES INSURERS; COMPANIES NOT ORGANIZED IN TEXAS

CHAPTER 981. SURPLUS LINES INSURANCE

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 981.001. PURPOSE. (a) An insurance transaction that is entered into by a resident of this state with an eligible surplus lines insurer through a surplus lines agent because of difficulty in obtaining coverage from an authorized insurer is a matter of public interest.

(b) The transaction of surplus lines insurance is a subject of concern and it is necessary to provide for the regulation, taxation, supervision, and control of these transactions and the practices and matters related to these transactions by:

- (1) requiring appropriate standards and reports concerning the placement of surplus lines insurance;
- (2) imposing requirements necessary to make regulation and control of surplus lines insurance reasonably complete and effective;
- (3) providing orderly access to eligible surplus lines insurers;
- (4) ensuring the maintenance of fair and honest markets;
- (5) protecting the revenues of this state; and
- (6) protecting authorized insurers, which under the laws of this state must meet strict standards relating to the regulation and taxation of the business of insurance, from unfair competition by unauthorized insurers.

(c) To regulate and tax surplus lines insurance placed in accordance with this chapter within the meaning and intent of 15 U.S.C. Section 1011 and 15 U.S.C. Chapter 108, this chapter provides an orderly method for each person whose home state is this state for a particular transaction to effect insurance with eligible surplus lines insurers through qualified, licensed, and supervised surplus lines agents in this state, if coverage is not available from authorized and regulated insurers engaged in business in this state, under reasonable and practical safeguards.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 595 (S.B. 951), Sec. 1, eff. June 14, 2013.

Sec. 981.002. DEFINITIONS. In this chapter:

(1) "Affiliate" means, with respect to determining the home state of an insured, and solely for the purpose of determining whether an entity is another entity's affiliate, a person or entity that controls, is controlled by, or is under common control with the insured.

(2) "Affiliated group" means a group of entities whose members are all affiliated.

(3) "Control" means, with respect to determining the home state of an insured, and solely for the purpose of determining whether an entity is another entity's affiliate:

(A) to directly or indirectly, acting through one or more persons, own, control, or hold the power to vote at least 25 percent of any class of voting security of the other entity; or

(B) to control in any manner the election of the majority of directors or trustees of the other entity.

(4) "Eligible surplus lines insurer" means an insurer that is not an authorized insurer, but that is eligible under Subchapter B or B-1, in which surplus lines insurance is placed or may be placed under this chapter.

(5) "Home state" means, with respect to an insured:

(A) the state in which the insured maintains the insured's principal residence, if the insured is an individual;

(B) the state in which the insured maintains the

insured's principal place of business, if the insured is not an individual;

(C) if 100 percent of the insured risk is located outside of the state in which the insured maintains the insured's principal residence or principal place of business, as applicable, the state to which the greatest percentage of the insured's taxable premium for the insurance contract that covers the risk is allocated; or

(D) for an affiliated group, the home state of the member, as determined under Paragraphs (A)-(C), that has the largest percentage of premium attributed to it under the insurance contract.

(6) "Managing underwriter" means a surplus lines agent or agency that exercises, pursuant to a written agreement with an eligible surplus lines insurer, underwriting authority for the eligible surplus lines insurer and that derives the agent or agency's business from a surplus lines agent.

(7) "Stamping office" means the Surplus Lines Stamping Office of Texas.

(8) "Surplus lines agent" means an agent licensed under Subchapter E to procure an insurance contract from a surplus lines insurer.

(9) "Surplus lines insurance" means insurance coverage that may be placed, in accordance with this chapter, with an eligible surplus lines insurer or the insurer's managing underwriter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 837 (H.B. [3410](#)), Sec. 2, eff. January 1, 2012.

Acts 2013, 83rd Leg., R.S., Ch. 595 (S.B. [951](#)), Sec. 2, eff. June 14, 2013.

Acts 2017, 85th Leg., R.S., Ch. 854 (H.B. [2492](#)), Sec. 2, eff. January 1, 2018.

Sec. 981.003. APPLICABILITY OF CHAPTER. This chapter applies to surplus lines insurance if the home state of the insured is this state.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 595 (S.B. 951), Sec. 3, eff. June 14, 2013.

Sec. 981.0031. EXEMPT COMMERCIAL PURCHASER DEFINED. (a) For purposes of this chapter, "exempt commercial purchaser" means a person who purchases commercial insurance and, at the time of placement:

- (1) employs or retains a qualified risk manager to negotiate insurance coverage;
- (2) has paid aggregate nationwide commercial property and casualty insurance premiums of more than \$100,000 in the immediately preceding 12 months; and
- (3) meets at least one of the following criteria:
 - (A) has a net worth of more than \$20 million;
 - (B) generates annual revenue of more than \$50 million;
 - (C) employs more than 500 full-time or full-time equivalent employees per individual insured, or is a member of an affiliated group that employs more than 1,000 employees in aggregate;
 - (D) is a nonprofit organization or public entity generating annual budgeted expenditures of at least \$30 million; or
 - (E) is a municipality with a population of more than 50,000.

(b) Effective on January 1, 2015, and on every fifth January 1 thereafter, the commissioner shall by order adjust the amounts provided by Subsections (a)(3)(A), (B), and (D) to reflect the percentage change in the Consumer Price Index for All Urban Consumers published by the Bureau of Labor Statistics of the United States Department of Labor for the five-year period immediately preceding January 1 of the year of the adjustment.

Added by Acts 2013, 83rd Leg., R.S., Ch. 595 (S.B. 951), Sec. 4, eff. June 14, 2013.

Sec. 981.0032. QUALIFIED RISK MANAGER DEFINED. For purposes of this chapter, "qualified risk manager" means, with respect to a policyholder of commercial insurance, a person who:

- (1) is an employee of, or third-party consultant retained by, a commercial policyholder;

(2) provides skilled services in loss prevention, loss reduction, or risk and insurance coverage analysis and the purchase of insurance; and

(3) satisfies the requirements of one of the following paragraphs:

(A) has:

(i) a bachelor's or higher degree from an accredited college or university in risk management, business administration, finance, economics, or another field determined by a state insurance commissioner or other state regulatory official or entity to demonstrate competence in risk management; and

(ii) either:

(a) at least three years of experience in risk financing, claims administration, loss prevention, risk and insurance analysis, or purchasing of commercial lines of insurance; or

(b) a designation, certification, or license:

(1) as a chartered property casualty underwriter (CPCU), issued by the American Institute for CPCU/Insurance Institute of America;

(2) as an associate in risk management (ARM) issued by the American Institute for CPCU/Insurance Institute of America;

(3) as a Certified Risk Manager (CRM) issued by the National Alliance for Insurance Education and Research;

(4) as a RIMS Fellow (RF) issued by the Global Risk Management Institute; or

(5) that is determined by a state insurance commissioner or other state insurance regulatory official or entity to demonstrate minimum competence in risk management;

(B) has at least seven years of experience in risk financing, claims administration, loss prevention, risk and insurance coverage analysis, or purchasing of commercial lines of insurance and one of the designations, certifications, or licenses described by Paragraph (A)(ii)(b);

(C) has at least 10 years of experience in risk financing, claims administration, loss prevention, risk and insurance coverage analysis, or purchasing commercial lines of insurance; or

(D) has a graduate degree from an accredited college or university in risk management, business administration, finance, economics, or another field determined by a state insurance

commissioner or other state regulatory official or entity to demonstrate competence in risk management.

Added by Acts 2013, 83rd Leg., R.S., Ch. 595 (S.B. 951), Sec. 4, eff. June 14, 2013.

Sec. 981.0033. INDUSTRIAL INSURED DEFINED. For purposes of this chapter, "industrial insured" means a person who purchases commercial insurance and, at the time of placement:

- (1) employs or retains a qualified risk manager to negotiate insurance coverage; and
- (2) either:
 - (A) has paid aggregate nationwide commercial property and casualty insurance premiums of more than \$25,000 in the immediately preceding 12 months; or
 - (B) employs at least 25 full-time employees.

Added by Acts 2017, 85th Leg., R.S., Ch. 92 (H.B. 1559), Sec. 1, eff. September 1, 2017.

Sec. 981.004. SURPLUS LINES INSURANCE AUTHORIZED. (a) An eligible surplus lines insurer may provide surplus lines insurance only if:

- (1) the full amount of required insurance cannot be obtained, after a diligent effort, from an insurer authorized to write and actually writing that kind and class of insurance in this state;
- (2) the insurance is placed through a surplus lines agent; and
- (3) the insurer meets the eligibility requirements of Subchapter B or B-1 as of the inception date and annual anniversary date of each insurance contract, cover note, or other confirmation of insurance.

(b) An eligible surplus lines insurer may provide surplus lines insurance only in the amount that exceeds the amount of insurance obtainable from authorized insurers.

(c) Subsection (a)(1) does not apply to insurance procured for an exempt commercial purchaser if:

- (1) the agent procuring or placing the insurance discloses

to the exempt commercial purchaser that:

(A) comparable insurance may be available from the admitted market that is subject to more regulatory oversight than the surplus lines market; and

(B) a policy purchased in the admitted market may provide greater protection than the surplus lines insurance policy; and

(2) after receiving the notice described by Subdivision (1), the exempt commercial purchaser requests in writing that the agent procure the insurance from or place the insurance with an eligible surplus lines insurer.

(d) Subsection (a)(1) does not apply to insurance procured for an industrial insured if:

(1) the agent procuring or placing the insurance discloses to the industrial insured that:

(A) comparable insurance may be available from the admitted market that is subject to more regulatory oversight than the surplus lines market; and

(B) a policy purchased in the admitted market may provide greater protection than the surplus lines insurance policy;

(2) the surplus lines company offering the coverage has a financial strength rating of A- or better from the A. M. Best Company; and

(3) after receiving the notice described by Subdivision (1), the industrial insured requests in writing that the agent procure the insurance from or place the insurance with an eligible surplus lines insurer.

(e) Subsections (a)(1) and (b) do not apply to flood coverage under an insurance policy issued by an eligible surplus lines insurer that has a financial strength rating of A- or better from the A. M. Best Company.

(f) Notwithstanding Subsection (a)(1), the availability of windstorm and hail insurance from the Texas Windstorm Insurance Association does not preclude an eligible surplus lines insurer from providing windstorm and hail insurance under Subsection (a) or limiting the amount of insurance that may be provided under Subsection (b).

(g) Except with respect to a line of insurance for which the commissioner has temporarily reinstated the requirements for rate and form filings under Section 2251.0031(d) or 2301.0031(d), Subsections

(a)(1) and (b) do not apply to an insurance policy issued by an eligible surplus lines insurer for any line of the kinds of insurance described by Sections 2251.0031(a) and 2301.0031(a) or exempted under Section 2251.0031(c) or 2301.0031(c).

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 595 (S.B. 951), Sec. 5, eff. June 14, 2013.

Acts 2017, 85th Leg., R.S., Ch. 92 (H.B. 1559), Sec. 2, eff. September 1, 2017.

Acts 2017, 85th Leg., R.S., Ch. 854 (H.B. 2492), Sec. 3, eff. January 1, 2018.

Acts 2019, 86th Leg., R.S., Ch. 763 (H.B. 1306), Sec. 1, eff. September 1, 2019.

Acts 2019, 86th Leg., R.S., Ch. 1089 (H.B. 1940), Sec. 1, eff. June 14, 2019.

Acts 2021, 87th Leg., R.S., Ch. 42 (S.B. 1367), Sec. 1, eff. September 1, 2021.

Acts 2021, 87th Leg., R.S., Ch. 915 (H.B. 3607), Sec. 21.001(58), eff. September 1, 2021.

Sec. 981.005. VALIDITY OF CONTRACTS. (a) Unless a material and intentional violation of this chapter or Chapter 225 exists, an insurance contract obtained from an eligible surplus lines insurer is:

- (1) valid and enforceable as to all parties; and
- (2) recognized in the same manner as a comparable contract issued by an authorized insurer.

(b) A material and intentional violation of this chapter or Chapter 225 does not preclude the insured from enforcing the insured's rights under the contract.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.125, eff. April 1, 2009.

Sec. 981.006. SANCTIONS. Chapter 82 applies to a surplus lines

agent or an eligible surplus lines insurer that violates:

- (1) this chapter;
- (2) Chapter 225; or
- (3) a rule or order adopted under Subchapter B or B-1 or Section 981.005.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.126, eff. April 1, 2009.

Acts 2017, 85th Leg., R.S., Ch. 854 (H.B. 2492), Sec. 4, eff. January 1, 2018.

Sec. 981.007. LIABILITY OF SURPLUS LINES INSURER FOR LOSSES AND UNEARNED PREMIUMS. (a) This section applies if:

(1) an eligible surplus lines insurer has assumed a risk under this chapter; and

(2) the surplus lines agent who placed the insurance has received the premium for that risk.

(b) If a coverage question between the eligible surplus lines insurer and the insured arises regarding the assumed risk, the insurer is considered to have received the premium due for that coverage.

(c) The eligible surplus lines insurer is liable to the insured for any:

(1) loss covered by the insurance; and

(2) unearned premium payable to the insured on cancellation of the insurance.

(d) This section applies without regard to whether the surplus lines agent is indebted to the insurer regarding the insurance or for any other cause.

(e) An eligible surplus lines insurer that assumes a risk under this chapter subjects itself to this section.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 981.008. SURPLUS LINES INSURANCE PREMIUM TAX. The premiums charged for surplus lines insurance are subject to the premium tax, if applicable, imposed under Chapter 225.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.127,
eff. April 1, 2009.

Acts 2011, 82nd Leg., 1st C.S., Ch. 4 (S.B. 1), Sec. 18.10, eff.
September 28, 2011.

Sec. 981.009. RULES. The commissioner may adopt rules to
implement this chapter or satisfy requirements under federal law or
regulations.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.228(a), eff.
Sept. 1, 2003.

SUBCHAPTER B. ELIGIBILITY REQUIREMENTS FOR SURPLUS LINES INSURERS

Sec. 981.051. AUTHORIZATION REQUIRED. (a) Before an insurer
may issue surplus lines insurance, the insurer must hold an
authorization to engage in the business of insurance from its
domiciliary state or country.

(b) The authorization from the domiciliary state or country
must be for the same kind or class of insurance to be written in this
state as surplus lines insurance.

(c) The surplus lines insurer must provide to the commissioner
satisfactory evidence that the insurer holds the authorization.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 981.054. CERTAIN PRECONDITIONS NOT ALLOWED. An eligible
surplus lines insurer may not require as a condition precedent to
writing new or renewal surplus lines insurance that the insured or
prospective insured place with the insurer other insurance that is
not obtainable as surplus lines insurance.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 981.057. MINIMUM CAPITAL AND SURPLUS REQUIREMENTS. (a)

Except as provided by Subsection (b), an eligible surplus lines insurer must maintain capital and surplus in an amount of at least \$15 million.

(b) Subsection (a) does not apply to alien surplus lines insurers listed on the Quarterly Listing of Alien Insurers maintained by the International Insurers Department, National Association of Insurance Commissioners.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 595 (S.B. 951), Sec. 6, eff. June 14, 2013.

Sec. 981.058. ALIEN INSURERS. An alien surplus lines insurer must be listed on the Quarterly Listing of Alien Insurers maintained by the International Insurers Department, National Association of Insurance Commissioners.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 595 (S.B. 951), Sec. 7, eff. June 14, 2013.

Sec. 981.063. COMMISSIONER OR DEPARTMENT NOT RESPONSIBLE FOR DETERMINING UNAUTHORIZED INSURER'S FINANCIAL CONDITION OR CLAIMS PRACTICES. This subchapter does not impose on the commissioner or department a responsibility to determine the actual financial condition or claims practices of an unauthorized insurer as described by Chapter 101.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 981.064. COMMISSIONER MAY ORDER REVOCATION OF CONTRACTS. The commissioner may order the revocation of an insurance contract issued by an eligible surplus lines insurer that does not meet the eligibility requirements of this subchapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 981.065. APPLICABILITY TO CONTRACT EXTENSION. This subchapter and Sections 981.101(b), 981.210, and 981.211 apply to an extension of an insurance contract beyond its original expiration date.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 981.066. UNIFORM STANDARDS. To issue surplus lines insurance in this state, an insurer must comply with all applicable nationwide uniform standards adopted by this state in accordance with 15 U.S.C. Section 8204.

Added by Acts 2013, 83rd Leg., R.S., Ch. 595 (S.B. 951), Sec. 8, eff. June 14, 2013.

SUBCHAPTER B-1. DOMESTIC SURPLUS LINES INSURER

Sec. 981.071. DEFINITION. In this subchapter, "domestic surplus lines insurer" means an insurance company designated as a domestic surplus lines insurer under Section 981.072.

Added by Acts 2017, 85th Leg., R.S., Ch. 854 (H.B. 2492), Sec. 5, eff. January 1, 2018.

Sec. 981.072. DESIGNATION AS DOMESTIC SURPLUS LINES INSURER.

(a) A property and casualty insurance company organized under Chapter 822 that has capital and surplus in an amount described by Section 981.057 may apply to the department in a form and manner prescribed by the commissioner for designation as a domestic surplus lines insurer.

(b) On approval of an application under Subsection (a), the commissioner shall designate an applicant as a domestic surplus lines insurer and issue to the applicant a domestic surplus lines insurer certificate.

(c) Notwithstanding Section 822.101, a domestic surplus lines insurer is not entitled to a certificate of authority to engage in the business of insurance in this state in the admitted market.

Added by Acts 2017, 85th Leg., R.S., Ch. 854 (H.B. 2492), Sec. 5, eff. January 1, 2018.

Sec. 981.073. APPLICABILITY OF OTHER LAW; CONFLICTS. (a) Except as provided by Subsection (b), a domestic surplus lines insurer is subject to:

(1) this chapter; and
(2) all other insurance laws, including Title 4, applicable to a property and casualty insurance company organized under Chapter 822.

(b) A domestic surplus lines insurer is not subject to:

- (1) Section 38.003;
- (2) Chapter 462;
- (3) Chapter 463;
- (4) Chapter 501;
- (5) Section 981.051;
- (6) Section 981.101(b);
- (7) Chapter 2007;
- (8) Chapter 2301;
- (9) Chapter 2251; and
- (10) Chapter 1006, Transportation Code.

(c) To the extent that this subchapter conflicts with any other insurance law, this subchapter controls.

Added by Acts 2017, 85th Leg., R.S., Ch. 854 (H.B. 2492), Sec. 5, eff. January 1, 2018.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 594 (S.B. 604), Sec. 5.25, eff. September 1, 2019.

Sec. 981.074. AUTHORIZED BUSINESS. (a) A domestic surplus lines insurer may only insure a risk in this state if:

(1) the insurance is procured as eligible surplus lines insurance under this chapter; and
(2) the insurance is a kind of insurance the insurer is authorized to write under the insurer's articles of incorporation.

(b) A domestic surplus lines insurer may not issue:

- (1) a policy in the admitted market; or

(2) a policy to satisfy the financial responsibility requirements of Chapter 601, Transportation Code, insurance requirements of Chapter 406, Labor Code, or requirements of any other law of this state mandating insurance coverage by an insurance company authorized to engage in the business of insurance in this state.

Added by Acts 2017, 85th Leg., R.S., Ch. 854 (H.B. 2492), Sec. 5, eff. January 1, 2018.

Sec. 981.075. TAXES IMPOSED. (a) The premium for a surplus lines policy written under this subchapter is subject to the premium tax, if applicable, imposed under Chapter 225.

(b) A domestic surplus lines insurer is subject to an applicable maintenance tax as if the domestic surplus lines insurer were an authorized insurer under Subtitle C, Title 3.

Added by Acts 2017, 85th Leg., R.S., Ch. 854 (H.B. 2492), Sec. 5, eff. January 1, 2018.

Sec. 981.076. REQUIREMENTS FOR DOMESTIC SURPLUS LINES DOCUMENTS. (a) In this section, "surplus lines document" has the meaning assigned by Section 981.101.

(b) A surplus lines document issued by a domestic surplus lines insurer must include a statement in the form and manner provided by commissioner rule.

Added by Acts 2017, 85th Leg., R.S., Ch. 854 (H.B. 2492), Sec. 5, eff. January 1, 2018.

Sec. 981.077. REDOMESTICATION. A foreign insurer may redomesticate to this state as a domestic surplus lines insurer as provided by Chapter 983 if the foreign insurer qualifies under Section 981.072.

Added by Acts 2017, 85th Leg., R.S., Ch. 854 (H.B. 2492), Sec. 5, eff. January 1, 2018.

**SUBCHAPTER C. REQUIREMENTS AND PROCEDURES FOR ISSUANCE OF SURPLUS
LINES DOCUMENTS**

Sec. 981.101. REQUIREMENTS FOR SURPLUS LINES DOCUMENTS. (a) In this section, "surplus lines document" means each new or renewal insurance contract, certificate, cover note, or other confirmation of insurance obtained and delivered as surplus line coverage under this chapter.

(b) A surplus lines document must state, in 11-point type, the following:

This insurance contract is with an insurer not licensed to transact insurance in this state and is issued and delivered as surplus line coverage under the Texas insurance statutes. The Texas Department of Insurance does not audit the finances or review the solvency of the surplus lines insurer providing this coverage, and the insurer is not a member of the property and casualty insurance guaranty association created under Chapter 462, Insurance Code. Chapter 225, Insurance Code, requires payment of a _____ (insert appropriate tax rate) percent tax on gross premium.

(c) A surplus lines document must show:

- (1) the description and location of the subject of the insurance;
- (2) the coverage, conditions, and term of the insurance;
- (3) the premium and rate charged, and premium taxes to be collected from the insured;
- (4) the name and address of:
 - (A) the insured;
 - (B) the insurer; and
 - (C) the insurance agent who obtained the surplus line coverage; and
- (5) if the direct risk is assumed by more than one insurer:
 - (A) the name and address of each insurer; and
 - (B) the proportion of the entire direct risk assumed by each insurer.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 2E.128, eff. April 1, 2009.

Sec. 981.102. LIMIT ON USE OF SURPLUS LINES POLICY OR CONTRACT FORMS. A surplus lines insurance policy or contract form may not be used unless use of the form is:

- (1) reasonably necessary for the principal purposes of the insurance coverage; or
- (2) not contrary to the purposes of this chapter regarding the reasonable protection of authorized insurers from unwarranted competition by unauthorized insurers.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 981.103. DELIVERY TO INSURED OF SURPLUS LINES DOCUMENTS.

(a) On placing new or renewal surplus lines coverage, a surplus lines agent shall promptly issue and deliver to the insured or to the insured's agent the following evidence of insurance:

- (1) the policy issued by the insurer; or
- (2) if the policy is not available, a certificate, cover note, or other confirmation of insurance.

(b) If the policy is not available at the time of placement of the insurance, the surplus lines agent shall, on the insured's request and as soon as reasonably possible:

- (1) obtain the policy from the insurer; and
- (2) deliver the policy to the insured to replace the certificate, cover note, or other confirmation of insurance previously issued.

(c) A surplus lines agent may not deliver the evidence of insurance described by Subsection (a), or purport to insure or represent that insurance will be or has been granted by an eligible surplus lines insurer, unless the agent:

- (1) has prior written authority from the insurer for the insurance; or
- (2) has received information from the insurer in the regular course of business that:
 - (A) the insurance has been granted; or
 - (B) an insurance policy providing the insurance actually has been issued by the insurer and delivered to the insured.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 981.104. DELIVERY TO INSURED OF REVISED SURPLUS LINES DOCUMENTS. (a) A surplus lines agent shall promptly deliver to the insured a substitute certificate, cover note, confirmation, or endorsement for the original document showing the current status of the coverage and the insurers responsible for that coverage if, after the delivery of the original document, a change is made:

- (1) to the identity of the insurers;
- (2) to the proportion of the direct risk assumed by the insurer as stated in the original document; or
- (3) in any other material respect as to the insurance coverage evidenced by the document.

(b) A change made under Subsection (a) may not result in coverage or an insurance contract that would violate this chapter or Chapter 225, if originally issued on that basis.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.129, eff. April 1, 2009.

Sec. 981.105. FILING WITH STAMPING OFFICE. (a) Not later than the 60th day after the later of the effective date or the issue date of new or renewal surplus lines insurance, a surplus lines agent responsible under Section 225.006 for the filing, reporting, collection, payment, and other requirements imposed by Chapter 225 shall file with the stamping office:

- (1) a copy of the policy issued; or
- (2) if the policy has not been issued, a copy of the certificate, cover note, or other confirmation of insurance delivered to the insured.

(b) The surplus lines agent described by Subsection (a) shall also promptly file with the stamping office:

- (1) a copy of each substitute certificate, cover note, or other confirmation of insurance delivered to an insured;
- (2) a copy of each endorsement of an original policy, certificate, cover note, or other confirmation of insurance delivered to an insured; and
- (3) a memorandum from the agent informing the stamping office of the substance of any change represented by a document

described by Subdivision (1) or (2), as compared with the original coverage.

(c) The commissioner may assess a fee against an agent who files a surplus lines policy after the filing deadline specified by Subsection (a).

(d) For an agent who files a surplus lines policy on or before the 180th day after the effective date or issue date described by Subsection (a), the amount of the fee is:

(1) \$50 for each late-filed policy if, in the calendar year immediately preceding the year in which the policy is late-filed, the agent has filed not more than five percent of the policies the agent was required to file after the filing deadline specified by Subsection (a); or

(2) \$100 for each late-filed policy if, in the calendar year immediately preceding the year in which the policy is late-filed, the agent has filed more than five percent of the policies the agent was required to file after the filing deadline specified by Subsection (a).

(e) For an agent who files a surplus lines policy after the 180th day but before the 365th day after the effective date or issue date described by Subsection (a) and who, during the immediately preceding calendar year, filed not more than two percent of the policies the agent was required to file after the filing deadline specified by Subsection (a), the amount of the fee for the late-filed policy is \$200.

(f) Notwithstanding any other provision of this section, for an agent who not later than January 1, 2012, files a late-filed policy with an effective date before January 1, 2010, that, at the time the policy is filed, has not been listed in a previous late-filed policy report of the stamping office, the amount of the fee is \$50 for each late-filed policy.

(g) The assessment, imposition, or payment of a fee under this section does not establish a violation for purposes of Section 81.004, 82.051, 82.052, 82.054, 82.056, or 84.022(b)(3).

(h) An agent who files a surplus lines policy after the filing deadline specified by Subsection (a) is subject to Chapters 81, 82, and 84 only if the agent:

(1) fails to timely pay a fee assessed under this section;

(2) files a surplus lines policy on or after the 365th day after the effective date or issue date; or

(3) files a surplus lines policy after the 180th day but before the 365th day of the effective date or issue date, and in the calendar year immediately preceding the year in which the policy is late-filed, filed more than two percent of the policies the agent was required to file after the filing deadline specified in Subsection (a).

(i) The department shall provide notice to each agent of the amount of fees assessed under this section during each calendar year not later than June 15 of the year immediately following the year for which fees are assessed, and each agent shall pay the assessed fees not later than the 30th day after the date of the notice.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 197 (S.B. 1806), Sec. 1, eff. May 28, 2011.

Acts 2013, 83rd Leg., R.S., Ch. 920 (H.B. 1405), Sec. 2, eff. January 1, 2014.

SUBCHAPTER D. SURPLUS LINES STAMPING OFFICE

Sec. 981.151. STATUS AS NONPROFIT ASSOCIATION. The Surplus Lines Stamping Office of Texas is a nonprofit association.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 981.152. BOARD OF DIRECTORS. (a) The board of directors of the stamping office exercises the powers of the office.

(b) The board consists of nine members appointed by the commissioner. Four members must represent the public and have a minimum of three years of experience in purchasing commercial insurance. A public representative may not:

(1) be an officer, director, or employee of an insurer, insurance agency, agent, broker, solicitor, or adjuster or any other business entity regulated by the department;

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

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

(c) A board member serves a term as established in the plan of

operation.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 981.153. PLAN OF OPERATION. (a) The procedures to administer the stamping office are established by a plan of operation approved by the commissioner. The plan of operation establishes the terms of the members of the board of directors of the office.

(b) The stamping office shall submit any amendment to the plan of operation to the commissioner. An amendment to the plan of operation is effective on approval by commissioner order.

(c) If the stamping office fails to submit a suitable amendment to the plan of operation, the commissioner may, after notice and hearing, adopt:

- (1) an amendment to the plan of operation; and
- (2) any rules necessary or advisable to implement this subchapter.

(d) A rule adopted under Subsection (c) continues until:

- (1) modified by the commissioner; or
- (2) superseded by an amendment to the plan of operation submitted by the stamping office and approved by the commissioner.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 981.154. POWERS AND DUTIES. (a) The stamping office shall perform its functions under the plan of operation.

(b) The stamping office shall conduct the following activities as provided in the plan of operation:

(1) receive, record, and review each surplus lines insurance contract that a surplus lines agent is required to file with the office;

(2) provide to the commissioner an evaluation of the eligibility of each surplus lines insurance contract and surplus lines insurer;

(3) prepare monthly reports for the commissioner relating to surplus lines insurance obtained during the preceding month in a form prescribed by the commissioner;

(4) prepare reports for the commissioner relating to surplus lines business;

(5) collect from each surplus lines agent a stamping fee for the costs of operations to be paid by the insured and determined by the department in an amount not to exceed three-fourths of one percent of gross premium resulting from surplus lines insurance contracts;

(6) employ persons;

(7) borrow money;

(8) enter into contracts;

(9) perform any other acts to facilitate or encourage compliance with this chapter and rules adopted under this chapter; and

(10) provide any other service incidental or related to an office purpose.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 981.155. SUPERVISION BY COMMISSIONER. The commissioner shall supervise the stamping office. The stamping office is subject to the applicable provisions of this code and rules of the commissioner.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 981.156. EXAMINATION BY COMMISSIONER. (a) The commissioner shall examine the stamping office at any time the commissioner considers an examination necessary.

(b) The stamping office shall pay the cost of the examination.

(c) During an examination, a stamping office board member, officer, agent, or employee:

(1) may be examined under oath regarding the operation of the office; and

(2) shall make available any book, record, account, document, or agreement relating to the operation of the office.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 981.157. IMMUNITY FROM LIABILITY. A person or entity is not liable for, and a cause of action does not arise out of, an act

or omission in performing a power or duty under this subchapter if the person or entity is:

(1) the stamping office or a board member, officer, agent, or employee of the stamping office; or

(2) the department or an employee or representative of the department, including the commissioner.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 981.158. EXEMPTION FROM PUBLIC INFORMATION LAW. (a) An individual surplus lines insurance contract filed with the stamping office is:

(1) confidential; and

(2) not public information under Chapter 552, Government Code.

(b) This section does not prevent access by a state agency to an individual surplus lines insurance contract filed with the stamping office.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 981.159. EXEMPTION FROM LIBRARY AND ARCHIVES LAW. Chapter 441, Government Code, does not apply to the stamping office or its records.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 981.160. NO ENFORCEMENT AUTHORITY. This subchapter does not give the stamping office authority to enforce this chapter or Chapter 225.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 2E.130, eff. April 1, 2009.

SUBCHAPTER E. SURPLUS LINES AGENTS

Sec. 981.201. DEFINITION. In this subchapter, "managing general agent" means an agent licensed under Chapter 4053.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.131, eff. April 1, 2009.

Sec. 981.202. SURPLUS LINES LICENSE REQUIRED. An agent licensed by this state may not issue or cause to be issued an insurance contract with an eligible surplus lines insurer unless the agent possesses a surplus lines license issued by the department.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 981.203. QUALIFICATIONS FOR SURPLUS LINES LICENSE. (a) The department may issue a surplus lines license to an applicant who the department determines complies with Subsection (b) and is:

(1) an individual who:

(A) has passed an examination under Chapter 4002 and department rules; and

(B) holds a current license as:

(i) a general property and casualty agent authorized under Subchapter B, Chapter 4051; or

(ii) a managing general agent; or

(2) a corporation, limited liability company, or partnership that:

(A) has at least one officer or director or at least one active partner who has passed the required surplus lines license examination;

(B) holds a current license as:

(i) a general property and casualty agent authorized under Subchapter B, Chapter 4051; or

(ii) a managing general agent; and

(C) conducts insurance activities under this chapter only through an individual licensed under this section.

(a-1) Notwithstanding Subsection (a)(1)(B), an individual is not required to obtain a general property and casualty agent license to hold a surplus lines agent license if:

- (1) the home state of each insured is Texas;
 - (2) the individual is a nonresident of this state;
 - (3) the individual is licensed as a surplus lines agent in the individual's state of residence;
 - (4) the individual is not required by the individual's state of residence to hold a general property and casualty agent license to become licensed as a surplus lines agent;
 - (5) the individual has provided information acceptable to the commissioner that the individual's state of residence does not require a general property and casualty agent license for a surplus lines agent license;
 - (6) the individual's state of residence does not require a surplus lines agent to search for the availability of insurance in the individual's state of residence before the insurance is placed through a surplus lines agent;
 - (7) the individual's state of residence allows a licensed general property and casualty agent to search for the availability of insurance in the individual's state of residence;
 - (8) the individual has a professional relationship with, and each transaction is conducted through, a person who:
 - (A) is a licensed general property and casualty agent in this state or in the state of each transaction; and
 - (B) searches for the availability of insurance in this state before the insurance is placed through a surplus lines agent; and
 - (9) each transaction complies with the laws of the state in which it occurs.
- (b) The agent must:
- (1) pay an application fee as determined by the department; and
 - (2) submit a properly completed license application.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.229(a), eff. Sept. 1, 2003.

Amended by:

Acts 2005, 79th Leg., Ch. 402 (S.B. [1564](#)), Sec. 1, eff. January 1, 2006.

Acts 2007, 80th Leg., R.S., Ch. 548 (S.B. [1263](#)), Sec. 2.09, eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.132, eff. April 1, 2009.

Acts 2009, 81st Leg., R.S., Ch. 87 (S.B. 1969), Sec. 14.012, eff. September 1, 2009.

Acts 2013, 83rd Leg., R.S., Ch. 562 (S.B. 697), Sec. 1, eff. January 1, 2014.

Sec. 981.204. CLASSIFICATION OF SURPLUS LINES AGENTS. The department may classify surplus lines agents and issue a surplus lines license to an agent in accordance with:

- (1) a classification created under this section; and
- (2) reasonable rules of the commissioner.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 981.210. PLACEMENT OF COVERAGE. A surplus lines agent may not place surplus lines coverage with an insurer unless:

- (1) the insurer meets the eligibility requirements of Subchapter B or B-1; and
- (2) the stamping office provides evidence to the department that the insurer meets those requirements.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 854 (H.B. 2492), Sec. 6, eff. January 1, 2018.

Sec. 981.211. FINANCIAL CONDITION OF SURPLUS LINES INSURERS.

(a) A surplus lines agent must make a reasonable effort to determine the financial condition of an eligible surplus lines insurer before placing insurance with that insurer.

(b) A surplus lines agent may not knowingly place surplus lines insurance with a financially unsound insurer.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 981.212. ACCEPTING SURPLUS LINES INSURANCE FROM OTHER

AGENTS. (a) A surplus lines agent may originate surplus lines insurance or accept surplus lines insurance from another agent who is licensed to handle the kind of insurance being accepted.

(b) A surplus lines agent who accepts surplus lines insurance from an agent may share a commission with that agent.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 981.213. FILING CONTRACT WITH STAMPING OFFICE. A surplus lines agent responsible under Section 225.006 for the filing, reporting, collection, payment, and other requirements imposed by Chapter 225 shall report to and file with the stamping office a copy of each surplus lines insurance contract as provided in the stamping office's plan of operation. The department may accept that filing instead of the filings required under Section 981.105.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 920 (H.B. 1405), Sec. 3, eff. January 1, 2014.

Sec. 981.214. COMPLIANCE WITH STAMPING OFFICE PLAN OF OPERATION. A surplus lines agent shall comply with the stamping office's plan of operation.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 981.215. SURPLUS LINES AGENT RECORDS. (a) A surplus lines agent shall maintain a complete record of each surplus lines contract obtained by the agent, including any of the following, if applicable:

- (1) a copy of the daily report;
- (2) the amount of the insurance and risks insured against;
- (3) a brief general description of the property insured and the location of that property;
- (4) the gross premium charged;
- (5) the return premium paid;
- (6) the rate of premium charged on the different items of

property;

- (7) the contract terms, including the effective date;
- (8) the insured's name and post office address;
- (9) the insurer's name and home office address;
- (10) the amount collected from the insured;
- (11) an agreement under Section 225.006(c);
- (12) evidence establishing that:

(A) the insured qualified as an exempt commercial purchaser and that the surplus lines agent complied with the requirements of Section 981.004(c) if a diligent effort to obtain insurance in the admitted market was not made pursuant to Section 981.004(a)(1); or

(B) the insured qualified as an industrial insured and that the surplus lines agent complied with the requirements of Section 981.004(d) if a diligent effort to obtain insurance in the admitted market was not made pursuant to Section 981.004(a)(1); and

- (13) any other information required by the department.

(b) The surplus lines agent shall keep the record required by this section open for examination by the department without notice at any time until the third anniversary of the date the surplus lines contract expires or is canceled.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.233(a), eff. Sept. 1, 2003.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 595 (S.B. 951), Sec. 9, eff. June 14, 2013.

Acts 2013, 83rd Leg., R.S., Ch. 920 (H.B. 1405), Sec. 4, eff. January 1, 2014.

Acts 2015, 84th Leg., R.S., Ch. 1236 (S.B. 1296), Sec. 11.002, eff. September 1, 2015.

Acts 2017, 85th Leg., R.S., Ch. 92 (H.B. 1559), Sec. 3, eff. September 1, 2017.

Sec. 981.216. ANNUAL REPORT. (a) Before March 1 of each year, a surplus lines agent shall submit a report to the department for the preceding calendar year.

(b) The commissioner shall adopt the form for the annual

report.

(c) The annual report must:

(1) demonstrate that the amount of insurance obtained from each eligible surplus lines insurer is only the amount that exceeds the amount obtainable from an authorized insurer; and

(2) include any other information required by the commissioner.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 981.217. NOTICE TO DEPARTMENT REQUIRED. (a) A surplus lines agent shall notify the department not later than the 30th day after the date any of the following occurs:

(1) balances due for more than 90 days to an eligible surplus lines insurer or for more than 60 days to the agent acting on behalf of the surplus lines insurer exceed \$1 million or 10 percent of the insurer's policyholder surplus calculated on December 31 of the preceding year;

(2) balances due for more than 60 days from a managing general agent or a local recording agent appointed by or reporting to the managing general agent exceed \$500,000;

(3) authority to settle claims for an eligible surplus lines insurer is withdrawn;

(4) funds held for an eligible surplus lines insurer for losses are greater than \$100,000 more than the amount necessary to pay losses and loss adjustment expenses expected to be paid on behalf of the insurer in the next 60-day period; or

(5) the agent's contract to act on behalf of a surplus lines insurer is canceled or terminated.

(b) The commissioner shall adopt the form to be used under Subsection (a).

(c) A surplus lines agent may comply with the notification requirement under Subsections (a)(1), (2), and (4) by submitting a single annual report if:

(1) the agent or applicable eligible surplus lines insurer routinely operates beyond the limits provided by those subdivisions; and

(2) the commissioner verifies that fact under a procedure adopted by the commissioner.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 981.218. DEPARTMENT MONITORING OF SURPLUS LINES AGENTS. The commissioner shall monitor the activities of surplus lines agents as necessary to protect the public interest.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.228(b), eff. Sept. 1, 2003.

Sec. 981.219. ADVERTISING. A surplus lines agent may advertise regarding the agent's ability to place surplus lines insurance permitted by this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 981.220. MANAGING GENERAL AGENTS; LIMITED AUTHORITY OF CERTAIN AGENTS. A surplus lines license granted to a managing general agent who is not also licensed under Chapter 4051 is limited to the acceptance of business originating through a licensed general property and casualty agent. The license does not authorize the agent to engage in business directly with the insurance applicant.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.234(a), eff. Sept. 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 548 (S.B. [1263](#)), Sec. 2.10, eff. September 1, 2007.

Sec. 981.221. SUSPENSION OR REVOCATION OF LICENSE. If a license holder does not maintain the qualifications necessary to obtain the license, the department may revoke or suspend the license or deny the renewal of that license in accordance with Chapter 4003 and Subchapters B and C, Chapter 4005.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.229(b), eff. Sept.

1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.134, eff. April 1, 2009.

Sec. 981.222. APPLICABILITY OF OTHER LAW. In addition to the requirements of this chapter, the administration and regulation of a surplus lines agent's license is governed by Title 13, except that the provisions of Sections 4001.002(b)(2)-(6), 4001.003, and 4001.004 and Subchapters C-G, Chapter 4001, do not apply to a license issued under this subchapter.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.229(c), eff. Sept. 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.135, eff. April 1, 2009.

Sec. 981.223. MANAGING UNDERWRITERS. (a) A managing underwriter with whom an insurance policy is placed in the manner described by Section 225.006(b) shall maintain appropriate records and make the records available for inspection by the department and the comptroller, including records of:

- (1) the name and address of the insured;
- (2) the policy number and policy period;
- (3) the name of the eligible surplus lines insurer;
- (4) the gross premium charged for the insurance;
- (5) the name of the surplus lines agent who placed the policy with the managing underwriter;
- (6) the license number of the surplus lines agent who placed the policy with the managing underwriter; and
- (7) an agreement, if any, under Section 225.006(c) that applies to the policy.

(b) A managing underwriter who acts as a surplus lines agent for a policy issued by an eligible surplus lines insurer shall maintain appropriate records and make the records available for inspection by the department and the comptroller, including the information listed in Subdivisions (a)(1) through (6). The records

must reflect the name and license number of the managing underwriter as the surplus lines agent placing the policy.

(c) A managing underwriter may hold both a surplus lines agent license and a managing general agent license.

Added by Acts 2011, 82nd Leg., R.S., Ch. 837 (H.B. 3410), Sec. 3, eff. January 1, 2012.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 920 (H.B. 1405), Sec. 5, eff. January 1, 2014.

CHAPTER 982. FOREIGN AND ALIEN INSURANCE COMPANIES

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 982.001. DEFINITIONS. In this chapter:

(1) "Accident insurance company," "health insurance company," "life insurance company," and "United States branch" have the meanings assigned by Section 841.001.

(2) "Alien insurance company" means an insurance company organized under the laws of a foreign country. The term includes an unincorporated insurance company (other than an unincorporated life insurance company, accident insurance company, life and accident insurance company, health and accident insurance company, or life, health, and accident insurance company) that is organized under the laws of a foreign country in a form recognized by the department.

(3) "Domestic insurance company" has, in the context of a life insurance company, accident insurance company, life and accident insurance company, health and accident insurance company, or life, health, and accident insurance company, the meaning assigned by Section 841.001.

(4) "Foreign insurance company" means an insurance company organized under the laws of another state of the United States.

(5) "Insurance company" means a company engaged as a principal in the business of insurance.

(6) "Policyholder" has, in the context of a life insurance company, accident insurance company, life and accident insurance company, health and accident insurance company, or life, health, and accident insurance company, the meaning assigned by Section 841.001.

(7) "Trusted asset" means an asset that an authorized alien insurance company is required or permitted by this chapter to

deposit with one or more trustees for the security of the company's policyholders in the United States.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 982.002. APPLICABILITY OF CHAPTER. This chapter applies to any insurance company that is organized under the laws of another state or country and that wants to engage in or is engaging in the business of insurance in this state.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 982.003. LIFE INSURANCE COMPANIES WANTING TO LOAN MONEY. A life insurance company that wants to loan money in this state but does not want to engage in the business of life insurance in this state may obtain from the secretary of state a permit to loan money by complying with the laws of this state relating to foreign corporations engaged in loaning money in this state without having to obtain a certificate of authority to engage in the business of life insurance in this state.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 982.004. FINANCIAL STATEMENTS OF FOREIGN OR ALIEN INSURANCE COMPANIES. (a) Each foreign insurance company shall file with the department a statement in the form required by Section 982.101 or 982.102 not later than March 1 of each year.

(b) Each authorized alien insurance company shall file with the department a financial statement in the form required by Section 982.252 not later than March 1 of each year.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER B. AUTHORITY TO ENGAGE IN BUSINESS

Sec. 982.051. CERTIFICATE OF AUTHORITY REQUIRED FOR LIFE, HEALTH, OR ACCIDENT COMPANIES. A foreign insurance company may not engage in the business of insurance as a life insurance company,

accident insurance company, life and accident insurance company, health and accident insurance company, or life, health, and accident insurance company in this state, except for the lending of money, without first obtaining from the department a certificate of authority that:

(1) shows that the foreign insurance company has fully complied with the laws of this state; and

(2) authorizes the foreign insurance company to engage in the business of insurance in this state.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 982.052. CERTIFICATE OF AUTHORITY REQUIRED FOR OTHER COMPANIES. Except as provided by Chapter 101 or 981, a foreign or alien insurance company, other than a life insurance company, accident insurance company, life and accident insurance company, or life, health, and accident insurance company, may not engage in this state in the business of insuring others against losses without first obtaining from the department a certificate of authority that authorizes the company to engage in that business.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER C. REQUIREMENTS FOR CERTIFICATE OF AUTHORITY

Sec. 982.101. FILING OF FINANCIAL STATEMENT BY LIFE, HEALTH, OR ACCIDENT INSURANCE COMPANY. A foreign or alien life insurance company, accident insurance company, life and accident insurance company, health and accident insurance company, or life, health, and accident insurance company that wants to engage in the business of insurance in this state shall provide to the department a written or printed statement, under the oath of the president or vice president or under the oath of the treasurer and secretary of the company, that shows:

- (1) the company's name and location;
- (2) the amount of the company's capital stock;
- (3) the amount of the company's paid up capital stock;
- (4) the company's assets, including in the following order:
 - (A) the amount of cash on hand;
 - (B) the amount of cash held by other persons and the

names and residences of those persons;

(C) unencumbered real estate, its location, and its value;

(D) bonds the company owns, the manner in which the bonds are secured, and the rate of interest on the bonds;

(E) debts due the company that are secured by mortgage, a description of the mortgaged property, and the property's market value;

(F) debts due the company that are secured other than by mortgage and a statement of how they are secured;

(G) debts due the company for premiums; and

(H) all other money and securities;

(5) the amount of the company's liabilities and the name of the person or corporation to whom each liability is owed;

(6) losses adjusted and due;

(7) losses adjusted and not due;

(8) losses adjusted;

(9) losses in suspense and the reason for the suspension;

(10) all other claims against the company and a description of each claim; and

(11) any additional facts required by the department to be shown.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 982.102. FILING OF FINANCIAL STATEMENT BY OTHER INSURANCE COMPANY; EXAMINATION. (a) This section applies only to a foreign or alien insurance company, other than a life insurance company, accident insurance company, life and accident insurance company, health and accident insurance company, or life, health, and accident insurance company.

(b) A foreign or alien insurance company that wants to engage in the business of insurance in this state shall provide to the department copies of its annual financial statements for the two most recent years. The copies must be certified by the commissioner or other insurance supervising official of the state or country in which the company is organized and incorporated. The department may require that the statement show additional facts as requested by the department.

(c) Before approving or denying the application of a foreign or alien insurance company for a certificate of authority to engage in the business of insurance in this state, the commissioner shall:

(1) examine the company, at the company's expense, at its principal office in the United States; or

(2) accept a report of an examination made by the insurance department or other insurance supervisory official of another state or government of a foreign country.

(d) On the applicant's request, the commissioner shall hold a hearing on a denial. Not later than the 30th day after the date of the applicant's request for a hearing, the commissioner shall request a hearing date.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1022 (H.B. [4291](#)), Sec. 17, eff. June 19, 2009.

Sec. 982.103. FILING OF FINANCIAL STATEMENT BY ALIEN INSURANCE COMPANY. An alien insurance company that wants to engage in the business of insurance in this state shall file a financial statement as provided by Section 982.252.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 982.104. FILING OF ARTICLES OF INCORPORATION. (a) A foreign or alien insurance company shall file with the statement required by Section 982.101 or 982.102:

(1) a copy of the company's acts or articles of incorporation and any amendments to those acts or articles; and

(2) a copy of the company's bylaws and a statement of the name and residence of each of the company's officers and directors.

(b) The president or the secretary of the company shall certify the documents filed under Subsection (a).

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 982.105. CAPITAL STOCK AND SURPLUS REQUIREMENTS FOR LIFE,

HEALTH, OR ACCIDENT INSURANCE COMPANIES. (a) A foreign or alien life insurance company, accident insurance company, life and accident insurance company, health and accident insurance company, or life, health, and accident insurance company is subject to Sections 841.054, 841.201, 841.204, 841.205, 841.207, 841.301, and 841.302. The department may not issue a certificate of authority to a foreign or alien stock insurance company, and the company may not engage in any business of life, health, or accident insurance in this state, unless the company possesses at least the minimum capital and surplus required for a similar domestic insurance company organized under Chapter 841 in similar circumstances. The minimum capital and surplus must be invested in the same character of investments as required for a domestic insurance company.

(b) The department may not issue a certificate of authority to a foreign or alien mutual insurance company, and the company may not engage in the business of life insurance in this state, unless the company possesses at least the minimum unencumbered surplus required by Chapter 882 for a similar domestic company in similar circumstances. The minimum unencumbered surplus must be invested in the same character of investments as required for a domestic insurance company.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 982.106. CAPITAL STOCK AND SURPLUS REQUIREMENTS FOR OTHER INSURANCE COMPANIES. (a) This section applies only to a foreign or alien insurance company other than a life insurance company, accident insurance company, life and accident insurance company, health and accident insurance company, or life, health, and accident insurance company.

(b) A foreign or alien insurance company is subject to Sections 822.203, 822.205, 822.210, and 822.212. The department may not authorize a foreign or alien insurance company to engage in the business of insurance in this state unless the company has and maintains the minimum capital and surplus amounts as required by this code for companies organized under this code and engaging in the same kinds of business.

(c) The department may not deny authorization for a foreign or alien insurance company to engage in the business of insurance in

this state because all of the company's capital stock has not been fully subscribed and paid for, if:

(1) at least the minimum dollar amount of capital stock of the company required by the laws of this state, which may be less than all of the company's authorized capital stock, has been subscribed and paid for; and

(2) the company:

(A) has at least the minimum dollar amount of surplus required by the laws of this state for the kinds of business the company seeks to write; and

(B) has fully complied with the laws of the company's domiciliary state or country relating to authorization and issuance of capital stock.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 982.107. APPLICABILITY OF OTHER LAW. Chapter 402 applies to a foreign or alien insurance company.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 2E.136, eff. April 1, 2009.

Sec. 982.108. DEPOSIT REQUIREMENTS FOR ALIEN INSURANCE COMPANY. An alien insurance company may not engage in the business of insurance in this state without first depositing with the comptroller, for the benefit of the company's policyholders who are citizens or residents of the United States, bonds or securities of the United States or this state in an amount at least equal to:

(1) the minimum capital required to be maintained by a domestic stock insurer authorized to engage in the same kind of insurance; or

(2) one-half the minimum unencumbered surplus required to be maintained by a domestic mutual insurer authorized to engage in the same kind of insurance.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 982.109. DURATION OF DEPOSIT BY LIFE, HEALTH, OR ACCIDENT INSURANCE COMPANIES. An alien life insurance company, accident insurance company, life and accident insurance company, health and accident insurance company, or life, health, and accident insurance company shall maintain the deposit required by Section 982.108 for the period that the company has any outstanding liability arising from its insurance transactions in the United States. The deposit is liable to pay the judgments, as decreed by courts, of the company's policyholders in the United States.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 982.110. DURATION OF DEPOSIT FOR OTHER INSURANCE COMPANIES. An alien insurance company, other than an alien life insurance company, accident insurance company, life and accident insurance company, health and accident insurance company, or life, health, and accident insurance company, shall maintain the deposit required by Section 982.108 for the period that the company has any outstanding liability arising from its insurance transactions in the United States. The deposit is for the exclusive benefit, security, and protection of the company's policyholders in the United States.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 982.111. EXCEPTION TO DEPOSIT REQUIREMENT: TRUSTEED ASSETS. (a) On approval by the commissioner as provided by Subchapter D, instead of making the deposit with the comptroller under Section 982.108, an authorized alien insurance company may deposit bonds or securities of the United States or this state with a trustee or trustees for the security of the company's policyholders in the United States.

(b) An alien insurance company shall maintain the deposit permitted by Subsection (a) as provided by Subchapter D.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 982.112. EXCEPTION TO DEPOSIT REQUIREMENT: DEPOSIT WITH OFFICER IN ANOTHER STATE. (a) The deposit required under Section

982.108 is not required in this state if the deposit required by that section has been made in any state of the United States, under the laws of that state, in a manner that secures equally the policyholders of the company who are citizens and residents of the United States.

(b) An alien insurance company that desires to meet the requirements of Section 982.108 as provided by Subsection (a) shall file with the department a certificate of the deposit. The certificate must be signed by and under the seal of the officer of the state with whom the deposit was made.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 982.113. ISSUANCE OF CERTIFICATE OF AUTHORITY TO LIFE, HEALTH, OR ACCIDENT INSURANCE COMPANY. (a) The commissioner shall file in the commissioner's office the documents delivered to the department under this subchapter and shall approve or deny an application for a certificate of authority.

(b) The commissioner shall issue to a foreign or alien life insurance company, accident insurance company, life and accident insurance company, health and accident insurance company, or life, health, and accident insurance company a certificate of authority to engage in this state in the kind of business specified in the documents if:

- (1) the company has complied with the requirements of this chapter and any other requirement imposed on the company by law; and
- (2) the company's operational history demonstrates that the expanded operation of the company in this state or its operations outside this state will not create a condition that might be hazardous to the company's policyholders or creditors or to the public.

(c) The operational history of a life insurance company, accident insurance company, life and accident insurance company, health and accident insurance company, or life, health, and accident insurance company under Subsection (b)(2) must be reviewed in conjunction with:

- (1) the company's loss experience;
- (2) the kinds and nature of risks insured by the company;
- (3) the company's financial condition and its ownership;

- (4) the company's proposed method of operation;
- (5) the company's affiliations;
- (6) the company's investments;
- (7) the company's contracts, if any, leading to contingent liability or agreements in respect to guaranty and surety, other than insurance; and
- (8) the ratio of total annual premium and net investment income to commission expenses, general insurance expenses, policy benefits paid, and required policy reserve increases.

(d) On the applicant's request, the commissioner shall hold a hearing on a denial. Not later than the 30th day after the date of the applicant's request for a hearing, the commissioner shall request a hearing date.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1022 (H.B. [4291](#)), Sec. 18, eff. June 19, 2009.

Sec. 982.114. PAYMENT OF TAX BY FOREIGN OR ALIEN LIFE INSURANCE COMPANY. (a) A foreign or alien life insurance company that obtains a certificate of authority under this subchapter on or after April 2, 1909, accepts that certificate and agrees to engage in the business of insurance in this state subject to a requirement that, if the company ceases to transact new insurance business in this state but continues to collect renewal premiums from residents of this state, the company shall continue to pay an occupation tax based on gross premiums for each year from residents of this state.

(b) The rate of the tax imposed by this section may not exceed the rate imposed by law on insurance companies transacting new insurance business in this state.

(c) The foreign or alien life insurance company shall pay the tax and make reports relating to its gross premium receipts in the same manner as a foreign or alien life insurance company that is transacting new insurance business in this state.

(d) The foreign or alien life insurance company is subject to examination by the department or by a department designee in the same manner and to the same extent as a company that is transacting new insurance business in this state.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 19, eff. April 1, 2005.

SUBCHAPTER D. TRUSTEED ASSETS OF ALIEN INSURANCE COMPANIES

Sec. 982.201. DEED OF TRUST: GENERAL PROVISIONS. (a) A deed of trust relating to the trustee assets of an authorized alien insurance company and all amendments to the deed of trust are effective only if approved by the commissioner.

(b) The deed of trust must contain provisions that:

(1) vest legal title to trustee assets in the trustee or trustees and the trustees' lawfully appointed successors, in trust for the security of the policyholders of the alien insurance company in the United States;

(2) provide for substitution of a new trustee or trustees, subject to the commissioner's approval, in the event of vacancy by death, resignation, or other incapacity; and

(3) require that the trustee or trustees continuously maintain a record sufficient to identify the trustee assets.

(c) The deed of trust may provide that income, earnings, dividends, or interest accumulations of the trustee assets may be paid over to the United States manager of the alien insurance company on request.

(d) The deed of trust and all amendments to the deed of trust must be authenticated in the form and manner prescribed by the commissioner.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 982.202. DEED OF TRUST: APPROVAL BY COMMISSIONER. (a) The commissioner shall approve a deed of trust relating to the trustee assets of an alien insurance company if the commissioner determines:

(1) the deed of trust or its amendments are sufficient in form and conform with applicable law;

(2) the trustee or trustees are eligible to serve in that capacity; and

(3) the deed of trust is adequate to protect the interests of the beneficiaries of the trust.

(b) If, after notice and hearing, the commissioner determines

that a requisite for approval of a deed of trust under Subsection (a) does not exist, the commissioner may withdraw approval.

(c) The commissioner may approve a change in any deed of trust that in the commissioner's judgment is in the best interests of the policyholders of the alien insurance company in the United States.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 982.203. LOCATION OF TRUSTEED ASSETS. (a) The trustee assets of an alien insurance company shall be kept continuously in the United States.

(b) The trustee assets of an alien insurance company that enters the United States through this state shall be kept continuously in this state.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 982.204. WITHDRAWAL OF TRUSTEED ASSETS. (a) The deed of trust relating to the trustee assets of an alien insurance company must provide that the trustee or trustees may not make or permit a withdrawal of assets, other than as specified by Section 982.201(c), without the commissioner's prior written approval except to:

(1) make deposits required by law in any state for the security or benefit of the policyholders of the company in the United States;

(2) substitute other assets permitted by law and at least equal in value to those withdrawn, subject to Subsection (b); or

(3) transfer the assets to an official liquidator or rehabilitator in accordance with an order of a court of competent jurisdiction.

(b) A withdrawal under Subsection (a)(2) may be made only on the specific written direction of the United States manager or an assistant United States manager when authorized and acting under general or specific written authority previously given or delegated by the board of directors.

(c) On withdrawal of trustee assets deposited in another state in which the alien insurance company is authorized to engage in the business of insurance:

(1) the deed of trust may require similar written approval

of the insurance supervising official of that state instead of the commissioner's approval as provided by Subsection (a); and

(2) if approval under Subdivision (1) is required, the company shall notify the commissioner in writing of the nature and extent of the withdrawal.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER E. TRUSTEED SURPLUS OF ALIEN INSURANCE COMPANIES

Sec. 982.251. TRUSTEED SURPLUS OF ALIEN INSURANCE COMPANY. The total value of an alien insurance company's general state deposits and trustee assets less the total net amount of all the company's liabilities and reserves in the United States, as determined in accordance with Section 982.252, is the company's trustee surplus in the United States.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 982.252. FORM AND CONTENTS OF FINANCIAL STATEMENT OF ALIEN INSURANCE COMPANY. (a) A financial statement required to be filed by an alien insurance company under Section 982.004 must be on a form prescribed by the commissioner and must show, as of the preceding December 31:

(1) the company's general deposits of assets in the United States deposited with officers of any state in trust for the exclusive benefit, security, and protection of the company's policyholders in the United States;

(2) the company's special deposits of assets in the United States deposited with officers of any state in trust for the exclusive benefit, security, and protection of the company's policyholders in a particular state;

(3) the company's trustee assets in the United States held for the exclusive benefit, security, and protection of the company's policyholders in the United States;

(4) the company's reserves and other liabilities arising out of policies or obligations issued, assumed, or incurred in the United States; and

(5) any further information as determined necessary to implement this section.

(b) In addition to the requirements under Subsection (a), a financial statement filed by an alien life insurance company must show the amount of the company's policy loans to policyholders in the United States, not exceeding the amount of the legal reserve required on each policy.

(c) In determining the net amount of an alien insurance company's liabilities in the United States, the company may deduct:

(1) reinsurance on losses with insurers qualifying for credit, less unpaid reinsurance premiums, with a schedule showing by company the amount deducted; and

(2) unearned premiums on agents' balances or uncollected premiums not more than 90 days past due.

(d) Any liability on an asset not considered in the statement may be applied against that asset.

(e) A special state deposit held for the exclusive benefit of policyholders of a particular state may be allowed as an offset against the alien insurance company's liabilities in that state only.

(f) The statement may include accrued interest at the date of the statement on assets deposited with states and trustees if the interest is collected by the states or trustees.

(g) The United States manager, attorney-in-fact, or authorized assistant United States manager of the alien insurance company shall sign and verify the statement. The United States trustee or trustees shall certify the items of securities and other property held under deeds of trust.

(h) The commissioner may at any time and for any period determined necessary require additional statements of the kind required by this section.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 982.253. IMPAIRMENT OF TRUSTEED SURPLUS. (a) If the commissioner determines from a statement filed under Section 982.252 or any report that an alien insurance company's trusteed surplus is less than the greater of the minimum capital required of, or the minimum surplus required to be maintained by, a domestic insurance company authorized to engage in the same kinds of insurance, the commissioner shall:

(1) determine the amount of the impairment; and

(2) order the company, through its United States manager or attorney, to eliminate the impairment within the period designated by the commissioner.

(b) The period for eliminating an impairment under Subsection (a) must end not later than the 90th day after the date the order is served.

(c) The commissioner may also by order revoke or suspend an alien insurance company's certificate of authority or prohibit the company from issuing new policies in the United States while an impairment under Subsection (a) exists.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 982.254. FAILURE TO ELIMINATE IMPAIRMENT OF TRUSTEED SURPLUS. If an alien insurance company has not satisfied the commissioner at the end of the designated period under Section 982.253(a) that the impairment has been eliminated, the commissioner may proceed against the company as provided by Chapter 441 as an insurance company whose further transaction of the business of insurance in the United States will be hazardous to its policyholders in the United States.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 2E.137, eff. April 1, 2009.

Sec. 982.255. EXAMINATION OF ALIEN INSURANCE COMPANY. (a) The books, records, accounting, and verification relating to an authorized alien insurance company's trusteed assets are subject to examination by the department or the department's appointed representative at the United States branch office of the company, in the same manner and to the same extent that applies under Subchapter A, Chapter 86, and Sections 401.051, 401.052, 401.054-401.062, 401.151, 401.152, 401.155, and 401.156 to domestic and foreign insurance companies authorized to engage in the same kind of insurance.

(b) The books, records, and accounting for trusteed assets of an alien insurance company that enters the United States through this

state shall be maintained in English in the company's branch office in this state.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.138, eff. April 1, 2009.

SUBCHAPTER F. PROVISIONS APPLICABLE TO CERTAIN COMPANIES

Sec. 982.301. **APPLICABILITY OF SUBCHAPTER.** This subchapter applies only to a foreign or alien insurance company that is not a life insurance company, accident insurance company, life and accident insurance company, health and accident insurance company, or life, health, and accident insurance company.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 982.302. **REINSURANCE NOT PROHIBITED.** This chapter does not prohibit a foreign insurance company from:

- (1) reinsuring a domestic insurance company; or
- (2) locating in this state, if the company does not directly insure persons domiciled in this state or insure against risks located in this state.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 982.303. **TEXAS LAW ACCEPTED.** A foreign or alien insurance company that issues a contract or policy in this state is considered to have agreed to comply with this code as a prerequisite to engaging in the business of insurance in this state.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 982.304. **SAME OR DECEPTIVELY SIMILAR NAME.** A foreign or alien insurance company may not be denied permission to engage in the business of insurance in this state because the name of the company is the same as or deceptively similar to the name of a domestic

corporation existing under the laws of this state or of another foreign or alien insurance company authorized to engage in the business of insurance in this state if the company desiring to engage in the business of insurance in this state:

(1) files with the department and with any county clerk as provided by Subchapter B or C, Chapter 71, Business & Commerce Code, an assumed name certificate stating a name permitted under the laws of this state; and

(2) does not engage in any business in this state except under the assumed name.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 885 (H.B. 2278), Sec. 2.21, eff. April 1, 2009.

Sec. 982.305. LIMITATION ON ACTIONS IN OTHER STATE COURTS. An action involving a contract entered into in this state between a foreign or alien insurance company and a resident of this state may not be brought in or transferred to a court in another state without the consent of the resident of this state.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

CHAPTER 983. REDOMESTICATION OF INSURERS AND HEALTH MAINTENANCE ORGANIZATIONS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 983.001. DEFINITION. In this chapter, "redomestication" means a change in domicile of an insurer or health maintenance organization by merger, consolidation, or another legal method.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 983.002. RULES. The commissioner may adopt rules as necessary to implement this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER B. REDOMESTICATION PROCESS

Sec. 983.051. REDOMESTICATION: FOREIGN TO DOMESTIC. (a) An insurer or health maintenance organization that is organized under the laws of another state and authorized to write insurance or provide a health care plan in this state may redomesticate to this state if:

(1) the entity amends or restates its articles of incorporation to comply with each requirement of this code relating to the organization and authorization of a domestic entity of the same type; and

(2) the commissioner approves the redomestication.

(b) An insurer or health maintenance organization that redomesticates under this section is:

(1) considered to be domiciled in this state; and

(2) entitled to a certificate of authority to engage in the business of insurance or the business of a health maintenance organization in this state as a domestic insurer or health maintenance organization, as applicable, without interruption of its authority to engage in business in this state.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 983.052. REDOMESTICATION: DOMESTIC TO FOREIGN. (a) An insurer or health maintenance organization that is organized under the laws of this state and authorized to write insurance or provide a health care plan in another state may redomesticate to that other state if the commissioner and the supervising regulatory official of the proposed state of domicile approve the redomestication.

(b) On the effective date of redomestication, the entity:

(1) ceases to be a domestic insurer or health maintenance organization, as applicable; and

(2) is a qualified foreign insurer or health maintenance organization, as applicable, in this state without interruption of its authority to engage in the business of insurance or the business of a health maintenance organization in this state.

(c) The commissioner may approve a proposed redomestication under this section unless the commissioner determines that:

(1) the proposed redomestication would not be in the interest of this state's policyholders or enrollees; or

(2) the entity cannot qualify for a certificate of authority in this state as a foreign insurer or health maintenance organization, as applicable.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 983.053. REDOMESTICATION: FOREIGN TO FOREIGN. (a) An insurer or health maintenance organization that is organized under the laws of another state and authorized to engage in the business of insurance or the business of a health maintenance organization in this state may redomesticate to another foreign state without interruption of its authority to engage in business in this state as a foreign insurer or health maintenance organization, as applicable, if:

(1) the entity:

(A) amends or restates its articles of incorporation as required by law; and

(B) provides proper notice to the commissioner; and

(2) the commissioner:

(A) determines that:

(i) the proposed redomestication would not, on the effective date of redomestication, result in a reduction in the amount of the entity's capital or surplus below the amount required for authorization as a foreign insurer or health maintenance organization, as applicable;

(ii) there would not be a material change in the lines of insurance to be written or health care plan provided by the entity;

(iii) the proposed redomestication has been approved by the supervising regulatory officials of both the current and proposed state of domicile;

(iv) the proposed redomestication would not be detrimental to the interest of the insurer's policyholders or the health maintenance organization's enrollees in this state; and

(v) the proposed redomestication is not related to a change in the control of the entity, unless the commissioner has given prior approval to the change in control; and

(B) approves the redomestication.

(b) Subsection (a)(2)(A)(v) does not apply if the

redomesticating insurer or health maintenance organization is to become a parent, subsidiary, or affiliate of a qualified insurer or health maintenance organization, as applicable, that has held a certificate of authority in this state for at least seven years before the date of the redomestication.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 983.054. NOTICE AND FILING REQUIRED. An insurer or health maintenance organization shall:

(1) notify the commissioner of the details of a proposed redomestication; and

(2) promptly file with the commissioner any amendments to its corporate documents filed or required to be filed with the commissioner.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 983.055. FORMS OF INSURANCE POLICY OR EVIDENCE OF COVERAGE. (a) A redomesticated insurer or health maintenance organization shall file with the commissioner a new insurance policy or evidence of coverage form, or an endorsement to an approved policy or evidence of coverage form, that implements the redomestication.

(b) The insurer or health maintenance organization, under conditions approved by the commissioner and with an appropriate endorsement, may continue to use an insurance policy or evidence of coverage form that was approved before the redomestication.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 983.056. OUTSTANDING INSURANCE POLICY OR EVIDENCE OF COVERAGE: CHANGE OF NAME. A redomesticating insurer or health maintenance organization that changes its name shall endorse each outstanding insurance policy or evidence of coverage with the new name.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 983.057. ISSUANCE OF AMENDED CERTIFICATE OF AUTHORITY. The commissioner shall issue an amended certificate of authority on approval of a redomestication.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER C. EFFECT OF REDOMESTICATION

Sec. 983.101. CONTINUATION OF BUSINESS. (a) If a redomesticating insurer or health maintenance organization remains qualified to engage in the business of insurance or the business of a health maintenance organization in this state, the following continue in effect after redomestication:

- (1) the approved agents' appointments and licenses;
- (2) the approved insurance policy forms and provider contracts;
- (3) the authorized premium rates;
- (4) the quality of care certificates; and
- (5) any other relevant item that exists on the effective date of the redomestication.

(b) Each outstanding insurance policy, evidence of coverage, provider contract, or quality of care certificate of a redomesticating insurer or health maintenance organization continues in effect after redomestication.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 983.102. EFFECT ON ADMITTED ASSETS. Except as provided by other law, the admitted assets of a redomesticating insurer or health maintenance organization that qualify, on the effective date of the redomestication, as admitted assets under this code continue to qualify as admitted assets after the redomestication.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

CHAPTER 984. MEXICAN CASUALTY INSURANCE COMPANIES

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 984.001. AUTHORITY OF MEXICAN CASUALTY INSURANCE COMPANIES. (a) An insurance company that complies with this chapter

may issue an insurance policy described by Subsection (b) as a Mexican casualty insurance company if the company is:

(1) organized under the laws of the United Mexican States or any state of that nation; and

(2) authorized to write insurance policies described by Subsection (b) by those laws, the company's charter or articles of association, and a license that is in effect and that is issued by the appropriate insurance regulatory authority of the United Mexican States or any state of that nation.

(b) A Mexican casualty insurance company described by Subsection (a) may issue in this state an insurance policy only if the policy:

(1) provides automobile coverage or accident or other casualty insurance coverage on a person or personal property; and

(2) is in effect only while the person or property covered by the policy is within the boundaries of the United Mexican States.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 984.002. AUTHORIZED AGENT REQUIRED. A Mexican casualty insurance company may engage in the business of insurance in this state only through an agent licensed by the department under Subchapters A-E and G, Chapter 4051, or Chapter 4055.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.235(a), eff. Sept. 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 2E.139, eff. April 1, 2009.

SUBCHAPTER B. AUTHORITY TO ENGAGE IN BUSINESS IN THIS STATE

Sec. 984.051. CERTIFICATE OF AUTHORITY REQUIRED. A Mexican casualty insurance company must hold a certificate of authority to engage in the business of insurance under this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 984.052. APPLICATION. (a) To issue insurance policies under this chapter, a Mexican casualty insurance company must file with the department an application for a certificate of authority under this chapter.

(b) The application must be:

- (1) in writing;
- (2) accompanied by a correct English translation of the company's charter and bylaws; and
- (3) certified by:
 - (A) two of the company's principal officers; and
 - (B) the insurance regulatory officials under whose supervision the company operates in the United Mexican States.

(c) Before the department issues a certificate of authority under this chapter to a Mexican casualty insurance company, the company must file with the department:

- (1) a photostatic copy of any license held by the company to engage in the business of insurance in the United Mexican States;
- (2) a copy of the company's most recent financial reports or statements; and
- (3) a copy of the most recent examination reports of the company's affairs and financial condition by the insurance regulatory authorities under which the company operates in the United Mexican States.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER C. DEPOSIT WITH COMPTROLLER

Sec. 984.101. DEPOSIT WITH COMPTROLLER REQUIRED. (a) A Mexican casualty insurance company shall deposit with the comptroller at least \$25,000 in:

- (1) United States currency; or
- (2) securities that are:
 - (A) eligible for other casualty insurance companies authorized to engage in the business of insurance in this state; and
 - (B) approved by the department.

(b) The deposit shall be used to pay any lawful claim or final judgment against the company, including any claim or judgment for tax due to this state and any policy claim or other debt or obligation incurred in the course of the company's operations as provided by

this chapter.

(c) The company shall periodically deposit additional currency or securities described by Subsection (a) as necessary to maintain a minimum total deposit of \$25,000.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 984.102. PAYMENTS FROM DEPOSIT. On approval of the department, the comptroller shall pay from the deposit required under this subchapter any unsatisfied final judgment obtained against the Mexican casualty insurance company in a court of this state based on substituted service as authorized by Chapter 804.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 984.103. RETURN OF DEPOSIT. With the approval of the department, the comptroller shall return the deposit required under this subchapter, or the unencumbered balance of the deposit, to the Mexican casualty insurance company on:

(1) the company's withdrawal from the business of insurance in this state; and

(2) a showing to the department that:

(A) each policy written by the company in this state has expired or been canceled; and

(B) each claim or obligation of the company on a policy written in this state that constitutes a lawful charge against the deposit has been satisfied.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER D. TAXES AND CHARGES; REPORTS

Sec. 984.151. PREMIUM TAX. (a) A Mexican casualty insurance company shall pay to this state an annual premium tax based solely on the company's gross premium receipts from insurance policies issued by the company in this state that cover resident citizens of this state or property or risks principally domiciled or located in this state, as shown by reports made to the department each year.

(b) The company shall pay the tax at the same percentage rate

and in the same manner that is required of other insurance companies authorized to write accident and casualty coverage in this state.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 984.152. OTHER TAXES AND CHARGES. In addition to paying a premium tax as required by Section 984.151, a Mexican casualty insurance company shall pay any other maintenance fee, charge, or tax that is required of other insurance companies authorized to write accident and casualty coverage in this state on the same basis as is required of those companies.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 984.153. REPORTS. A Mexican casualty insurance company shall make the same reports that other insurance companies authorized to write accident and casualty coverage in this state are required to make. The company shall make the reports on forms adopted by the department.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

SUBCHAPTER E. REGULATION AND ENFORCEMENT

Sec. 984.201. AGREEMENT TO COMPLY WITH CHAPTER. A Mexican casualty insurance company shall file in English a document executed by the company's officials expressly accepting the terms of this chapter and agreeing that the department may revoke, suspend, or refuse to grant a certificate of authority under this chapter on a determination by the commissioner that the company:

- (1) is insolvent or in hazardous financial condition; or
- (2) has violated an applicable law of this state or of the company's home jurisdiction.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 984.202. ANNUAL STATEMENT. A Mexican casualty insurance company shall file annually with the department each of the items

listed in Section 984.052(c).

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 984.203. AUTHORITY TO CONDUCT EXAMINATION. The department may examine at any time the affairs and condition and any books or records of a Mexican casualty insurance company, at the company's expense, to determine the company's:

- (1) financial condition and solvency; and
- (2) compliance with the applicable laws of this state and of the company's home jurisdiction.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 984.204. AUTHORITY TO REVOKE OR SUSPEND CERTIFICATE OF AUTHORITY. The commissioner may revoke or suspend a Mexican casualty insurance company's certificate of authority under this chapter if the commissioner, after notice and an opportunity for a hearing, determines that the company, with neglect and wilful disregard, systematically failed to comply with obligations derived from insurance policies issued in this state and the laws applicable to those policies.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

TITLE 7. LIFE INSURANCE AND ANNUITIES

SUBTITLE A. LIFE INSURANCE IN GENERAL

CHAPTER 1101. LIFE INSURANCE

SUBCHAPTER A. REQUIRED POLICY PROVISIONS

Sec. 1101.001. APPLICABILITY OF SUBCHAPTER. This subchapter applies to a life insurance policy:

- (1) issued or delivered in this state; or
- (2) issued by a life insurance company organized under the laws of this state.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1101.002. POLICY PROVISIONS REQUIRED. (a) Except as provided by this section, a life insurance policy must contain provisions that are substantially the same as the provisions required by this subchapter.

(b) A single premium life insurance policy is not required to contain a provision under this subchapter to the extent that the provision is not applicable to a single premium insurance policy.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1101.003. ENTIRE CONTRACT. A life insurance policy must provide that the policy or the policy and the application for the policy constitute the entire contract between the parties.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.204(a), (b), eff. Sept. 1, 2003.

Sec. 1101.004. PREMIUMS PAYABLE IN ADVANCE. A life insurance policy must provide that all premiums are payable in advance at the home office of the company that issues the policy or to an agent of the company on delivery of a receipt signed by at least one of the company officers designated in the policy.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1101.005. GRACE PERIOD. (a) Except as provided by Subsection (b), a life insurance policy:

(1) must contain a provision for a grace period of at least one month for the payment of each premium after the first payment during which the policy remains in force; and

(2) may:

(A) provide for an interest charge on a premium paid during a grace period; or

(B) provide that if an insured dies during a grace period the overdue premium will be deducted from any settlement made under the policy.

(b) The commissioner by rule may require a life insurance

policy issued under Section 884.402(3) to contain a grace period that is longer than the grace period required by this section.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1101.006. INCONTESTABILITY. (a) Except as provided by Subsection (b), a life insurance policy must provide that a policy in force for two years from its date of issue during the lifetime of the insured is incontestable, except for nonpayment of premiums.

(b) At the option of the company, a life insurance policy may provide that the policy may be contested at any time for violation of policy conditions relating to naval and military service in a time of war.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1101.007. STATEMENTS OF INSURED. A life insurance policy must provide that, in the absence of fraud, a statement made by an insured is considered a representation and not a warranty.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1101.008. ADJUSTMENT OF AMOUNT PAYABLE IF AGE OF INSURED IS UNDERSTATED. A life insurance policy must provide that if the age of an insured has been understated, the amount payable under the policy is the amount that the premium paid would have purchased if the insured's age had been stated correctly.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1101.009. POLICY LOANS. (a) The following policies are not required to comply with this section:

- (1) a term life insurance policy;
- (2) a pure endowment contract issued or granted:
 - (A) as an original contract; or
 - (B) in exchange for a lapsed or surrendered policy; or
- (3) a policy that does not provide for cash values or

nonforfeiture values and that meets the requirements of Section 884.403(b).

(b) A life insurance policy must provide that the company that issues the policy will loan to the policy owner at a specified interest rate an amount equal to the sum of the policy's cash value and any dividend additions to the policy, or, at the policy owner's option, an amount less than that sum, if:

(1) the policy is in force;

(2) the premiums for the policy have been paid for at least three full years; and

(3) the policy is properly assigned.

(c) A life insurance policy must also provide that:

(1) a policy loan is secured only by the policy;

(2) the company may deduct from a policy loan the sum of the amount of existing debt on the policy and the balance of unpaid premiums for the current policy year;

(3) the company may collect in advance interest on the policy loan to the end of the current policy year; and

(4) failure to repay the policy loan or interest on the loan does not void the policy until the total amount owed under the loan equals or exceeds the policy's cash value.

(d) A life insurance policy may provide that a policy loan may be deferred for a period not to exceed six months after the date the application for the loan is made.

(e) A life insurance policy may not require a prerequisite to a policy loan if the prerequisite is not required or authorized by this section.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1101.010. NONFORFEITURE BENEFITS AND CASH SURRENDER VALUES IN GENERAL. A life insurance policy must provide nonforfeiture benefits, including cash surrender values, in accordance with:

(1) Subchapter D; or

(2) Chapter 1105, for a policy issued on or after the date determined under Section 1105.002(a) or (b), as applicable.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1101.011. TIME FOR SETTLEMENT OF CLAIM. (a) Except as provided by Subsection (b), a life insurance policy must provide that settlement under the policy after the death of the insured will be made not later than two months after the date of receipt of proof of:

- (1) the death; and
- (2) the right of the claimant to the proceeds of the

policy.

(b) A private placement contract issued under Section 1152.110 may provide that:

(1) settlement of that portion of the contract attributable to separate account assets is subject to the liquidity of those assets; and

(2) the portion of the contract described by Subdivision (1) must be settled by the insurer when the separate account assets are converted to cash under any applicable terms, which may be a period longer than the two-month period described by Subsection (a).

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 737 (H.B. [2765](#)), Sec. 2, eff. September 1, 2007.

Sec. 1101.012. TABLE OF INSTALLMENTS OF PROCEEDS. A life insurance policy that provides that the policy proceeds are payable in installments must include a table that shows the amount of the installments.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1101.013. STATEMENT OF MAXIMUM AMOUNT PAYABLE UNDER FAMILY GROUP LIFE INSURANCE POLICY. A family group life insurance policy must clearly state:

(1) the maximum amount that is payable to the payee in the policy on the death of an insured or insureds; and

(2) any terms under which an amount other than the maximum amount of the policy is payable.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

SUBCHAPTER B. PROHIBITED POLICY PROVISIONS

Sec. 1101.051. APPLICABILITY OF SUBCHAPTER. Unless otherwise provided by this subchapter, this subchapter applies to a life insurance policy:

- (1) issued or delivered in this state; or
- (2) issued by a life insurance company organized in this state.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1101.052. EXCLUSION. Unless otherwise provided by this subchapter, this subchapter does not apply to a policy issued instead of or in exchange for a policy issued before July 10, 1909.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1101.053. CERTAIN LIMITATIONS PERIODS. A life insurance policy may not include a provision that limits the time during which an action under the policy may be commenced to a period of less than two years after the date the cause of action accrues.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1101.054. RETROACTIVE ISSUANCE OR EFFECT; EXCHANGE OR CONVERSION. (a) Except as provided by Subsection (b), a life insurance policy may not contain a provision under which the policy is issued or takes effect on a date more than six months before the date of the original policy application if the provision causes the insured to rate at an age that is younger than the age of the insured on the date of the application. For the purposes of this subsection, the age of the insured on the date of the application is the age of the insured on the birthday of the insured that is nearest to the date of the application.

(b) An issuer of a life or endowment insurance policy or annuity contract may, with the consent of the policyholder or contract holder, exchange the policy or contract for, or convert the policy or contract into, a policy of another plan of insurance or an endowment or annuity contract as of a date not earlier than the

effective date of the original policy or contract.

(c) If an exchange or conversion is made under Subsection (b) and the newly written policy or contract is issued as of a date earlier than the date of the application for exchange or conversion, the amount of life or endowment insurance or annuity provided under the newly written policy or contract may not exceed the greater of:

(1) the amount that the premium paid for the original policy or contract would have purchased on the plan of the newly written policy or contract for an individual the age of the insured on the effective date of the original policy or contract; or

(2) the amount of the original policy or contract.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1101.055. SETTLEMENT ON MATURITY LESS THAN FACE VALUE.

(a) Except as provided by Subsection (b), a life insurance policy may not contain a provision for a settlement at maturity that is less than the amount insured on the face of the policy plus the amount of any dividend additions to the policy minus the sum of the amount of any debt to the company that issues the policy and the amount of any premium that may be deducted from the settlement under the terms of the policy.

(b) A life insurance policy may provide for a settlement that will be less than the amount required under Subsection (a) if the death of the insured is:

(1) by the insured's own hand regardless of whether the insured is sane or insane;

(2) caused by following a hazardous occupation that is stated in the policy; or

(3) the result of aviation activities under conditions specified in the policy and approved by the department under Chapter 1701.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 2F.001, eff. April 1, 2009.

Sec. 1101.056. PRELIMINARY TERM INSURANCE OF MORE THAN ONE YEAR

IN LEVEL PREMIUM POLICY. (a) Sections 1101.051 and 1101.052 do not apply to this section.

(b) This section does not apply to a life insurance policy issued on or after the date determined under Section 1105.002(a) or (b), as applicable.

(c) A level premium life insurance policy may not be issued or sold in this state by any company if the policy provides for more than one year of preliminary term insurance.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

SUBCHAPTER C. POLICY PROVISIONS REQUIRED BY OTHER JURISDICTIONS

Sec. 1101.101. REQUIRED POLICY PROVISIONS. (a) A policy issued in this state by a life insurance company not organized under the laws of this state may contain any provision that the law of the state, territory, district, or county under which the company is organized requires the policy to contain.

(b) Notwithstanding Chapter 1701, a policy issued or delivered in another state, territory, district, or county by a life insurance company organized under the laws of this state may contain any provision required by the laws of that state, territory, district, or county.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2F.002, eff. April 1, 2009.

SUBCHAPTER D. RIGHTS OF INSURED UNDER CERTAIN OLDER POLICIES

Sec. 1101.151. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a life insurance policy issued before a date described by Section 1101.010(a)(2). A term life insurance policy is not required to comply with this subchapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1101.152. STIPULATED FORM OF INSURANCE. In case of a default in the payment of a premium after premiums have been paid for

three years, a life insurance policy to which this subchapter applies must contain a provision that secures a stipulated form of insurance on the life of the insured.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1101.153. COMPUTATION OF NET VALUE OF STIPULATED FORM OF INSURANCE. (a) Except as provided by Subsection (c), the net value of a life insurance policy secured under Section 1101.152 must be equal to the amount of the reserve on the policy for which premium payment is in default and on any dividend additions to that policy on the date of default, less the sum of:

(1) not more than two and one-half percent of the amount insured under the policy and any existing dividend additions to the policy; and

(2) the amount of any existing indebtedness to the company on the policy.

(b) The reserve described by Subsection (a) excludes any reserve for disability or accidental death benefits.

(c) The net value of a life insurance policy that is secured under Section 1101.152 for a policy other than an industrial life insurance policy and that is issued to insure a female risk may be computed using an age not more than three years younger than the actual age of the insured if the policy uses the same age differential to compute the policy reserve.

(d) Except as provided by Subsection (e), the amount of the policy reserve under Subsection (a) must be computed according to the mortality table, interest rate, and method adopted in the policy for computing the reserve.

(e) In computing the value of paid-up term insurance with any accompanying pure endowment, a rate of mortality may be assumed that is not more than:

(1) 130 percent of the rate of mortality according to the applicable table, or, for a substandard policy, the adopted multiple of that mortality rate, if the American Men Ultimate Table of Mortality or the Commissioners 1941 Standard Ordinary Mortality Table is adopted for computing the reserve; or

(2) the rate of mortality shown by the Commissioners 1958 Extended Term Insurance Table, or, for a substandard policy, the

adopted multiple of that mortality rate, if the Commissioners 1958 Standard Ordinary Mortality Table is adopted for computing the reserve.

(f) Subject to Subsection (g), a life insurance policy must state:

(1) the amount and term of the insurance to be secured in accordance with Section 1101.152 computed as if there were no indebtedness on the policy and no dividend additions to the policy; and

(2) the mortality table, interest rate, method, and, if the policy is issued to insure the life of a woman, any age differential, that will be used to compute the policy reserve.

(g) A mortality table, interest rate, method, or age differential stated under Subsection (f) must be authorized by law to compute the reserve liability on the policy.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1101.154. SURRENDER OF POLICY FOR SPECIFIED CASH SURRENDER VALUE. (a) A life insurance policy to which this subchapter applies must:

(1) provide within one month after a due date for a premium, after premiums have been paid for three years, the policy may be surrendered to the company that issues the policy at the company's home office in return for an amount equal to the cash value of the policy; and

(2) specify the cash value of the policy, which, subject to Subsection (b), may not be less than the amount that would otherwise be available to secure insurance in accordance with Section 1101.152.

(b) The cash value of the policy may not exceed the amount of the policy reserve.

(c) The policy may provide that the company that issues the policy may defer payment of the cash value of the policy for a period not to exceed six months after the date of application for the payment.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1101.155. CASH VALUE TABLE. A life insurance policy to

which this subchapter applies must include a table that shows in dollar amounts the cash value of the policy and the options available to the policy owner if the owner defaults in premium payments during each of the first 20 years that the policy will be in force or each of the years during which premiums are payable, beginning with the first year in which the cash values and options are available.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1101.156. PURCHASE OF OTHER INSURANCE AND REINSTATEMENT.

A life insurance policy to which this subchapter applies must provide that if there is a default in premium payments, the value of the policy shall be applied to the purchase of other insurance and the original life insurance policy may be reinstated within three years after the date of default if:

- (1) other insurance purchased with the value of the original life insurance policy remains in force;
- (2) the original life insurance policy has not been surrendered to the company and canceled;
- (3) the company receives evidence of insurability that is satisfactory to the company; and
- (4) the arrears of premiums are paid with interest.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

SUBCHAPTER E. DISCLOSURES AND NOTICES RELATING TO LIFE INSURANCE POLICIES WITH NON-GUARANTEED CHARGES

Sec. 1101.201. PURPOSE. This subchapter is intended to provide standards for disclosures relating to changes in certain non-guaranteed charges of life insurance policies subject to this subchapter.

Added by Acts 2019, 86th Leg., R.S., Ch. 1026 (H.B. 207), Sec. 1, eff. September 1, 2019.

Sec. 1101.202. DEFINITIONS. In this subchapter:

- (1) "Adverse change" means a change by an insurer in the insurer's current scale of charges applied to a policy that increases

a premium or charge to a policy owner.

(2) "Current scale of charges" means the scale or schedule of non-guaranteed charges in effect for a policy during the period of time immediately before an adverse change to the policy.

(3) "Non-guaranteed charges" means the scale or schedule of charges in a policy provision at the time the policy was issued that may be changed at the insurer's discretion without the consent or request of the policy owner. The term does not include a policy loan interest rate charged on a policy loan.

Added by Acts 2019, 86th Leg., R.S., Ch. 1026 (H.B. 207), Sec. 1, eff. September 1, 2019.

Sec. 1101.203. APPLICABILITY. (a) This subchapter applies to a life insurance policy issued by an insurer, as defined by Section 1102.001, that contains non-guaranteed charges that may change at the discretion of the insurer.

(b) This subchapter does not apply to:

(1) group life insurance without separately identifiable accounts for insureds;

(2) a life insurance policy in which the insurer assumes all risk and contractually guarantees a death benefit in exchange for a guaranteed premium set at the time of the policy's issuance;

(3) an individual or group annuity contract;

(4) credit life insurance;

(5) a life insurance policy with no illustrated death benefits on any individual exceeding \$10,000;

(6) a bank-owned or corporate-owned life insurance policy;

or

(7) a life insurance policy that does not provide for cash values or nonforfeiture values.

Added by Acts 2019, 86th Leg., R.S., Ch. 1026 (H.B. 207), Sec. 1, eff. September 1, 2019.

Sec. 1101.204. DISCLOSURE OF NON-GUARANTEED CHARGE INCREASE AFTER ISSUANCE OF POLICY. (a) If an insurer increases a non-guaranteed charge applied to a policy, the insurer must provide a written notice to the policy owner:

- (1) disclosing:
- (A) each non-guaranteed charge that has changed;
 - (B) the new scale of non-guaranteed charges after the change;
 - (C) the current scale of charges; and
 - (D) the guaranteed maximum scale of charges; and
- (2) including a prominent display of any adverse change in the current scale of charges identifying:
- (A) the nature of the change;
 - (B) that the change is adverse or the conditions under which the change would be adverse; and
 - (C) the new age and year at which the policy will lapse if there are no changes to payments or coverage.
- (b) The notice under Subsection (a) must include the insurer's telephone number and the following statement placed prominently on the front of the notice:
- "YOU SHOULD KNOW: This increase may change the value of your policy and may change how long your policy will last unless you increase your premium payments or reduce your coverage, if permitted under your policy. Ask your insurance company for an illustration, at no cost, that shows the effect of this change on your policy and discuss with your agent or financial advisor other options that are available to you."
- (c) The notice required by Subsection (a) must be given not later than the 90th day before the date the change is applied.
- (d) The notice required by Subsection (a) does not constitute an illustration, as defined by rules adopted by the department relating to life insurance illustrations.

Added by Acts 2019, 86th Leg., R.S., Ch. 1026 (H.B. 207), Sec. 1, eff. September 1, 2019.

Sec. 1101.205. DISCLOSURE OF CREDITED INTEREST RATE DECREASE AFTER ISSUANCE OF POLICY. (a) If an insurer decreases the credited interest rate paid on a policy's accumulation value, the insurer must provide annually a written notice to the policy owner:

- (1) disclosing:
- (A) the new current credited interest rate;
 - (B) the previous credited interest rate;

(C) the minimum credited interest rate stated in the policy; and

(D) the effective date of the change; and

(2) including a prominent display of the new age and year at which the policy will lapse based on all changes to non-guaranteed charges and the credited interest rate if there are no changes to payments or coverage.

(b) The notice under Subsection (a) must include the insurer's telephone number and the following statement placed prominently on the front of the notice:

"YOU SHOULD KNOW: This decrease may change the value of your policy and may change how long your policy will last unless you increase your premium payments or reduce your coverage. Ask your insurance company for an in-force illustration that shows the effect of this change on your policy and discuss with your agent or financial advisor other options that are available to you."

(c) Notwithstanding any other provision of this section, this section does not apply to or require disclosures for a variable universal or indexed life insurance policy.

Added by Acts 2019, 86th Leg., R.S., Ch. 1026 (H.B. 207), Sec. 1, eff. September 1, 2019.

Sec. 1101.206. ANNUAL ILLUSTRATION. Regardless of whether any non-guaranteed charges are changed, an insurer that issues a policy subject to this subchapter must offer to provide to the policy owner at least annually an in-force illustration. If the insurer has changed any non-guaranteed charges or the credited interest rate, the insurer must offer the illustration at no charge.

Added by Acts 2019, 86th Leg., R.S., Ch. 1026 (H.B. 207), Sec. 1, eff. September 1, 2019.

Sec. 1101.207. RULES. (a) The commissioner may adopt rules as necessary to implement this subchapter.

(b) The commissioner by rule may exempt certain types of life insurance policies from one or more of the requirements of this subchapter.

(c) Section 2001.0045, Government Code, does not apply to rules

adopted under this section.

Added by Acts 2019, 86th Leg., R.S., Ch. 1026 (H.B. 207), Sec. 1, eff. September 1, 2019.

SUBCHAPTER F. PROHIBITED PRACTICES RELATING TO PRESCRIPTION FOR OR OBTAINMENT OF OPIOID ANTAGONIST

Sec. 1101.251. DEFINITION. In this subchapter, "opioid antagonist" means any drug that binds to opioid receptors and blocks or otherwise inhibits the effects of opioids acting on those receptors to reverse the effects of an opioid overdose.

Added by Acts 2019, 86th Leg., R.S., Ch. 515 (S.B. 437), Sec. 1, eff. September 1, 2019.

Redesignated by Acts 2021, 87th Leg., R.S., Ch. 915 (H.B. 3607), Sec. 21.001(59), eff. September 1, 2021.

Sec. 1101.252. APPLICABILITY OF SUBCHAPTER. This subchapter applies to a life insurance policy:

- (1) issued or delivered in this state; or
- (2) issued by a life insurance company organized in this state.

Added by Acts 2019, 86th Leg., R.S., Ch. 515 (S.B. 437), Sec. 1, eff. September 1, 2019.

Redesignated by Acts 2021, 87th Leg., R.S., Ch. 915 (H.B. 3607), Sec. 21.001(59), eff. September 1, 2021.

Sec. 1101.253. PROHIBITION. A life insurance company may not, based solely on whether an individual has been prescribed or has obtained through a standing order an opioid antagonist:

- (1) deny coverage to the individual;
- (2) limit the amount, extent, or kind of coverage available to the individual; or
- (3) charge the individual or a group to which the individual belongs a rate that is different from the rate charged to other individuals or groups, respectively, for the same coverage, unless the charge is based on sound underwriting or actuarial

principles reasonably related to actual or anticipated loss experience for a particular risk.

Added by Acts 2019, 86th Leg., R.S., Ch. 515 (S.B. 437), Sec. 1, eff. September 1, 2019.

Redesignated by Acts 2021, 87th Leg., R.S., Ch. 915 (H.B. 3607), Sec. 21.001(59), eff. September 1, 2021.

CHAPTER 1102. PAYMENT OF INSURANCE BENEFITS IN CURRENCY

Sec. 1102.001. DEFINITIONS. In this chapter:

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

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

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

(C) industrial life insurance;

(D) accident or health insurance;

(E) group accident or health insurance;

(F) hospitalization insurance;

(G) group hospitalization insurance;

(H) medical or surgical insurance;

(I) group medical or surgical insurance; or

(J) fraternal benefit insurance.

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

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

(B) mutual life insurance company;

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

(D) mutual or natural premium life insurance company;

(E) general casualty company;

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

(G) fraternal benefit society; or

(H) group hospital service corporation.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

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

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1102.003. STATEMENT REGARDING VALUE OF FOREIGN CURRENCY.

(a) An insurance policy described by Section 1102.002 providing that benefits are payable in foreign currency must include a conspicuous statement that the value of the currency denominated in the policy can fluctuate as compared to the value of United States currency.

(b) The statement must be:

- (1) included as part of the policy; or
- (2) attached to the insurance policy at the time it is

issued.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1102.004. PREVIOUSLY APPROVED INSURANCE POLICY FORM PAYABLE IN FOREIGN CURRENCY. (a) The commissioner may disapprove or withdraw approval of a previously approved insurance policy form that provides benefits payable in foreign currency if the commissioner determines that the foreign currency has been less stable than United States currency in the previous 20-year period.

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

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

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

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 2F.003, eff. April 1, 2009.

Sec. 1102.005. RULES. The commissioner may adopt reasonable

rules to accomplish the purposes of this chapter, including rules requiring:

- (1) appropriate reserves for insurance policies subject to this chapter; or
- (2) prudent investment of premiums collected from insurance policies subject to this chapter regardless of any other provision of this code related to the investment of money by an insurance company.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

CHAPTER 1103. LIFE INSURANCE POLICY BENEFICIARIES
SUBCHAPTER A. STATUTORY LIFE INSURANCE BENEFICIARIES; INSURABLE INTEREST

Sec. 1103.001. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a life insurance policy issued by a legal reserve life insurance company.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1103.002. INSURABLE INTEREST OF BENEFICIARY. A beneficiary described by this subchapter who is designated in a life insurance policy has an insurable interest for the face amount of the policy and is entitled to collect that amount.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1103.003. CORPORATION, JOINT STOCK ASSOCIATION, OR TRUST ESTATE AS BENEFICIARY. A corporation, a joint stock association, or a trust estate that is engaging in business for profit may be designated as a beneficiary in a policy that insures the life of an officer or stockholder of the corporation, joint stock association, or trust estate.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1103.004. PARTNERSHIP OR PARTNER AS BENEFICIARY. A partnership or a member of a partnership may be designated as a

beneficiary in a policy that insures the life of a member of the partnership.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1103.005. RELIGIOUS, EDUCATIONAL, ELEEMOSYNARY, CHARITABLE, OR BENEVOLENT INSTITUTION OR UNDERTAKING AS BENEFICIARY. A religious, educational, eleemosynary, charitable, or benevolent institution or undertaking may be designated as a beneficiary in a policy that insures the life of an individual.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

SUBCHAPTER B. DESIGNATION OF BENEFICIARY OR OWNER OF LIFE INSURANCE POLICY; INSURABLE INTEREST

Sec. 1103.051. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a life insurance policy issued by:

- (1) a legal reserve life insurance company; or
- (2) a mutual assessment life insurance company.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1103.052. LIBERAL CONSTRUCTION. This subchapter shall be liberally construed to implement the purposes of this subchapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1103.053. INSURABLE INTEREST OF BENEFICIARY, OWNER, TRANSFEREE, OR ASSIGNEE. (a) Except as provided by Subsection (b), a beneficiary or owner of a life insurance policy who is designated in accordance with this subchapter or an entity to which a life insurance policy or an interest, benefit, right, or title in a life insurance policy is transferred or assigned in accordance with this subchapter has, at all times after the designation, an insurable interest in the life of the individual who is insured under the policy.

- (b) An individual, partnership, association, corporation, or

other legal entity that is directly or indirectly engaged in the business of burying the dead does not directly or indirectly have an insurable interest in the life of an individual unless the interest is established under other applicable statutory law or under common law.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.
Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.0225, eff. September 1, 2005.

Sec. 1103.054. DESIGNATION OF BENEFICIARY OR OWNER IN POLICY APPLICATION. An individual of legal age may:

(1) apply for a policy insuring the individual's life; and
(2) designate in writing in the application for the policy any individual, partnership, association, corporation, or other legal entity as:

(A) a beneficiary of the policy;
(B) an absolute or partial owner of the policy; or
(C) both a beneficiary and an absolute or partial owner of the policy.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1103.055. DESIGNATION OF BENEFICIARY OF POLICY; TRANSFER OR ASSIGNMENT OF POLICY OR INTEREST. An individual of legal age who is insured under a life insurance policy may in writing:

(1) in a manner and to the extent permitted by the policy, designate any individual, partnership, association, corporation, or other legal entity as a beneficiary of the policy; and

(2) in a manner and to the extent not prohibited by the policy, transfer or assign to any entity described by Subdivision (1):

(A) the policy; or
(B) an interest, benefit, right, or title in the policy.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1103.056. PURCHASE OF OR APPLICATION FOR POLICY BY THIRD PARTY. An individual of legal age may in a single written document:

(1) consent to the purchase of or application for an individual or group life insurance policy by a third party; and

(2) designate or consent to the designation of any individual, partnership, association, corporation, or other legal entity as:

(A) a beneficiary of the policy;

(B) an absolute or partial owner of the policy; or

(C) both a beneficiary and an absolute or partial owner of the policy.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

SUBCHAPTER C. PAYMENT OF PROCEEDS

Sec. 1103.101. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a life insurance policy issued by a legal reserve life insurance company.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1103.102. PAYMENT TO DESIGNATED BENEFICIARY. (a) Except as provided by Subsection (b) or (c), if an individual obtains a policy insuring the individual's life, designates in writing a beneficiary to receive the proceeds of the policy, and files the written designation with the company, the company shall pay the proceeds that become due on the death of the insured to the designated beneficiary.

(b) A company that issues a life insurance policy is not required to pay the proceeds of the policy to a designated beneficiary under Subsection (a) if the company receives notice of an adverse claim to the proceeds from a person who has a bona fide legal claim to all or part of the proceeds.

(c) A private placement contract issued under Section 1152.110 may provide that:

(1) settlement of that portion of the contract attributable to separate account assets is subject to the liquidity of those assets; and

(2) the portion of the contract described by Subdivision

(1) must be settled by the insurer when the separate account assets are converted to cash under any applicable terms, which may be a period longer than the two-month period described by Section 1101.011(a).

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 737 (H.B. 2765), Sec. 3, eff. September 1, 2007.

Sec. 1103.103. DISCHARGE OF LIABILITY. In the absence of notice under Section 1103.102(b) received by the company before the date of payment, a company that issues a life insurance policy is discharged from all liability under the policy if the company pays the proceeds of the policy to a designated beneficiary under Section 1103.102(a).

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1103.104. INTEREST ON PROCEEDS. (a) Interest on the proceeds of a life insurance policy accrues from the date the company that issues the policy receives due proof of loss until the date the company accepts the claim and offers to pay.

(b) Interest that accrues under this section shall be paid at the same time that the proceeds of the policy are paid under this subchapter.

(c) The interest rate under this section is the rate provided in the policy or, if a rate is not provided in the policy, the rate at which interest accrues on proceeds that are left on deposit with the company that issues the policy.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

SUBCHAPTER D. FORFEITURE OF BENEFICIARY'S RIGHTS

Sec. 1103.151. FORFEITURE. A beneficiary of a life insurance policy or contract forfeits the beneficiary's interest in the policy or contract if the beneficiary is a principal or an accomplice in wilfully bringing about the death of the insured.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1103.152. PAYMENT OF PROCEEDS TO CONTINGENT BENEFICIARY OR TO RELATIVE. (a) Except as provided by Subsection (b), if a beneficiary of a life insurance policy or contract forfeits an interest in the policy or contract under Section 1103.151, a contingent beneficiary named by the insured in the policy or contract is entitled to receive the proceeds of the policy or contract.

(b) A contingent beneficiary is not entitled to receive the proceeds of a life insurance policy or contract if the contingent beneficiary forfeits an interest in the policy or contract under Section 1103.151.

(c) If there is not a contingent beneficiary entitled to receive the proceeds of a life insurance policy or contract under Subsection (a), the nearest relative of the insured is entitled to receive those proceeds.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

CHAPTER 1104. LIFE INSURANCE AND ANNUITY CONTRACTS ISSUED TO CERTAIN PERSONS

SUBCHAPTER A. LIFE INSURANCE AND ANNUITY CONTRACTS WITH CERTAIN MINORS

Sec. 1104.001. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a policy or contract issued by a stock or mutual legal reserve life insurance company that:

- (1) is licensed by the department to transact the business of life insurance in this state; and
- (2) maintains the legal reserve required by state law.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1104.002. CERTAIN TRANSACTIONS EXEMPT. This subchapter does not apply to a transaction between an insurance company and a minor described by Section 1104.003(a) that occurs after the date the company receives at its home office or its principal office in this state written notice from a parent of the minor stating that a parent or the parents of the minor elect that this subchapter not apply to

the minor specifically named in the notice.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1104.003. AUTHORITY TO CONTRACT. (a) Subject to this subchapter, a minor 14 years of age or older who is without a guardian of the estate of the minor may:

(1) contract for or otherwise acquire a life, term, or endowment insurance policy or an annuity contract, including:

(A) applying for the policy or contract; and

(B) making agreements with respect to the policy or contract or a right, privilege, or benefit under the policy or contract;

(2) exercise all rights and powers in regard to the policy or contract in the same manner as an adult; and

(3) surrender an interest in the policy or contract and give a discharge for a benefit paid under the policy or contract.

(b) An insurance policy acquired by a minor under this subchapter must:

(1) be owned by the minor; and

(2) insure the life of:

(A) the minor;

(B) a spouse, child, parent, grandparent, or sibling of the minor; or

(C) another in whose life the minor has an insurable interest.

(c) A minor who acquires an annuity contract under this subchapter is the annuitant of the contract during the minor's life.

(d) A minor who acquires an insurance policy or an annuity contract under this subchapter, the estate of the minor, or a spouse, child, parent, grandparent, or sibling of the minor must be the beneficiary of the policy or, in the case of an annuity contract, of the death benefit of the contract.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1104.004. WRITTEN APPROVAL BY ADULT REQUIRED. An application or agreement made by a minor under this subchapter must be signed or approved in writing by:

(1) a parent, grandparent, or adult sibling of the minor;
or

(2) if the minor does not have a parent, grandparent, or adult sibling, an adult eligible under the Estates Code to be appointed guardian of the estate of the minor.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.
Amended by:

Acts 2017, 85th Leg., R.S., Ch. 324 (S.B. 1488), Sec. 22.048,
eff. September 1, 2017.

Sec. 1104.005. RESCISSION BECAUSE OF MINORITY PROHIBITED. A minor who acquires a policy or contract under this subchapter may not by reason of minority rescind, avoid, or repudiate:

- (1) the policy or contract; or
- (2) the exercise of a right or privilege, or the receipt of any benefit, under the policy or contract.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1104.006. EFFECT ON POLICY OR CONTRACT. This subchapter does not modify any provision in a policy or contract.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

SUBCHAPTER B. TRUSTEE NAMED AS BENEFICIARY OF LIFE INSURANCE POLICY

Sec. 1104.021. TRUSTEE NAMED AS BENEFICIARY IN POLICY. (a) An individual may make a trust agreement providing that the proceeds of a life insurance policy insuring the individual be made payable to a trustee named as beneficiary in the policy. The validity of a trust agreement or declaration of trust that is designated as a beneficiary of a life insurance policy is not affected by whether any corpus of the trust exists in addition to the right of the trustee to receive insurance proceeds.

(b) Life insurance policy proceeds described by Subsection (a) shall be paid to the trustee. The trustee shall hold and dispose of the proceeds as provided by the trust agreement.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.
Amended by:

Acts 2009, 81st Leg., R.S., Ch. 672 (H.B. 2368), Sec. 1, eff.
September 1, 2009.

Sec. 1104.022. TRUSTEE NAMED AS BENEFICIARY IN WILL. (a) A life insurance policy may provide that the beneficiary of the policy be a trustee designated by will in accordance with the policy provisions and the requirements of the insurance company.

(b) Except as provided by Subsection (c), on probate of a will described by Subsection (a), the life insurance policy proceeds shall be paid to the trustee. The trustee shall hold and dispose of the proceeds as provided under the terms of the will as the will existed on the date of the testator's death and in the same manner as other testamentary trusts are administered.

(c) Except as otherwise provided by agreement with the insurance company during the life of the insured, the insurance company shall pay the life insurance policy proceeds to the executors, administrators, or assigns of the insured if, during the 18-month period beginning on the first day after the date of the insured's death:

(1) a qualified trustee does not make to the insurance company a claim to the proceeds; or

(2) the insurance company is provided satisfactory evidence showing that there is or will be no trustee to receive the proceeds.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1104.023. DEBTS; INHERITANCE TAX. Life insurance policy proceeds received by a trustee under this subchapter are not subject to debts of the insured or to inheritance tax to any greater extent than if the proceeds were payable to a beneficiary other than the executor or administrator of the insured's estate.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1104.024. COMMINGLING. Life insurance policy proceeds received by a trustee under this subchapter may be commingled with

any other assets properly coming into the trust.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1104.025. CERTAIN PRIOR BENEFICIARY DESIGNATIONS NOT AFFECTED. This subchapter does not affect the validity of a life insurance policy beneficiary designation made before July 1, 1967, that names as beneficiary a trustee of a trust established by will.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

CHAPTER 1105. STANDARD NONFORFEITURE LAW FOR LIFE INSURANCE
SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1105.001. SHORT TITLE. This chapter may be cited as the Standard Nonforfeiture Law for Life Insurance.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1105.0015. DEFINITION. In this chapter, "operative date of the valuation manual" means the date, if any, on which the valuation manual described by Subchapter B, Chapter 425 (Standard Valuation Law), becomes operative as provided by that subchapter.

Added by Acts 2015, 84th Leg., R.S., Ch. 313 (S.B. 1654), Sec. 16, eff. September 1, 2015.

Sec. 1105.002. APPLICABILITY OF CHAPTER. (a) This chapter applies to a policy issued by a company on or after January 1, 1974.

(b) This chapter also applies to a policy issued by a company after a date specified in a written notice:

(1) that was filed by the company with the State Board of Insurance after August 23, 1963, but before January 1, 1974; and

(2) under which the company filing the notice elected to comply before January 1, 1974, with the law codified by this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1105.003. EXEMPTIONS. (a) This chapter does not apply to:

- (1) reinsurance;
- (2) group insurance;
- (3) pure endowment;
- (4) an annuity or reversionary annuity contract;
- (5) a term policy of uniform amount that:
 - (A) does not provide guaranteed nonforfeiture or endowment benefits or renewal of the policy;
 - (B) has a term of 20 years or less that expires before the insured reaches 71 years of age; and
 - (C) has uniform premiums that are payable during the entire term of the policy;
- (6) a term policy of decreasing amount:
 - (A) that does not provide guaranteed nonforfeiture or endowment benefits; and
 - (B) on which each adjusted premium, computed as specified by Subchapter B or D, is less than the adjusted premium computed in that manner for a term policy of uniform amount, or a renewal of a term policy of uniform amount, that:
 - (i) does not provide guaranteed nonforfeiture or endowment benefits;
 - (ii) is issued at the same age and for the same initial amount of insurance;
 - (iii) has a term of 20 years or less and expires before the insured reaches 71 years of age; and
 - (iv) has uniform premiums that are payable during the entire term of the policy;
- (7) a policy:
 - (A) that does not provide guaranteed nonforfeiture or endowment benefits; and
 - (B) for which no cash surrender value, if any, or present value of any paid-up nonforfeiture benefit, at the beginning of any policy year, computed as specified by Section 1105.007, 1105.008, 1105.009, Subchapter B, or Subchapter D, exceeds 2-1/2 percent of the amount of insurance at the beginning of the same policy year;
- (8) a policy delivered outside this state through an agent or other representative of the company that issued the policy; or
- (9) a policy that:

(A) does not provide for cash values or nonforfeiture values; and

(B) meets the requirements of Section 884.403(b).

(b) For purposes of determining the applicability of this chapter, the age at expiry of a joint term life insurance policy is the age at expiry of the oldest insured life on that date.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1105.004. REQUIRED NONFORFEITURE PROVISIONS. (a) A life insurance policy delivered or issued for delivery in this state must contain in substance the provisions prescribed by Subsections (b), (c), and (d) or corresponding provisions that:

(1) in the opinion of the department, are at least as favorable to the defaulting or surrendering policyholder; and

(2) essentially comply with Section 1105.012.

(b) A life insurance policy must provide that if there is a default in the payment of a premium the company, on proper request not later than the 60th day after the due date of the premium that is in default, will grant a paid-up nonforfeiture benefit on a plan stipulated in the policy, effective as of that due date, in the amount specified by this chapter. A company may substitute for the paid-up nonforfeiture benefit required by this subsection an actuarially equivalent alternative paid-up nonforfeiture benefit that provides a greater amount or longer period of death benefits or, if applicable, a greater amount or earlier payment of endowment benefits. To elect an alternative paid-up nonforfeiture benefit under this subsection, the person entitled to make the election must submit a proper request not later than the 60th day after the due date of the premium that is in default.

(c) A life insurance policy must:

(1) provide that on surrender of the policy not later than the 60th day after the due date of a premium payment that is in default the company will pay, in lieu of a paid-up nonforfeiture benefit, a cash surrender value in the amount specified by this chapter if the premiums have been paid for at least:

(A) three full years for a policy of ordinary insurance; or

(B) five full years for a policy of industrial

insurance;

(2) provide that a specified paid-up nonforfeiture benefit is effective as specified by the policy unless the person entitled to make the election elects another available option not later than the 60th day after the due date of a premium payment that is in default; and

(3) provide that on surrender of the policy not later than the 30th day after any policy anniversary the company will pay a cash surrender value in the amount specified by this chapter if:

(A) the policy has become paid up by completion of all premium payments; or

(B) the policy is continued under a paid-up nonforfeiture benefit that became effective on or after:

(i) the third policy anniversary for a policy of ordinary insurance; or

(ii) the fifth policy anniversary for a policy of industrial insurance.

(d) A life insurance policy must contain:

(1) subject to Subsection (e), a statement of:

(A) the mortality table, interest rate, and method used to compute the cash surrender values and the paid-up nonforfeiture benefits available under the policy, if the policy:

(i) causes, on a basis guaranteed by the policy, unscheduled changes in benefits or premiums; or

(ii) provides an option for changes in benefits or premiums other than a change to a new policy; or

(B) the mortality table and interest rate used to compute the cash surrender values and the paid-up nonforfeiture benefits available under the policy, with a table showing the cash surrender value, if any, and paid-up nonforfeiture benefit, if any, available under the policy on each policy anniversary during the first 20 policy years or the term of the policy, whichever is shorter, if the policy is a policy other than one described by Paragraph (A)(i) or (ii);

(2) a statement that the cash surrender values and the paid-up nonforfeiture benefits available under the policy are not less than the minimum values and benefits required by the insurance laws of this state;

(3) an explanation of the manner in which the cash surrender values and the paid-up nonforfeiture benefits are altered

by the existence of any paid-up additions credited to the policy or any indebtedness to the company on the policy and, if a detailed statement of the method used to compute the values and benefits shown in the policy is not stated in the policy, a statement that the method of computation has been filed with the department; and

(4) a statement of the method to be used to compute the cash surrender value and paid-up nonforfeiture benefit available under the policy on any policy anniversary after the last anniversary for which those values and benefits are consecutively shown in the policy.

(e) The values and benefits described by Subsection (d)(1)(B) must be computed on the assumption that:

(1) there are no dividends or paid-up additions credited to the policy; and

(2) there is no indebtedness to the company on the policy.

(f) A provision prescribed by Subsection (b), (c), or (d) or a portion of a provision that does not apply because of the plan of insurance may, to the extent inapplicable, be omitted from the policy.

(g) A company shall reserve the right to defer payment of any cash surrender value for a period of six months after demand for payment of the cash surrender value and surrender of the policy.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1105.005. COMPUTATION OF ADJUSTED PREMIUMS AND PRESENT VALUES; MORTALITY TABLES AND INTEREST RATES. (a) Except as provided by Subsection (b) or (e) or Section 1105.055, 1105.152, or 1105.153, an adjusted premium or present value determined under this chapter must be computed on the basis of:

(1) the Commissioners 1941 Standard Ordinary Mortality Table for a policy of ordinary insurance; and

(2) the Commissioners 1941 Standard Industrial Mortality Table for a policy of industrial insurance.

(b) For a category of ordinary insurance issued to insure a female risk, an adjusted premium or present value may be computed according to an age not more than three years younger than the actual age of the insured.

(c) All computations must be made using the rate of interest,

not to exceed 3-1/2 percent a year, specified by the policy for computing cash surrender values and paid-up nonforfeiture benefits.

(d) In the computation of the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than 130 percent of the rates shown in the applicable mortality table.

(e) Subject to approval by the department, a company may specify a mortality table other than the applicable table required by this section for use in computing an adjusted premium or present value for insurance issued on a substandard basis.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1105.006. DETERMINATION OF RATED AGE. For purposes of this chapter, the date a policy is issued is the date as of which the rated age of the insured is determined.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1105.007. COMPUTATION OF CASH SURRENDER VALUE FOLLOWING DEFAULT. (a) Any cash surrender value available under a policy on a default in payment of a premium due on a policy anniversary, regardless of whether required by Section 1105.004, must be an amount not less than the amount, if any, by which the present value, on the policy anniversary, of the future guaranteed benefits that would have been available under the policy, including any existing paid-up additions, had there not been a default exceeds the sum of:

(1) the then present value of the adjusted premiums as determined under Subchapter B or D that correspond to premiums that would have become due on and after the policy anniversary; and

(2) the amount of any indebtedness to the company on the policy.

(b) Subsection (a) does not require a cash surrender value greater than the reserve for the policy computed as provided by Subchapter B, Chapter 425.

(c) For a policy to which Subchapter B applies and that by rider or supplemental policy provision provides supplemental life insurance or annuity benefits at the option of the insured and for an

identifiable additional premium, the cash surrender value computed under Subsection (a) must be an amount not less than the sum of:

(1) the cash surrender value as computed under Subsection (a) for an otherwise similar policy issued at the same age without the rider or supplemental policy provision; and

(2) the cash surrender value as computed under Subsection (a) for a policy that provides only the benefits provided by the rider or supplemental policy provision.

(d) For a family policy to which Subchapter B applies and that defines a primary insured and provides term insurance on the life of the spouse of the primary insured that expires before the spouse reaches 71 years of age, the cash surrender value as computed under Subsection (a) must be an amount not less than the sum of:

(1) the cash surrender value as computed under Subsection (a) for an otherwise similar policy issued at the same age that does not provide the term insurance on the life of the spouse; and

(2) the cash surrender value as computed under Subsection (a) for a policy that provides only the benefits provided by the term insurance on the life of the spouse.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 2F.004, eff. April 1, 2009.

Sec. 1105.008. COMPUTATION OF CASH SURRENDER VALUE ON SURRENDER FOLLOWING POLICY ANNIVERSARY. Any cash surrender value available not later than the 30th day after the date of a policy anniversary under a policy paid up by completion of all premium payments or a policy continued under any paid-up nonforfeiture benefit, regardless of whether required by Section 1105.004, must be an amount not less than the present value, on the policy anniversary, of the future guaranteed benefits available under the policy, including any existing paid-up additions, less any indebtedness to the company on the policy.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1105.009. COMPUTATION OF PAID-UP NONFORFEITURE BENEFITS.

Any paid-up nonforfeiture benefit available under the policy on default in the payment of a premium due on a policy anniversary must be such that its present value as of the policy anniversary is at least equal to:

(1) the cash surrender value then available under the policy; or

(2) if a cash surrender value is not available under the policy, the cash surrender value that would have been required by this chapter in the absence of the condition that premiums must have been paid for at least a specified period.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1105.010. PRORATION OF VALUES; NET VALUE OF PAID-UP ADDITIONS. (a) Any cash surrender value and any paid-up nonforfeiture benefit available under a policy on default in the payment of a premium due at any time other than on the policy anniversary must be computed with allowance for the lapse of time and the payment of fractional premiums after the preceding policy anniversary, except that a cash surrender value or nonforfeiture benefit is not required unless the cash surrender value or nonforfeiture benefit was required on the preceding policy anniversary.

(b) A value determined under Sections 1105.005-1105.009, Subchapter B, or Subchapter D may be computed on the assumption that any death benefit is payable at the end of the policy year of death.

(c) The net value of any paid-up additions, other than paid-up term additions, may not be less than the amounts used to provide those additions.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1105.011. INCLUSION OF CERTAIN ADDITIONAL BENEFITS IN COMPUTING NONFORFEITURE BENEFITS NOT REQUIRED. (a) Notwithstanding Section 1105.007 or 1105.008, additional benefits described by Subsection (b), and premiums for those benefits, may not be included in computing a cash surrender value or nonforfeiture benefits required by this chapter. Additional benefits described by Subsection (b) are not required to be included in any paid-up

nonforfeiture benefits.

(b) This section applies to additional benefits payable:

(1) in the event of death or dismemberment by accident;

(2) in the event of total and permanent disability;

(3) as reversionary annuity or deferred reversionary annuity benefits;

(4) as term insurance benefits provided by a rider or supplemental policy provision to which, if issued as a separate policy, this chapter would not apply;

(5) as term insurance on the life of a child that:

(A) is provided in a policy on the life of a parent of the child;

(B) expires before the child reaches 26 years of age;

(C) is uniform in amount after the child reaches one year of age; and

(D) has not become paid up by reason of the death of a parent of the child; or

(6) as other policy benefits additional to life insurance and endowment benefits.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1105.012. PROGRESSION OF CASH SURRENDER VALUES. (a) This section applies only to a policy issued on or after January 1, 1985.

(b) Any cash surrender value available under a policy to which this section applies on default in the payment of a premium due on any policy anniversary must be in an amount that does not differ by more than two-tenths of one percent of the amount of insurance, if the insurance is uniform in amount, or the average amount of insurance at the beginning of each of the first 10 policy years, from the sum of:

(1) the greater of:

(A) zero; or

(B) the basic cash value as determined under Subsection

(c); and

(2) the present value of any existing paid-up additions minus the amount of any indebtedness to the company under the policy.

(c) The basic cash value must be equal to the present value, on the applicable policy anniversary, of the future guaranteed benefits

that would have been available under the policy, excluding any existing paid-up additions and before deduction of any indebtedness to the company, had there not been a default, less the then present value of the nonforfeiture factors specified by Subsection (d) corresponding to premiums that would have become due on and after that anniversary. The effects on the basic cash value of supplemental life insurance or annuity benefits or of family coverage, as described by Section 1105.007 or 1105.151, as applicable, must be the same as the effects specified by Section 1105.007 or 1105.151, as applicable, on the cash surrender values determined under the applicable section.

(d) The nonforfeiture factor for each policy year must be an amount equal to a percentage of the adjusted premium for the policy year, as computed under Section 1105.052 or 1105.151, as applicable. That percentage must:

(1) be the same percentage for each policy year between the second policy anniversary and the later of:

(A) the fifth policy anniversary; or

(B) the first policy anniversary at which there is available under the policy a cash surrender value in an amount, before including any paid-up additions and before deducting any indebtedness, of at least two-tenths of one percent of:

(i) the amount of insurance, if the insurance is uniform in amount; or

(ii) the average amount of insurance at the beginning of each of the first 10 policy years; and

(2) be such that each percentage after the later of the policy anniversaries specified by Subdivision (1) applies to at least five consecutive policy years.

(e) Notwithstanding Subsection (d), the basic cash value may not be less than the value that would be obtained if the adjusted premiums for the policy, as computed under Section 1105.052 or 1105.151, as applicable, were substituted for the nonforfeiture factors in the computation of the basic cash value.

(f) In this section:

(1) an adjusted premium or present value for a particular policy must be computed on the same mortality and interest bases as those used to demonstrate that the policy complies with the other sections of this chapter; and

(2) the cash surrender values must include any endowment

benefits available under the policy.

(g) The amount of any cash surrender value available other than on default in payment of a premium due on a policy anniversary, and the amount of any paid-up nonforfeiture benefits available under the policy on default in the payment of a premium, must be determined in a manner consistent with the manner specified by Section 1105.004, 1105.007, 1105.008, 1105.009, 1105.010, 1105.011, or Subchapter B to determine the analogous minimum amount. The amounts of any cash surrender value or paid-up nonforfeiture benefits granted in connection with additional benefits, such as those listed in Section 1105.011(b), must comply with the principles of this section.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

**SUBCHAPTER B. COMPUTATION OF ADJUSTED PREMIUMS USING NONFORFEITURE
NET LEVEL PREMIUM METHOD**

Sec. 1105.051. APPLICABILITY OF SUBCHAPTER. (a) This subchapter applies to a policy issued on or after January 1, 1989.

(b) This subchapter also applies to a policy issued by a company after the date specified in a written notice:

(1) that was filed with the State Board of Insurance after August 31, 1981, but before January 1, 1989; and

(2) under which the company filing the notice elected to comply before January 1, 1989, with the law codified by this subchapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1105.052. COMPUTATION OF ADJUSTED PREMIUMS USING NONFORFEITURE NET LEVEL PREMIUM METHOD. (a) Except as provided by Section 1105.054 and subject to Subsection (b), the adjusted premiums for a policy to which this section applies must be computed on an annual basis and must be a uniform percentage of the respective premiums specified by the policy for each policy year so that the present value, at the date of issue of the policy, of all adjusted premiums is equal to the sum of:

(1) the then present value of the future guaranteed benefits available under the policy;

(2) one percent of:

(A) the amount of insurance, if the insurance is uniform in amount; or

(B) the average amount of insurance at the beginning of each of the first 10 policy years; and

(3) 125 percent of the nonforfeiture net level premium as determined under Subsection (d).

(b) The amount of premiums specified by the policy and used in computing adjusted premiums under Subsection (a) does not include:

(1) an amount payable as an extra premium to cover an impairment or special hazard; or

(2) any uniform annual contract charge or policy fee specified by the policy in a statement of the method to be used to compute the cash surrender values and paid-up nonforfeiture benefits.

(c) In applying the percentage specified by Subsection (a)(3), a nonforfeiture net level premium may not be considered to exceed four percent of:

(1) the amount of insurance, if the insurance is uniform in amount; or

(2) the average amount of insurance at the beginning of each of the first 10 policy years.

(d) The nonforfeiture net level premium must be equal to the present value, at the date of issue of the policy, of the guaranteed benefits available under the policy divided by the present value, on the date of issue of the policy, of an annuity of one per year payable on the date of issue of the policy and on each anniversary of the policy on which a premium becomes due.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1105.053. COMPUTATION OF AMOUNTS FOR POLICY WITH CHANGING BENEFITS OR PREMIUMS. (a) This section applies only to a policy that:

(1) causes, on a basis guaranteed by the policy, unscheduled changes in benefits or premiums; or

(2) provides an option for changes in benefits or premiums other than a change to a new policy.

(b) The adjusted premiums and present values as to a policy to which this section applies must initially be computed on the assumption that future benefits and premiums will not change from

those specified on the date the policy is issued. At the time of a change in the benefits or premiums, the future adjusted premiums, nonforfeiture net level premiums, and present values must be recomputed on the assumption that future benefits and premiums will not change from those specified by the policy immediately after the change.

(c) Except as provided by Section 1105.054, the recomputed future adjusted premiums as to a policy to which this section applies must be a uniform percentage of the respective future premiums specified by the policy for each policy year, so that the present value, at the time of change to the newly defined benefits or premiums, of all future adjusted premiums is equal to the amount by which the sum of the then present value of the then future guaranteed benefits available under the policy and the additional expense allowance, as computed under Subsection (e), if any, exceeds the then cash surrender value, if any, or present value of any paid-up nonforfeiture benefit under the policy.

(d) The amount of future premiums specified by the policy and used in computing adjusted premiums under Subsection (c) does not include:

- (1) an amount payable as an extra premium to cover an impairment or special hazard; or
- (2) any uniform annual contract charge or policy fee specified by the policy in a statement of the method to be used to compute the cash surrender values and paid-up nonforfeiture benefits.

(e) The additional expense allowance, at the time of the change to the newly defined benefits or premiums, is the sum of:

- (1) one percent of the amount, if any, by which the average amount of insurance at the beginning of each of the first 10 policy years after the change exceeds the average amount of insurance before the change at the beginning of each of the first 10 policy years after the time of the most recent previous change or, if there has not been a previous change, the date the policy is issued; and
- (2) 125 percent of any increase in the nonforfeiture net level premium.

(f) The recomputed nonforfeiture net level premium must be equal to the quotient of:

- (1) the sum of:
 - (A) the nonforfeiture net level premium applicable before the change multiplied by the present value of an annuity of

one per year payable on each anniversary of the policy on or after the date of the change on which a premium would have become due had the change not occurred; and

(B) the present value of the increase in future guaranteed benefits available under the policy; divided by

(2) the present value of an annuity of one per year payable on each anniversary of the policy, on or after the date of the change, on which a premium becomes due.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1105.054. COMPUTATION OF AMOUNTS FOR POLICY ISSUED ON SUBSTANDARD BASIS. (a) This section applies only to a policy issued on a substandard basis that provides reduced graded amounts of insurance so that, in each policy year, the policy has the same tabular mortality cost as an otherwise similar policy issued on the standard basis that provides higher uniform amounts of insurance. This section applies notwithstanding any provision of this subchapter to the contrary.

(b) Adjusted premiums and present values as to a policy to which this section applies may be computed as if the policy were issued to provide the higher uniform amounts of insurance of an otherwise similar policy issued on the standard basis.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1105.055. USE OF MORTALITY TABLES AND INTEREST RATES WITH NONFORFEITURE NET LEVEL PREMIUM METHOD. (a) Subject to Subsections (c)-(i), an adjusted premium or present value computed under this subchapter must be computed:

(1) for a policy of ordinary insurance:

(A) on the basis of the Commissioners 1980 Standard Ordinary Mortality Table; or

(B) at the option of the company for any one or more specified plans of life insurance, on the basis of the Commissioners 1980 Standard Ordinary Mortality Table with Ten-Year Select Mortality Factors; and

(2) for a policy of industrial insurance, on the basis of the Commissioners 1961 Standard Industrial Mortality Table.

(b) Subject to Subsections (c)-(i), computations on each policy issued in a particular calendar year must be made using a rate of interest not to exceed the nonforfeiture interest rate as defined by Section 1105.056 for a policy issued in that calendar year.

(c) At the option of the company, computations for each policy issued in a particular calendar year may be made using a rate of interest not to exceed the nonforfeiture interest rate, as defined by Section 1105.056, for a policy issued in the preceding calendar year.

(d) Under any paid-up nonforfeiture benefit, including any paid-up dividend additions, any cash surrender value available, regardless of whether required by Section 1105.004, must be computed on the basis of the mortality table and rate of interest used to determine the amount of the paid-up nonforfeiture benefit and any paid-up dividend additions.

(e) A company may compute the amount of any guaranteed paid-up nonforfeiture benefit, including any paid-up additions under the policy, on the basis of an interest rate not less than the rate specified by the policy for computing cash surrender values.

(f) In the computation of the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than the rates shown in:

(1) the Commissioners 1980 Extended Term Insurance Table, for a policy of ordinary insurance; or

(2) the Commissioners 1961 Industrial Extended Term Insurance Table, for a policy of industrial insurance.

(g) For a policy issued on a substandard basis, the computation of any adjusted premium or present value may be based on appropriate modifications to a table described by Subsection (f).

(h) For a policy issued before the operative date of the valuation manual, any ordinary mortality table adopted after 1980 by the National Association of Insurance Commissioners that is approved by rules adopted by the commissioner for use in determining the minimum nonforfeiture standard may be substituted for:

(1) the Commissioners 1980 Standard Ordinary Mortality Table with or without Ten-Year Select Mortality Factors; or

(2) the Commissioners 1980 Extended Term Insurance Table.

(i) For a policy issued before the operative date of the valuation manual, any industrial mortality table adopted after 1980 by the National Association of Insurance Commissioners that is

approved by rules adopted by the commissioner for use in determining the minimum nonforfeiture standard may be substituted for:

(1) the Commissioners 1961 Standard Industrial Mortality Table; or

(2) the Commissioners 1961 Industrial Extended Term Insurance Table.

(j) Except as provided by Subsection (k), for a policy described by Subsection (h) issued on or after the operative date of the valuation manual, the valuation manual must provide the commissioners standard ordinary mortality table for use in determining the minimum nonforfeiture standard that may be substituted for:

(1) the Commissioners 1980 Standard Ordinary Mortality Table with or without Ten-Year Select Mortality Factors; or

(2) the Commissioners 1980 Extended Term Insurance Table.

(k) If the commissioner by rule adopts a commissioners standard ordinary mortality table adopted by the National Association of Insurance Commissioners for use in determining the minimum nonforfeiture standard for policies issued on or after the operative date of the valuation manual, the minimum nonforfeiture standard determined in accordance with that table supersedes the standard provided by the valuation manual.

(l) Except as provided by Subsection (m), for a policy described by Subsection (i) issued on or after the operative date of the valuation manual, the valuation manual must include the commissioners standard industrial mortality table for use in determining the minimum nonforfeiture standard that may be substituted for:

(1) the 1961 Standard Industrial Mortality Table; or

(2) the Commissioners 1961 Industrial Extended Term Insurance Table.

(m) If the commissioner by rule adopts a commissioners standard industrial mortality table adopted by the National Association of Insurance Commissioners for use in determining the minimum nonforfeiture standard for policies issued on or after the operative date of the valuation manual, the minimum nonforfeiture standard determined in accordance with that table supersedes the standard provided by the valuation manual.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 313 (S.B. 1654), Sec. 17, eff. September 1, 2015.

Sec. 1105.056. NONFORFEITURE INTEREST RATE. (a) For a policy issued before the operative date of the valuation manual, the annual nonforfeiture interest rate for a policy issued in a particular calendar year is equal to 125 percent of the calendar year statutory valuation interest rate for that policy as defined by Subchapter B, Chapter 425, rounded to the nearest one-fourth of one percent, except that the rate may not be less than four percent.

(b) For a policy issued on or after the operative date of the valuation manual, the annual nonforfeiture interest rate for any policy issued in a particular calendar year is provided by the valuation manual.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2F.005, eff. April 1, 2009.

Acts 2015, 84th Leg., R.S., Ch. 313 (S.B. 1654), Sec. 18, eff. September 1, 2015.

Sec. 1105.057. REFILEING OF POLICY PROVISIONS NOT REQUIRED. Notwithstanding any provision of this code to the contrary, as to a policy to which this subchapter applies, a refiling of nonforfeiture values or of the method of computing nonforfeiture values for a previously approved policy form that involves only a change in the interest rate or mortality table used to compute nonforfeiture values does not require refiling of any provision of the policy form.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

SUBCHAPTER C. NONFORFEITURE BENEFITS FOR CERTAIN PLANS

Sec. 1105.101. NONFORFEITURE BENEFITS FOR INDETERMINATE PREMIUM PLANS AND CERTAIN OTHER PLANS. (a) This section applies to a plan of life insurance that:

- (1) provides for future premium determination, the amounts

of which are to be determined by the insurance company based on then estimates of future experience; or

(2) is such that minimum values cannot be determined by a method described by Sections 1105.004-1105.009, Subchapter B, or Subchapter D.

(b) The department must be satisfied that:

(1) the benefits provided under the plan are substantially as favorable to policyholders and insureds as the minimum benefits otherwise required by Sections 1105.004-1105.009, Subchapter B, or Subchapter D; and

(2) the benefits and the pattern of premiums of the plan are not such as to mislead prospective policyholders or insured persons.

(c) The cash surrender values and paid-up nonforfeiture benefits provided by the plan may not be less than the minimum values and benefits required for the plan computed by a method consistent with the principles of this subchapter as determined under rules adopted by the commissioner.

(d) Notwithstanding any other law of this state, any policy, contract, or certificate providing life insurance under the plan must be approved by the department before the plan may be marketed, issued, delivered, or used in this state.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

SUBCHAPTER D. COMPUTATION OF ADJUSTED PREMIUMS FOR CERTAIN POLICIES

Sec. 1105.151. COMPUTATION OF ADJUSTED PREMIUMS FOR CERTAIN POLICIES ISSUED BEFORE JANUARY 1, 1989. (a) This section applies only to a policy issued before January 1, 1989, to which Subchapter B does not apply.

(b) The adjusted premiums for a policy to which this section applies must be computed on an annual basis or, at the option of the company, on a fully continuous basis if that basis is consistent with actual policy provisions and the use of that basis is specified by the policy.

(c) Except as provided by Subsection (f), the adjusted premiums must be a uniform percentage of the respective premiums specified by the policy for each policy year, excluding amounts stated in the policy as extra premiums to cover impairments or special hazards, so

that the present value, as of the date the policy is issued, of all the adjusted premiums is equal to the sum of:

- (1) the then present value of the future guaranteed benefits available under the policy;
- (2) two percent of:
 - (A) the amount of insurance, if the insurance is uniform in amount; or
 - (B) the equivalent uniform amount of insurance, as determined under this section, if the amount of insurance varies with the duration of the policy;
- (3) 40 percent of the adjusted premium for the first policy year; and
- (4) 25 percent of the lesser of:
 - (A) the adjusted premium for the first policy year; or
 - (B) the adjusted premium for a whole life policy of the same or an equivalent uniform amount with uniform premiums for the whole of life issued at the same age for the same amount of insurance.

(d) In applying the percentages specified by Subsections (c)(3) and (4), an adjusted premium may not be considered to exceed four percent of the amount of insurance or equivalent uniform amount.

(e) For purposes of this section, for a policy that provides an amount of insurance that varies with the duration of the policy:

(1) except as provided by Subdivision (2), the equivalent uniform amount of insurance is considered to be the uniform amount of insurance provided by an otherwise similar policy, containing the same endowment benefit, if any, issued at the same age and for the same term, the amount of which does not vary with duration and the benefits under which have the same present value at the date of issue as the benefits under the policy; and

(2) if the policy is issued on the life of a child younger than 10 years of age, the equivalent uniform amount of insurance may be computed as though the amount of insurance provided by the policy before the insured reaches 10 years of age were the amount provided by the policy at age 10.

(f) The adjusted premiums for a policy that provides term insurance benefits by rider or a supplemental policy provision must be equal to the adjusted premiums for an otherwise similar policy issued at the same age without the term insurance benefits, increased, during the period for which premiums for the term

insurance benefits are payable, by the adjusted premiums for the term insurance. The adjusted premiums specified by this subsection must be computed separately in the manner specified by Subsections (b)-(e).

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1105.152. COMPUTATION OF ADJUSTED PREMIUMS FOR CERTAIN ORDINARY POLICIES ISSUED BEFORE JANUARY 1, 1989. (a) Except as provided by Subsection (b), this section applies only to an ordinary policy to which Subchapter B does not apply and that is issued on or after January 1, 1974 and before January 1, 1989.

(b) This section also applies to an ordinary policy issued by a company after a date specified in a written notice:

(1) that was filed by the company with the State Board of Insurance after August 23, 1963, but before January 1, 1974; and

(2) under which the company filing the notice elected to comply before January 1, 1974, with the law codified by this section.

(c) An adjusted premium or present value determined under this chapter as to a policy to which this section applies must be computed on the basis of the Commissioners 1958 Standard Ordinary Mortality Table.

(d) A computation as to a policy to which this section applies must be made using the rate of interest specified by the policy for computing cash surrender values and paid-up nonforfeiture benefits, except that the rate of interest may not exceed:

(1) 3-1/2 percent a year for a policy issued before June 14, 1973;

(2) 4 percent a year for a policy issued on or after June 14, 1973, and before August 29, 1977;

(3) 5-1/2 percent a year for a policy issued on or after August 29, 1977, other than a single premium whole life or endowment insurance policy; or

(4) 6-1/2 percent a year for a single premium whole life or endowment insurance policy issued on or after August 29, 1977.

(e) For a category of ordinary insurance issued to insure a female risk:

(1) an adjusted premium or present value for a policy issued before August 29, 1977, may be computed according to an age

not more than three years younger than the actual age of the insured;
and

(2) an adjusted premium or present value for a policy issued on or after August 29, 1977, may be computed according to an age not more than six years younger than the actual age of the insured.

(f) In the computation of the present value of paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may not exceed the rates shown in the Commissioners 1958 Extended Term Insurance Table.

(g) Subject to approval by the department, a company may specify a mortality table other than the table required by this section for use in computing an adjusted premium or present value for insurance issued on a substandard basis.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1105.153. COMPUTATION OF ADJUSTED PREMIUMS FOR CERTAIN INDUSTRIAL POLICIES ISSUED BEFORE JANUARY 1, 1989. (a) Except as provided by Subsection (b), this section applies only to an industrial policy to which Subchapter B does not apply and that is issued on or after January 1, 1974, and before January 1, 1989.

(b) This section also applies to an industrial policy issued by a company after a date specified in a written notice:

(1) that was filed by the company with the State Board of Insurance after August 23, 1963, but before January 1, 1974; and

(2) under which the company filing the notice elected to comply before January 1, 1974, with the law codified by this section.

(c) An adjusted premium or present value determined under this chapter as to a policy to which this section applies must be computed on the basis of the Commissioners 1961 Standard Industrial Mortality Table.

(d) A computation as to a policy to which this section applies must be made using the rate of interest specified by the policy for computing cash surrender values and paid-up nonforfeiture benefits, except that the rate of interest may not exceed:

(1) 3-1/2 percent a year for a policy issued before June 14, 1973;

(2) 4 percent a year for a policy issued on or after June 14, 1973, and before August 29, 1977;

(3) 5-1/2 percent a year for a policy issued on or after August 29, 1977, other than a single premium whole life or endowment insurance policy; or

(4) 6-1/2 percent a year for a single premium whole life or endowment insurance policy issued on or after August 29, 1977.

(e) In the computation of the present value of paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may not exceed the rates shown in the Commissioners 1961 Industrial Extended Term Insurance Table.

(f) Subject to approval by the department, a company may specify a mortality table other than the table required by this section for use in computing an adjusted premium or present value for insurance issued on a substandard basis.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

CHAPTER 1106. REINSTATEMENT OF CERTAIN LIFE INSURANCE POLICIES

Sec. 1106.001. APPLICABILITY OF CHAPTER. (a) This chapter applies to each individual life insurance policy issued to a resident of this state by an insurer authorized to engage in the business of insurance in this state, including a stipulated premium company and a fraternal benefit society, that is subject to lapse on or after September 1, 1995.

(b) This chapter does not apply to a life insurance policy that provides nonforfeiture benefits in accordance with the requirements of this code.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1106.002. REINSTATEMENT REQUIRED; EXCEPTION. (a) On the lapse of an individual life insurance policy following the unintentional default in the payment of premiums caused by the mental incapacity of the insured, a person is entitled to have the policy reinstated under this chapter if:

(1) the policy had been in effect continuously for at least five years immediately preceding the lapse; and

(2) there was not a default in the payment of premiums on the policy during the period described by Subdivision (1).

(b) The insurer is not required to reinstate a policy or pay benefits under this chapter if the insured first became mentally incapacitated after the expiration of an applicable grace period contained in the policy.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1106.003. MENTAL INCAPACITY DEFINED. In this chapter, "mental incapacity" means a lack of the ability to:

- (1) understand and appreciate the nature and consequences of a decision regarding the failure to pay a premium when due; and
- (2) reach an informed decision in the matter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1106.004. DIAGNOSIS OF MENTAL INCAPACITY REQUIRED. For purposes of this chapter, mental incapacity must be:

- (1) established by the clinical diagnosis of a physician licensed in this state who is qualified to make the diagnosis; and
- (2) based on reasonable medical judgment.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1106.005. REQUEST FOR REINSTATEMENT; LIMITATION. (a) A request for reinstatement of a policy under this chapter and proof of mental incapacity may be filed with the insurer by:

- (1) the insured;
- (2) the insured's legal guardian or other legal representative; or
- (3) the legal representative of the insured's estate.

(b) The request and the proof of mental incapacity must be filed not later than the first anniversary of the date the policy lapses.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1106.006. REINSTATEMENT. (a) After the requirements of Section 1106.005 have been satisfied, the insurer shall reinstate the policy.

(b) The policy must be reinstated within one year from the date of lapse on payment of:

(1) the premiums owed from the date of initial lapse to the date of reinstatement; and

(2) interest on the premiums at a rate not to exceed six percent a year for the period.

(c) The insurer may not require evidence of insurability as a condition of reinstatement.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1106.007. EFFECT OF REINSTATEMENT. On reinstatement of the policy, the original contractual provisions apply as if the coverage had been continuous.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1106.008. REDUCTION IN BENEFITS. If there is an uncontroverted claim for benefits in an amount that exceeds the amount of premiums and interest owed and unpaid under a policy that is eligible for reinstatement under this chapter, the insurer shall pay the amount of benefits owed reduced by the amount of premiums and interest owed and unpaid on the date the benefits are paid.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1106.009. DISCLOSURE. (a) Each insurer shall disclose fully to each policyholder or insured the requirements of this chapter.

(b) As to a policy to which this chapter applies that was issued on or after September 1, 1995, an insurer may make the disclosure required by Subsection (a):

(1) not later than the 90th day after the date the policy lapses; or

(2) by including the disclosure information in the policy

or in an endorsement attached to the policy.

(c) As to a policy to which this chapter applies that was issued before September 1, 1995, and for which the insurer did not make the required disclosure on or before November 30, 1995, the insurer shall make the disclosure required by Subsection (a) not later than the 90th day after the date the policy lapses.

(d) Notice is considered to comply with Subsection (b) or (c) if the notice is mailed by first class mail to the last known address of the policyholder.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1106.010. RULES. The commissioner shall adopt reasonable rules to implement this chapter, and the disclosure required by Section 1106.009 must be made in the form and manner prescribed by the commissioner after notice and hearing.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

CHAPTER 1107. STANDARD NONFORFEITURE LAW FOR CERTAIN ANNUITIES
SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1107.001. APPLICABILITY OF CHAPTER. (a) This chapter applies to an annuity contract issued on or after August 29, 1979.

(b) This chapter also applies to an annuity contract issued by a company after a date specified in a written notice:

(1) that was filed with the State Board of Insurance after August 29, 1977, but before August 29, 1979; and

(2) under which the company filing the notice elected to comply before August 29, 1979, with the law codified by this chapter.

(c) Companies shall issue, and the department shall review, annuity contracts as follows:

(1) under Sections 1107.051-1107.054 until August 31, 2005;
 or

(2) under Sections 1107.055-1107.057 after September 1, 2003.

(d) Companies shall not issue annuity contracts under Sections 1107.051-1107.054 after August 31, 2005.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Amended by Acts 2003, 78th Leg., ch. 869, Sec. 1, eff. June 20, 2003.

Sec. 1107.002. EXEMPTIONS. (a) This chapter does not apply to:

- (1) a reinsurance contract;
- (2) a group annuity contract that is purchased under a retirement plan or plan of deferred compensation established or maintained by an employer, including a partnership or sole proprietorship, by an employee organization, or by both, other than a plan that provides individual retirement accounts or individual retirement annuities under Section 408, Internal Revenue Code of 1986, as amended;
- (3) a premium deposit fund;
- (4) a variable annuity contract;
- (5) an investment annuity contract;
- (6) an immediate annuity contract;
- (7) a deferred annuity contract under which annuity payments have begun;
- (8) a reversionary annuity contract; or
- (9) a contingent deferred annuity contract as defined by Section 1116.003.

(b) This chapter does not apply to a contract delivered outside this state through an agent or other representative of the company that issues the contract.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Amended by Acts 2003, 78th Leg., ch. 869, Sec. 1, eff. June 20, 2003.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 375 (S.B. [1107](#)), Sec. 1, eff. June 9, 2015.

Sec. 1107.003. REQUIRED NONFORFEITURE PROVISIONS. (a) An annuity contract delivered or issued for delivery in this state must contain in substance the provisions prescribed by this section or corresponding provisions that, in the opinion of the department, are at least as favorable to the contract holder when payment of considerations under the contract ceases.

(b) The annuity contract must provide that when payment of

considerations under a contract ceases, the company will grant a paid-up annuity benefit on a plan stipulated in the contract that has a value that complies with this chapter.

(c) An annuity contract that provides for a lump-sum settlement at maturity or at any other time must provide that on surrender of the contract on or before the time annuity payments begin, the company that issues the contract shall pay a cash surrender benefit in an amount that complies with this chapter in lieu of a paid-up annuity benefit. A company may reserve the right to defer payment of any cash surrender benefit for a period not to exceed six months after demand for payment of the benefit is made with surrender of the contract.

(d) An annuity contract must contain:

(1) a statement of the mortality table, if any, and interest rates to be used to compute any minimum paid-up annuity, cash surrender, or death benefits that are guaranteed under the contract, together with information that is sufficient to determine the amounts of the benefits;

(2) a statement that any paid-up annuity, cash surrender, or death benefits available under the contract are not less than the minimum benefits required by this state; and

(3) an explanation of the manner in which a paid-up annuity, cash surrender, or death benefit is altered by the existence of any additional amounts credited to the contract by the company that issues the contract, any indebtedness to the company on the contract, or any prior withdrawals from or partial surrenders of the contract.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Amended by Acts 2003, 78th Leg., ch. 869, Sec. 1, eff. June 20, 2003.

Sec. 1107.004. OPTIONAL TERMINATION PROVISION. (a)

Notwithstanding the requirements of Section 1107.003, an annuity contract may provide that the company has the option to terminate the contract by making a cash payment of the then present value of that portion of the paid-up annuity benefit if:

(1) no considerations are received under the contract for two years; and

(2) at maturity, payments on the portion of the paid-up

annuity benefit on the plan stipulated in the contract attributable to considerations paid before that period would be less than \$20 each month.

(b) If an annuity contract contains a provision permitted under Subsection (a):

(1) the present value of a portion of a paid-up annuity benefit paid under that provision must be computed on the basis of the mortality table, if any, and interest rates specified in the contract for determining the paid-up annuity benefit; and

(2) a payment made under that provision relieves the company of any further obligation under the contract.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 869, Sec. 1, eff. June 20, 2003.

Sec. 1107.005. CONTACT DISCLOSURE THAT CERTAIN BENEFITS NOT PROVIDED. An annuity contract that does not provide a cash surrender benefit or that does not provide a death benefit that is at least equal to the minimum nonforfeiture amount for the contract under Subchapter B before annuity payments begin must include a statement in a prominent place in the contract that those benefits are not provided.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 869, Sec. 1, eff. June 20, 2003.

Sec. 1107.006. MATURITY DATE. In determining the value of benefits under Sections 1107.102, 1107.103, and 1107.104, the maturity date is the latest date on which an election is permitted by the contract, but not later than the later of:

(1) the next anniversary of the annuity contract that follows the annuitant's 70th birthday; or

(2) the 10th anniversary of the contract.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 869, Sec. 1, eff. June 20, 2003.
Amended by:

Acts 2009, 81st Leg., R.S., Ch. 408 (H.B. [1919](#)), Sec. 1, eff. September 1, 2009.

SUBCHAPTER B. COMPUTATION OF MINIMUM NONFORFEITURE AMOUNT

Sec. 1107.051. MINIMUM NONFORFEITURE AMOUNT. The minimum value under Subchapter C of a paid-up annuity, cash surrender, or death benefit shall be computed on the basis of the minimum nonforfeiture amount prescribed by this subchapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 869, Sec. 1, eff. June 20, 2003.

Sec. 1107.052. CONTRACT WITH FLEXIBLE CONSIDERATIONS. (a) This section applies only to an annuity contract that provides for the payment of flexible considerations.

(b) The minimum nonforfeiture amount on or before annuity payments begin is an amount equal to the accumulation of the prescribed percentages of the amount of net considerations paid to the date of computation, which are accumulated at an interest rate of three percent per year, plus any additional amount credited to the contract by the company, less the amount of:

(1) any withdrawal from or partial surrender of the contract made before the minimum nonforfeiture amount is computed, accumulated at an interest rate of three percent per year; and

(2) any indebtedness to the company on the contract, including any accrued interest due on the indebtedness.

(c) For the purposes of this section, the amount of net consideration for a contract year may not be less than \$0 and is computed by subtracting from the amount of gross considerations credited to the contract during that contract year:

(1) an annual contract charge of \$30; and

(2) a collection charge of \$1.25 for each consideration credited to the contract during that year.

(d) Except as provided by Subsection (e), the percentage of the amount of net consideration to be used in computing a minimum nonforfeiture amount under Subsection (b) is:

(1) 65 percent for the first contract year; and

(2) 87.5 percent for each subsequent contract year.

(e) For a renewal contract year, the percentage of the amount of net consideration to be used to compute a minimum nonforfeiture

amount under Subsection (b) is 65 percent of the portion of the total amount of net consideration that exceeds by not more than two times the sum of those portions of the amount of net consideration in all preceding contract years for which the percentage was 65 percent.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 869, Sec. 1, eff. June 20, 2003.

Sec. 1107.053. CONTRACT WITH FIXED, SCHEDULED CONSIDERATIONS.

(a) For an annuity contract that provides for the payment of fixed, scheduled considerations, the minimum nonforfeiture amount is computed in the same manner as the minimum nonforfeiture amount for an annuity contract with flexible considerations that are paid annually, except that:

(1) the amount of net consideration for a contract year is computed using an annual contract charge equal to the lesser of:

(A) \$30; or

(B) 10 percent of the amount of the gross annual considerations paid on the contract; and

(2) the percentage of the net consideration amount for the first contract year to be used to compute the minimum nonforfeiture amount is 65 percent of the amount of net consideration for the first contract year plus 22.5 percent of the amount by which the amount of net consideration for the first contract year exceeds the lesser of:

(A) the amount of net consideration for the second contract year; or

(B) the amount of net consideration for the third contract year.

(b) The computation made under Subsection (a) must assume that the considerations are paid annually in advance.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 869, Sec. 1, eff. June 20, 2003.

Sec. 1107.054. CONTRACT WITH SINGLE CONSIDERATION. For an annuity contract that provides for the payment of a single consideration, the minimum nonforfeiture amount is computed in the same manner as the minimum nonforfeiture amount for a contract with flexible considerations, except that:

(1) the net consideration amount to be used to compute the minimum nonforfeiture amount is the amount of the gross considerations paid under the contract less a contract charge of \$75; and

(2) the percentage of the net consideration amount to be used to compute the minimum nonforfeiture amount is 90 percent.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 869, Sec. 1, eff. June 20, 2003.

Sec. 1107.055. INTEREST RATE. The interest rate used in determining minimum nonforfeiture amounts shall be an annual rate of interest determined as the lesser of three percent per annum and the following, which must be specified in the contract if the interest rate will be redetermined:

(1) the five-year Constant Maturity Treasury Rate reported by the Federal Reserve as of a date, or average over a period, rounded to the nearest 1/20th of one percent, specified in the contract no longer than 15 months prior to the contract issue date or redetermination date under Subdivision (4);

(2) reduced by 125 basis points;

(3) where the resulting interest rate is not less than 0.15 percent; and

(4) the interest rate shall apply for an initial period and may be redetermined for additional periods. The redetermination date, basis, and period, if any, shall be stated in the contract. As used in this section, basis is the date, or average over a specified period, which produces the five-year Constant Maturity Treasury Rate to be used at each redetermination date.

Added by Acts 2003, 78th Leg., ch. 869, Sec. 1, eff. June 20, 2003.
Amended by:

Acts 2021, 87th Leg., R.S., Ch. 262 (H.B. [1777](#)), Sec. 1, eff. September 1, 2021.

Sec. 1107.056. ADDITIONAL INTEREST RATE ADJUSTMENTS. The commissioner may adopt rules to provide for further adjustments to Section 1107.055 for annuity contracts that provide substantive participation in an equity index benefit or other benefits as

appropriate.

Added by Acts 2003, 78th Leg., ch. 869, Sec. 1, eff. June 20, 2003.

Sec. 1107.057. MINIMUM NONFORFEITURE AMOUNT. (a) The minimum values as specified in Sections 1107.006 and 1107.101-1107.105 of any paid-up annuity, cash surrender, or death benefits available under an annuity contract shall be based upon minimum nonforfeiture amounts as defined in this section.

(b) The minimum nonforfeiture amount at any time at or prior to the commencement of any annuity payments shall be equal to an accumulation up to such time at rates of interest as indicated in this subchapter of the net considerations as defined by Subsection (c) paid prior to such time, decreased by the sum of Subdivisions (1) through (4):

(1) any withdrawal from or partial surrender of the contract made before the minimum nonforfeiture amount is computed, accumulated at an interest rate as indicated in this subchapter;

(2) an annual contract charge of \$50, accumulated at rates of interest as indicated in this subchapter;

(3) premium tax paid, if any, by the company, and not subsequently credited back to the company, for the contract, accumulated at rates of interest as indicated in this subchapter; and

(4) any indebtedness to the company on the contract, including any accrued interest due on the indebtedness.

(c) For the purposes of this section, the amount of net consideration for a contract year shall be an amount equal to 87.5 percent of the gross considerations credited to the contract during that contract year.

Added by Acts 2003, 78th Leg., ch. 869, Sec. 1, eff. June 20, 2003.

SUBCHAPTER C. VALUE OF NONFORFEITURE BENEFITS

Sec. 1107.101. PRESENT VALUE OF NONFORFEITURE BENEFITS. (a) The present value of any paid-up annuity benefit available under an annuity contract on the date annuity payments are to begin may not be less than the minimum nonforfeiture amount for that contract on that date as computed under Subchapter B.

(b) The present value of the paid-up annuity benefit shall be computed using the mortality table, if any, and the interest rates specified in the contract for computing the minimum paid-up annuity benefit guaranteed by the contract.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 869, Sec. 1, eff. June 20, 2003.

Sec. 1107.102. COMPUTATION OF PAID-UP ANNUITY BENEFIT UNDER CERTAIN CONTRACTS. (a) This section applies only to an annuity contract that does not provide a cash surrender benefit.

(b) Subject to Subsection (e), the present value of a paid-up annuity benefit available as a nonforfeiture option before the maturity date may not be less than the present value of the portion of the maturity value of the paid-up annuity benefit provided under the contract that arises from considerations paid on the contract before the date the contract is surrendered in exchange for or is changed to a deferred paid-up annuity.

(c) The present value of a paid-up annuity benefit under Subsection (b) shall be:

(1) computed for the period before the maturity date on the basis of the interest rate specified in the contract for accumulating the net considerations paid on the contract to determine the maturity value; and

(2) increased by any additional amount credited by the company to the contract.

(d) Subject to Subsection (e), for an annuity contract that does not provide a death benefit before annuity payments begin, the present value of a paid-up annuity benefit available as a nonforfeiture option shall be computed using the interest rate and the mortality table specified in the contract for determining the maturity value of the paid-up annuity benefit.

(e) The present value of a paid-up annuity benefit may not be less than the minimum nonforfeiture amount on the date of surrender or change.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 869, Sec. 1, eff. June 20, 2003.

Sec. 1107.103. COMPUTATION OF CASH SURRENDER BENEFIT. (a) Subject to Subsection (c), the value of a cash surrender benefit available under an annuity contract before the maturity date may not be less than the present value on the date the contract is surrendered of the portion of the maturity value of the paid-up annuity benefit that arises from considerations paid under the contract before that date and that would be provided under the contract at maturity less an amount reflecting any withdrawals from or partial surrenders of the contract before that date and the amount of any indebtedness to the company on the contract, including accrued interest due on the indebtedness, plus any additional amount credited by the company to the contract.

(b) The present value used to compute the minimum cash surrender benefit under Subsection (a) shall be computed using an interest rate that is not more than one percent higher than the interest rate specified in the contract for accumulating the net considerations paid on the contract to determine the maturity value.

(c) The value of a cash surrender benefit may not be less than the minimum nonforfeiture amount on the date the contract is surrendered.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 869, Sec. 1, eff. June 20, 2003.

Sec. 1107.104. COMPUTATION OF DEATH BENEFIT. The value of a death benefit available under an annuity contract that provides a cash surrender benefit may not be less than the value of the cash surrender benefit.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 869, Sec. 1, eff. June 20, 2003.

Sec. 1107.105. COMPUTATION OF BENEFITS AVAILABLE AT THE TIME OTHER THAN CONTRACT ANNIVERSARY. For an annuity contract that requires payment of fixed, scheduled considerations, the value of a paid-up annuity, cash surrender, or death benefit that is available under the contract on a date other than an anniversary of the contract date shall be computed to allow for the lapse of time and any scheduled considerations paid after the beginning of the contract

year in which payment of considerations under the contract ceased.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Amended by Acts 2003, 78th Leg., ch. 869, Sec. 1, eff. June 20, 2003.

Sec. 1107.106. MINIMUM NONFORFEITURE VALUES UNDER CONTRACT THAT PROVIDES ANNUITY AND LIFE INSURANCE BENEFITS. For a contract that provides, by rider or by supplemental provision, both annuity benefits and life insurance benefits that exceed the greater of the value of the cash surrender benefit or the amount with interest of the gross considerations paid on the contract, the minimum nonforfeiture benefits are equal to the sum of the minimum nonforfeiture benefits for the annuity portion of the contract and the minimum nonforfeiture benefits, if any, for the life insurance portion of the contract, computed as if each portion were a separate contract.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Amended by Acts 2003, 78th Leg., ch. 869, Sec. 1, eff. June 20, 2003.

Sec. 1107.107. COMPUTATIONS NOT AFFECTED BY ADDITIONAL BENEFITS. (a) Notwithstanding any other provision of this subchapter or Section 1107.006, a computation of a minimum nonforfeiture amount or of a paid-up annuity, cash surrender, or death benefit under this chapter may not include:

(1) any additional benefit that is:

(A) payable in the event of total and permanent disability;

(B) payable as a reversionary annuity or deferred reversionary annuity benefit; or

(C) payable as another policy benefit in addition to life insurance, endowment, or annuity benefits; or

(2) the considerations paid for the additional benefit.

(b) A paid-up benefit under an annuity contract is not required to include an additional benefit described by Subsection (a) unless the additional benefit separately requires:

(1) a minimum nonforfeiture amount; or

(2) a paid-up annuity, cash surrender, or death benefit.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 869, Sec. 1, eff. June 20, 2003.

Sec. 1107.108. RULES. The commissioner may adopt rules to implement the provisions of this chapter.

Added by Acts 2003, 78th Leg., ch. 869, Sec. 1, eff. June 20, 2003.

CHAPTER 1108. BENEFITS EXEMPT FROM SEIZURE

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1108.001. CONSTRUCTION WITH OTHER LAW. The exemptions under this chapter are in addition to the exemptions from garnishment, attachment, execution, or other seizure under Chapter 42, Property Code.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1108.002. ANNUITY CONTRACTS. For purposes of regulation under this code, an annuity contract is considered an insurance policy or contract if the annuity contract is issued:

- (1) by a life, health, or accident insurance company, including a mutual company or fraternal benefit society; or
- (2) under an annuity or benefit plan used by an employer or individual.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

SUBCHAPTER B. EXEMPTIONS FROM SEIZURE

Sec. 1108.051. EXEMPTIONS FOR CERTAIN INSURANCE AND ANNUITY BENEFITS. (a) Except as provided by Section 1108.053, this section applies to any benefits, including the cash value and proceeds of an insurance policy, to be provided to an insured or beneficiary under:

- (1) an insurance policy or annuity contract issued by a life, health, or accident insurance company, including a mutual company or fraternal benefit society; or
- (2) an annuity or benefit plan used by an employer or individual.

(b) Notwithstanding any other provision of this code, insurance or annuity benefits described by Subsection (a):

(1) inure exclusively to the benefit of the person for whose use and benefit the insurance or annuity is designated in the policy or contract; and

(2) are fully exempt from:

(A) garnishment, attachment, execution, or other seizure;

(B) seizure, appropriation, or application by any legal or equitable process or by operation of law to pay a debt or other liability of an insured or of a beneficiary, either before or after the benefits are provided; and

(C) a demand in a bankruptcy proceeding of the insured or beneficiary.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1108.052. EXEMPTIONS UNAFFECTED BY BENEFICIARY DESIGNATION. The exemptions provided by Section 1108.051 apply regardless of whether:

(1) the power to change the beneficiary is reserved to the insured; or

(2) the insured or the insured's estate is a beneficiary.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 91 (S.B. 649), Sec. 1, eff. September 1, 2013.

Sec. 1108.053. EXCEPTIONS TO EXEMPTIONS. The exemptions provided by Section 1108.051 do not apply to:

(1) a premium payment made in fraud of a creditor, subject to the applicable statute of limitations for recovering the payment;

(2) a debt of the insured or beneficiary secured by a pledge of the insurance policy or the proceeds of the policy; or

(3) a child support lien or levy under Chapter 157, Family Code.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.301(a), eff. Sept. 1, 2003.

SUBCHAPTER C. ASSIGNMENT OF BENEFITS

Sec. 1108.101. ASSIGNMENT GENERALLY. (a) This chapter does not prevent an insured, owner, or annuitant from assigning, in accordance with the terms of the policy or contract:

(1) any benefits to be provided under an insurance policy or annuity contract to which this chapter applies; or

(2) any other rights under the policy or contract.

(b) A benefit or right described by Subsection (a) assigned by an insured, owner, or annuitant after a child support lien notice has been filed against the insured, owner, or annuitant by the Title IV-D agency continues to be subject to the child support lien after the date of assignment. The lien continues to secure payment of all child support arrearages owed by the insured, owner, or annuitant under the underlying child support order, including arrearages that accrue after the date of assignment.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.
Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 508 (H.B. 1674), Sec. 20, eff. September 1, 2011.

Sec. 1108.102. CERTAIN ASSIGNMENTS VOID. If an insurance policy, annuity contract, or annuity or benefit plan described by Section 1108.051 prohibits a beneficiary from assigning or commuting benefits to be provided or other rights under the policy, contract, or plan, an assignment or commutation or attempted assignment or commutation of the benefits or rights by the beneficiary is void.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

CHAPTER 1109. UNCLAIMED LIFE INSURANCE AND ANNUITY CONTRACT PROCEEDS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1109.001. APPLICABILITY OF CHAPTER. (a) This chapter applies to proceeds held and owing by a life insurance company engaged in the business of insurance in this state if:

(1) the last known address, according to the company's records, of the person entitled to the proceeds is located in this state; and

(2) the proceeds have been unclaimed and unpaid for at least three years after the date, according to the company's records, that the proceeds became due and payable under a life or endowment insurance policy or annuity contract that has matured or terminated.

(b) If a person other than the insured or annuitant is entitled to the proceeds and that person's address is not known to the company or if the identity of the person entitled to the proceeds is not certain from the company's records, it is presumed that the last known address of the person entitled to the proceeds is the same as the last known address of the insured or annuitant according to the company's records.

(c) For purposes of Subsection (a), a life insurance policy not matured by proof of the death of the insured is considered to be matured and the proceeds of the policy are considered to be due and payable only if the policy is in force at the time the insured attained the limiting age under the mortality table on which the reserve is based.

(d) An annuity or other obligation, the payment of which is conditioned on the continued life of any individual, is not considered due and payable for purposes of Subsection (a) without proof that the individual was alive at the time or times required by the contract.

(e) Proceeds otherwise admittedly due and payable under a life or endowment insurance policy or annuity contract that has matured or terminated are considered to be held and owing even if the policy or contract has not been surrendered as required.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1109.002. ADMINISTRATION AND ENFORCEMENT; RULES. (a) This chapter shall be enforced in the manner provided for enforcement of Chapter 74, Property Code, under Subchapter H of that chapter.

(b) The comptroller may adopt rules necessary to administer this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1109.003. APPROPRIATIONS TO ADMINISTER CHAPTER. To enforce and administer this chapter, the legislature may appropriate unclaimed money received under Chapter 74, Property Code, or under any other statute requiring the delivery of unclaimed property to the comptroller.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

SUBCHAPTER A-1. DEATH MASTER FILE SEARCH; IDENTIFICATION OF UNCLAIMED PROCEEDS

Sec. 1109.010. DEFINITIONS. In this subchapter:

(1) "Annuity contract" means an annuity contract issued in this state. The term does not include an annuity used to fund an employment-based retirement plan or program for which the insurer:

- (A) does not perform the recordkeeping services; or
- (B) is not committed by the terms of the annuity contract to pay death benefits to the beneficiaries of specific plan participants.

(2) "Death Master File" means:

- (A) the United States Social Security Administration's Death Master File; or
- (B) any other database or service that is at least as comprehensive as the United States Social Security Administration's Death Master File for determining whether a person is dead.

(3) "Death Master File match" means a match of the social security number or the name and date of birth of an insured or retained asset account holder resulting from a search of the Death Master File.

(4) "Life insurance policy" means a policy or certificate of life insurance issued in this state that provides a death benefit. The term does not include:

- (A) a policy or certificate of life insurance that provides a death benefit under an employee benefit plan that is:
 - (i) subject to the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.); or
 - (ii) under any federal employee benefit program;
- (B) a policy or certificate of life insurance that is used to fund a pre-need funeral contract or prearrangement;
- (C) a policy or certificate of credit life or

accidental death insurance; or

(D) a policy issued to a group master policyholder for which the insurer does not provide recordkeeping services.

(5) "Recordkeeping services" means services provided by an insurer, under an agreement with a group policy or contract holder, to obtain, maintain, and administer in the insurer's or the insurer's agents' systems the following information about each individual insured under the group policy or contract or a line of coverage under that policy or contract:

(A) the social security number or name and date of birth of the insured;

(B) beneficiary designation information;

(C) coverage eligibility;

(D) benefit amount; and

(E) premium payment status.

(6) "Retained asset account" means a mechanism by which the proceeds payable under a life insurance policy or annuity contract are settled by the insurer or an entity acting on behalf of the insurer by depositing the proceeds into an account with check or draft writing privileges, where those proceeds are retained by the insurer or the insurer's agent, under a supplementary contract not involving annuity contract benefits other than death benefits.

Added by Acts 2017, 85th Leg., R.S., Ch. 42 (S.B. 561), Sec. 1, eff. September 1, 2017.

Sec. 1109.011. IDENTIFICATION OF DEATH MASTER FILE MATCHES.

(a) An insurer shall compare its in-force life insurance policies, annuity contracts, and retained asset accounts against a Death Master File at least semiannually to identify potential Death Master File matches. The insurer shall perform the first comparison of a policy, contract, or account against a full Death Master File and thereafter against Death Master File update files to identify potential Death Master File matches.

(b) An insurer shall first conduct the comparison required by Subsection (a) electronically to the extent the insurer's records are available in electronic format, and then use the most easily accessible insurer records for any records that are not available electronically.

(c) Each subsequent comparison made under this section shall include all in-force life insurance policies, annuity contracts, and retained asset accounts and any policies, contracts, or accounts that have lapsed since the previous comparison.

(d) An insurer shall implement procedures for conducting comparisons under this section to account for:

(1) common nicknames, initials used in lieu of a first or middle name, use of a middle name, compound first and middle names, and interchanged first and middle names;

(2) compound last names, maiden or married names, and hyphens, blank spaces, or apostrophes in last names;

(3) transposition of the month and date portions of the date of birth; and

(4) an incomplete social security number.

Added by Acts 2017, 85th Leg., R.S., Ch. 42 (S.B. 561), Sec. 1, eff. September 1, 2017.

Sec. 1109.012. DUTIES REGARDING DEATH MASTER FILE MATCH. (a) For each Death Master File match, the insurer shall, not later than the 90th day after the date the insurer identifies the match:

(1) complete a documented good faith effort to confirm the death of the insured or retained asset account holder against other available records and information;

(2) review the insurer's records to determine whether the deceased individual had purchased or was otherwise covered by any of the insurer's other products; and

(3) determine whether proceeds may be due in accordance with the applicable policy or contract or terms governing the applicable account.

(b) For group life insurance or a group annuity contract, an insurer is required to confirm the possible death of an insured or retained asset account holder under this section only if the insurer provides recordkeeping services for the group policy or group annuity contract.

(c) If the insurer determines under Subsection (a)(3) that proceeds may be due and a beneficiary or other authorized representative has not communicated with the insurer on or before the 90th day after the date the insurer identifies a Death Master File

match, the insurer shall:

(1) complete a documented good faith effort to locate and contact each beneficiary or other authorized representative on the relevant policy, contract, or account; and

(2) provide to the beneficiary or authorized representative the appropriate claim forms, instructions, or information to make a claim, including information about any need to provide an official death certificate or show proof of death under the applicable policy or contract or terms governing the applicable account.

(d) If an insurer is unable to confirm the death of an insured or retained asset account holder after the insurer identifies a Death Master File match, the insurer may consider the relevant policy, contract, or account to remain in force according to its terms.

(e) To the extent permitted by law, the insurer may disclose minimum necessary personal information about the insured, retained asset account holder, or beneficiary to a person the insurer reasonably believes may be able to assist the insurer in locating a person entitled to payment of the claim proceeds.

(f) An insurer or the insurer's service provider may not charge an insured, retained asset account holder, beneficiary, or authorized representative any fees or costs associated with conducting a Death Master File comparison under this subchapter or verifying a Death Master File match under this subchapter.

Added by Acts 2017, 85th Leg., R.S., Ch. 42 (S.B. [561](#)), Sec. 1, eff. September 1, 2017.

Sec. 1109.013. PRESUMPTION OF UNCLAIMED PROCEEDS; REPORT AND DELIVERY OF PROCEEDS. (a) The proceeds of a life insurance policy, annuity contract, or retained asset account, and any accrued contractual interest, are first payable to each designated beneficiary or owner as provided by the applicable policy or contract or terms governing the applicable account.

(b) If a Death Master File match is confirmed, the proceeds of the relevant policy, contract, or account are considered unclaimed proceeds for purposes of this chapter on the third anniversary of the date on which, according to the insurer's records, the insurer completed a good faith effort as required by Section 1109.012(c) that failed to locate a beneficiary or authorized representative if the

proceeds remain unpaid and no beneficiary or authorized representative has submitted a claim for the proceeds to the insurer before that date.

(c) An insurer shall report and deliver unclaimed proceeds to the comptroller as required by Chapter 74, Property Code.

(d) Repealed by Acts 2021, 87th Leg., R.S., Ch. 52 (H.B. 1514), Sec. 18(1), eff. May 18, 2021.

(e) For purposes of this section, unclaimed proceeds do not include any statutory interest under Section 1103.104.

Added by Acts 2017, 85th Leg., R.S., Ch. 42 (S.B. 561), Sec. 1, eff. September 1, 2017.

Amended by:

Acts 2021, 87th Leg., R.S., Ch. 52 (H.B. 1514), Sec. 2, eff. May 18, 2021.

Acts 2021, 87th Leg., R.S., Ch. 52 (H.B. 1514), Sec. 18(1), eff. May 18, 2021.

Sec. 1109.014. RULEMAKING AUTHORITY. The commissioner may adopt rules to implement this subchapter.

Added by Acts 2017, 85th Leg., R.S., Ch. 42 (S.B. 561), Sec. 1, eff. September 1, 2017.

Sec. 1109.015. AUTHORITY TO ISSUE CERTAIN ORDERS. The commissioner may issue an order:

(1) limiting the Death Master File comparisons required by this subchapter to only those files the insurer maintains in searchable electronic format or approving a plan and timeline for an insurer to convert the insurer's files to searchable electronic format;

(2) exempting an insurer from the Death Master File comparisons required by this subchapter or permitting an insurer to perform the comparisons less frequently than required by this subchapter on a showing of hardship to the insurer; or

(3) permitting an insurer to phase in compliance with this subchapter according to a plan and timeline approved by the commissioner.

Added by Acts 2017, 85th Leg., R.S., Ch. 42 (S.B. 561), Sec. 1, eff. September 1, 2017.

Sec. 1109.016. AUTHORITY TO REQUEST DEATH CERTIFICATE. Nothing in this subchapter limits an insurer's right to request a death certificate as part of a claim validation process.

Added by Acts 2017, 85th Leg., R.S., Ch. 42 (S.B. 561), Sec. 1, eff. September 1, 2017.

CHAPTER 1110. INTEREST RATES ON CERTAIN POLICY LOANS

Sec. 1110.001. DEFINITIONS. In this chapter:

(1) "Life insurance policy" includes:

(A) a benefit certificate issued by a fraternal benefit society; or

(B) an annuity contract that provides for a policy loan.

(2) "Policy loan" includes any premium loan made under a life insurance policy to pay one or more premiums not paid to the life insurer when due.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1110.002. APPLICABILITY OF CHAPTER. This chapter applies only to a life insurance policy issued on or after August 31, 1981.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1110.003. APPLICABILITY OF OTHER LAW. A law not included in this chapter applies to interest rates on policy loans only if that law is made specifically applicable to those rates.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1110.004. MAXIMUM INTEREST RATE ON POLICY LOANS. (a) In this section, "published monthly average" means:

(1) Moody's Corporate Bond Yield Average--Monthly Average Corporates as published by Moody's Investors Service, Inc., or a successor to that corporation; or

(2) if the rate described by Subdivision (1) is no longer published, a substantially similar average established by rule of the commissioner.

(b) A life insurance policy must include a provision for an interest rate on a policy loan that:

(1) does not exceed 10 percent a year; or

(2) is an adjustable maximum interest rate established from time to time by the life insurer as permitted by law and does not exceed the lesser of:

(A) 15 percent a year; or

(B) the greater of:

(i) the published monthly average for the calendar month that ended two months before the date on which the rate is determined; or

(ii) the rate used to compute the cash surrender values under the life insurance policy during the applicable period plus one percent per year.

(c) This section also applies to the interest rate charged, on reinstatement of a policy loan, for the period during and after a lapse of the life insurance policy.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1110.005. FREQUENCY OF ADJUSTABLE INTEREST RATE DETERMINATION. A life insurer shall determine the adjustable interest rate under Section 1110.004(b)(2) at regular intervals at least once every 12 months but not more frequently than once in any three-month period. At the intervals specified in the life insurance policy, the insurer:

(1) may increase the rate charged when the interest rate determined under Section 1110.004(b)(2) would result in a rate increase of at least one-half of one percent per year; and

(2) shall reduce the rate charged when the interest rate determined under Section 1110.004(b)(2) would result in a rate decrease of at least one-half of one percent per year.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1110.006. INFORMATION TO BE INCLUDED IN POLICY. (a) A life insurance policy must include the substance of the provisions of Section 1110.004(b) that are applicable to the policy.

(b) A life insurance policy that provides for an adjustable interest rate under Section 1110.004(b)(2) must state the frequency at which the rate is to be determined.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1110.007. NOTICE TO POLICYHOLDER. (a) In this section, "policyholder" includes the owner of a life insurance policy or the person designated to pay premiums as shown on the records of the life insurer.

(b) For a cash loan on a life insurance policy, the life insurer shall notify the policyholder of the initial interest rate on the loan at the time the insurer makes the loan.

(c) For a premium loan on a life insurance policy, the life insurer shall notify the policyholder of the initial interest rate on the loan as soon as reasonably practical after making the loan. Except as provided by Subsection (d), subsequent notice is not required to be given when the insurer makes an additional premium loan on the policy.

(d) At least 30 days before an increase in the interest rate on a policy loan, the life insurer shall send a notice of the rate increase to the policyholder.

(e) The life insurer shall include in a notice required by this section the substance of the provisions of Section 1110.004(b) applicable to the policy. For a policy loan with an adjustable interest rate, the notice must state the frequency at which the rate is to be determined.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1110.008. LOAN VALUE OF POLICY; TERMINATION OF POLICY BASED ON CHANGE IN INTEREST RATE. (a) The loan value of a life insurance policy shall be determined in accordance with Section 1101.009.

(b) A life insurance policy may not be terminated in a policy year solely as the result of a change in the policy loan interest rate during that policy year, and the life insurer shall maintain coverage during that policy year until the time at which coverage would otherwise have terminated if there had been no change in the interest rate.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

CHAPTER 1111. ACCELERATED TERM LIFE INSURANCE BENEFITS

SUBCHAPTER B. ACCELERATED TERM LIFE INSURANCE BENEFITS

Sec. 1111.051. DEFINITIONS. In this subchapter:

(1) "Accelerated benefit" means a benefit paid to an insured instead of a portion of a death benefit.

(2) "Death benefit" means a benefit payable to a beneficiary on the death of an insured.

(3) "Long-term care illness" means an illness or physical condition that results in the inability to perform the activities of daily life or the substantial and material duties of any occupation.

(4) "Terminal illness" means an illness or physical condition, including a physical injury, that can reasonably be expected to result in death within not more than two years.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1111.052. AUTHORITY TO PAY ACCELERATED TERM LIFE BENEFITS.

An insurer may pay an accelerated benefit under an individual or group term life insurance policy or certificate if:

(1) the insurer has received a written medical opinion, satisfactory to the insurer, that the insured has:

(A) a terminal illness;

(B) a long-term care illness; or

(C) an illness or physical condition that is likely to cause permanent disability or premature death, including:

(i) acquired immune deficiency syndrome (AIDS);

(ii) a malignant tumor;

(iii) a condition that requires an organ transplant; or

(iv) a coronary artery disease that results in

acute infarction or requires surgery; and

(2) the amount of the accelerated benefit is deducted from:

(A) the amount of the death benefit payable under the policy or certificate; and

(B) any amount the insured would otherwise be entitled to convert to an individual contract.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.302, eff. Sept. 1, 2003.

Sec. 1111.053. RULES. The commissioner may adopt rules to implement this subchapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

CHAPTER 1111A. LIFE SETTLEMENT CONTRACTS

Sec. 1111A.001. SHORT TITLE. This Act may be cited as the Life Settlements Act.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1156 (H.B. [2277](#)), Sec. 3, eff. September 1, 2011.

Sec. 1111A.002. DEFINITIONS. In this chapter:

(1) "Advertisement" means a written, electronic, or printed communication or a communication by means of a recorded telephone message or transmitted on radio, television, the Internet, or similar communications media, including film strips, motion pictures, and videos, published, disseminated, circulated, or placed directly before the public for the purpose of creating an interest in or inducing a person to purchase or sell, assign, devise, bequest, or transfer the death benefit or ownership of a life insurance policy or an interest in a life insurance policy under a life settlement contract.

(2) "Broker" means a person who, on behalf of an owner and for a fee, commission, or other valuable consideration, offers or attempts to negotiate a life settlement contract between an owner and a provider or estimates life expectancies for a life settlement

contract. A broker who offers or attempts to negotiate a life settlement contract represents only the owner and owes a fiduciary duty to the owner to act according to the owner's instructions, and in the best interest of the owner, notwithstanding the manner in which the broker is compensated. A broker does not include an attorney, certified public accountant, or financial planner retained in the type of practice customarily performed in a professional capacity to represent the owner whose compensation is not paid directly or indirectly by the provider or any other person, except the owner.

(3) "Business of life settlements" means an activity involved in, but not limited to, offering to enter into, soliciting, negotiating, procuring, effectuating, monitoring, or tracking, of life settlement contracts.

(4) "Chronically ill" means:

(A) being unable to perform at least two activities of daily living such as eating, toileting, transferring, bathing, dressing, or continence;

(B) requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment; or

(C) having a level of disability similar to that described in Paragraph (A) as determined under rules adopted by the commissioner after consideration of any applicable regulation, guideline, or determination of the United States Secretary of Health and Human Services.

(5) "Financing entity" means an underwriter, placement agent, lender, purchaser of securities, purchaser of a policy or certificate from a provider, credit enhancer, or any entity that has a direct ownership in a policy or certificate that is the subject of a life settlement contract whose principal activity related to the transaction is providing funds to effect the life settlement contract or purchase of a policy, and who has an agreement in writing with a provider to finance the acquisition of a life settlement contract. The term does not include a non-accredited investor or purchaser.

(6) "Financing transaction" means a transaction in which a licensed provider obtains financing from a financing entity including secured or unsecured financing, a securitization transaction, or a securities offering that is either registered or exempt from registration under federal and state securities law.

(7) "Fraudulent life settlement act" includes:

(A) an act or omission committed by a person who, knowingly and with intent to defraud, for the purpose of depriving another of property or for pecuniary gain, commits, or permits an employee or an agent to engage in, acts including:

(i) presenting, causing to be presented, or preparing with knowledge and belief that it will be presented to or by a provider, premium finance lender, broker, insurer, insurance agent, or any other person, false material information, or concealing material information, as part of, in support of, or concerning a fact material to one or more of the following:

(a) an application for the issuance of a life settlement contract or an insurance policy;

(b) the underwriting of a life settlement contract or an insurance policy;

(c) a claim for payment or benefit pursuant to a life settlement contract or an insurance policy;

(d) premium paid on an insurance policy;

(e) payment for and changes in ownership or beneficiary made in accordance with the terms of a life settlement contract or an insurance policy;

(f) the reinstatement or conversion of an insurance policy;

(g) in the solicitation, offer to enter into, or effectuation of a life settlement contract, or an insurance policy;

(h) the issuance of written evidence of life settlement contracts or insurance; or

(i) an application for or the existence of or any payment related to a loan secured directly or indirectly by an interest in a life insurance policy;

(ii) failing to disclose to the insurer, if the insurer has requested the disclosure, that the prospective insured has undergone a life expectancy evaluation by any person or entity other than the insurer or its authorized representatives in connection with the issuance of the policy; or

(iii) employing a device, scheme, or artifice to defraud in the business of life settlements; and

(B) acts or omissions in the furtherance of a fraud or to prevent the detection of a fraud, or acts or omissions that permit

an employee or an agent to:

(i) remove, conceal, alter, destroy, or sequester from the commissioner the assets or records of a license holder or another person engaged in the business of life settlements;

(ii) misrepresent or conceal the financial condition of a license holder, financing entity, insurer, or other person;

(iii) transact the business of life settlements in violation of laws requiring a license, certificate of authority, or other legal authority for the transaction of the business of life settlements;

(iv) file with the commissioner or the chief insurance regulatory official of another jurisdiction a document containing false information or concealing information about a material fact;

(v) engage in embezzlement, theft, misappropriation, or conversion of monies, funds, premiums, credits, or other property of a provider, insurer, insured, owner, insurance policy owner, or any other person engaged in the business of life settlements or insurance;

(vi) knowingly and with intent to defraud, enter into, broker, or otherwise deal in a life settlement contract, the subject of which is a life insurance policy that was obtained by presenting false information concerning any fact material to the policy or by concealing that fact, for the purpose of misleading another, or providing information concerning any fact material to the policy, if the owner or the owner's agent intended to defraud the policy's issuer;

(vii) attempt to commit, assist, aid or abet in the commission of, or engage in conspiracy to commit the acts or omissions specified in this paragraph; or

(viii) misrepresent the state of residence of an owner to be a state or jurisdiction that does not have a law substantially similar to this chapter for the purpose of evading or avoiding the provisions of this chapter.

(8) "Insured" means a person covered under the policy being considered for sale in a life settlement contract.

(9) "Life expectancy" means the arithmetic mean of the number of months the insured under the life insurance policy to be settled can be expected to live as determined by a life expectancy

company or provider considering medical records and appropriate experiential data.

(10) "Life insurance agent" means a person licensed in this state as a resident or nonresident insurance agent who has received qualification or authority to write life insurance coverage under this code.

(11) "Life settlement contract" means a written agreement entered into between a provider and an owner establishing the terms under which compensation or anything of value will be paid and is less than the expected death benefit of the insurance policy or certificate, in return for the owner's assignment, transfer, sale, devise, or bequest of the death benefit or a portion of an insurance policy or certificate of insurance for compensation; provided, however, that the minimum value for a life settlement contract must be greater than a cash surrender value or accelerated death benefit available at the time of an application for a life settlement contract. The term also includes the transfer for compensation or value of ownership or beneficial interest in a trust or other entity that owns the policy if the trust or other entity was formed or used for the principal purpose of acquiring one or more life insurance contracts that insure the life of an individual residing in this state. The term also includes:

(A) a written agreement for a loan or other lending transaction, secured primarily by an individual or group life insurance policy; and

(B) a premium finance loan made for a policy on or before the date of issuance of the policy if:

(i) the loan proceeds are not used solely to pay premiums for the policy and any costs or expenses incurred by the lender or the borrower in connection with the financing;

(ii) the owner receives on the date of the premium finance loan a guarantee of the future life settlement value of the policy; or

(iii) the owner agrees on the date of the premium finance loan to sell the policy or any portion of its death benefit on a date following the issuance of the policy.

(11-A) "Life settlement contract" does not include:

(A) a policy loan by a life insurance company under the terms of a life insurance policy or accelerated death provision contained in the life insurance policy, whether issued with the

original policy or as a rider;

(B) a premium finance loan or any loan made by a bank or other licensed financial institution, provided that neither default on the loan nor the transfer of the policy in connection with the default is under an agreement or understanding with any other person for the purpose of evading regulation under this chapter;

(C) a collateral assignment of a life insurance policy by an owner;

(D) a loan made by a lender that does not violate Chapter 651, provided that the loan is not described in Subdivision (11) and is not otherwise within the definition of life settlement contract;

(E) an agreement with respect to which all the parties are closely related to the insured by blood or law or have a lawful substantial economic interest in the continued life, health, and bodily safety of the person insured, or are trusts established primarily for the benefit of the parties;

(F) a designation, consent, or agreement by an insured who is an employee of an employer in connection with the purchase by the employer, or trust established by the employer, of life insurance on the life of the employee;

(G) a bona fide business succession planning arrangement:

(i) between one or more shareholders in a corporation or between a corporation and one or more of its shareholders or one or more trusts established by its shareholders;

(ii) between one or more partners in a partnership or between a partnership and one or more of its partners or one or more trusts established by its partners; or

(iii) between one or more members in a limited liability company or between a limited liability company and one or more of its members or one or more trusts established by its members;

(H) an agreement entered into by a service recipient, or a trust established by the service recipient, and a service provider, or a trust established by the service provider, who performs significant services for the service recipient's trade or business; or

(I) any other contract, transaction, or arrangement from the definition of life settlement contract that the commissioner determines is not of the type intended to be regulated by this

chapter.

(12) "Net death benefit" means the amount of the life insurance policy or certificate to be settled less any outstanding debts or liens.

(13) "Owner" means the owner of a life insurance policy or a certificate holder under a group policy, with or without a terminal illness, who enters or seeks to enter into a life settlement contract. In this chapter, the term "owner" is not limited to an owner of a life insurance policy or a certificate holder under a group policy that insures the life of an individual with a terminal or chronic illness or condition except as specifically provided. The term does not include:

(A) a provider or other license holder under this chapter;

(B) a qualified institutional buyer as defined by 17 C.F.R. Section 230.144A, as amended;

(C) a financing entity;

(D) a special purpose entity; or

(E) a related provider trust.

(14) "Patient identifying information" means an insured's address, telephone number, facsimile number, e-mail address, photograph or likeness, employer, employment status, social security number, or any other information that is likely to lead to the identification of the insured.

(15) "Policy" means an individual or group policy, group certificate, contract, or arrangement of life insurance owned by a resident of this state, regardless of whether delivered or issued for delivery in this state.

(16) "Premium finance loan" is a loan made primarily for the purposes of making premium payments on a life insurance policy that is secured by an interest in the life insurance policy.

(17) "Person" means an individual or legal entity, including a partnership, limited liability company, association, trust, or corporation.

(18) "Provider" means a person, other than an owner, who enters into or effectuates a life settlement contract with an owner. The term does not include:

(A) a bank, savings bank, savings and loan association, or credit union;

(B) a licensed lending institution or creditor or

secured party pursuant to a premium finance loan agreement that takes an assignment of a life insurance policy or certificate issued pursuant to a group life insurance policy as collateral for a loan;

(C) the insurer of a life insurance policy or rider to the extent of providing accelerated death benefits or riders under Subchapter B, Chapter 1111, or cash surrender value;

(D) an individual who enters into or effectuates not more than one agreement in a calendar year for the transfer of a life insurance policy or certificate issued pursuant to a group life insurance policy, for compensation or anything of value less than the expected death benefit payable under the policy;

(E) a purchaser;

(F) any authorized or eligible insurer that provides stop loss coverage to a provider, purchaser, financing entity, special purpose entity, or related provider trust;

(G) a financing entity;

(H) a special purpose entity;

(I) a related provider trust;

(J) a broker; or

(K) an accredited investor or qualified institutional buyer as those terms are defined by 17 C.F.R. Sections 230.501 and 230.144A, respectively, as amended, who purchases a life settlement policy from a provider.

(19) "Purchased policy" means a policy or group certificate that has been acquired by a provider pursuant to a life settlement contract.

(20) "Purchaser" means a person who pays compensation or anything of value as consideration for a beneficial interest in a trust that is vested with, or for the assignment, transfer, or sale of, an ownership or other interest in a life insurance policy or a certificate issued pursuant to a group life insurance policy that has been the subject of a life settlement contract.

(21) "Related provider trust" means a titling trust or other trust established by a licensed provider or a financing entity for the sole purpose of holding the ownership or beneficial interest in purchased policies in connection with a financing transaction. In order to qualify as a related provider trust, the trust must have a written agreement with the licensed provider under which the licensed provider is responsible for ensuring compliance with all statutory and regulatory requirements and under which the trust agrees to make

all records and files relating to life settlement transactions available to the department as if those records and files were maintained directly by the licensed provider.

(22) "Settled policy" means a life insurance policy or certificate that has been acquired by a provider pursuant to a life settlement contract.

(23) "Special purpose entity" means a corporation, partnership, trust, limited liability company, or other legal entity formed solely to provide either directly or indirectly access to institutional capital markets:

(A) for a financing entity or provider; or

(B) in connection with a transaction in which:

(i) the securities in the special purpose entity are acquired by the owner or by a qualified institutional buyer as defined by 17 C.F.R. Section 230.144A, as amended; or

(ii) the securities pay a fixed rate of return commensurate with established asset-backed institutional capital markets.

(24) "Terminally ill" means having an illness or sickness that can reasonably be expected to result in death not later than 24 months after the date of diagnosis.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1156 (H.B. [2277](#)), Sec. 3, eff. September 1, 2011.

Sec. 1111A.003. LICENSING REQUIREMENTS; EXEMPTION. (a) A person, wherever located, may not act as a provider or broker with an owner who is a resident of this state, unless the person holds a license from the department.

(b) An application for a provider or broker license must be made to the department by the applicant on a form prescribed by the commissioner. The application must be accompanied by a fee in an amount established by the commissioner by rule. The license and renewal fees for a provider license must be reasonable and the license and renewal fees for a broker license may not exceed those established for an insurance agent, as otherwise provided by this chapter.

(c) A person who has been licensed as a life insurance agent in this state or the person's home state for at least one year and is

licensed as a nonresident agent in this state meets the licensing requirements of this section and may operate as a broker.

(d) Not later than the 30th day after the first date of operating as a broker, a life insurance agent shall notify the commissioner on a form prescribed by the commissioner that the agent is acting as a broker and shall pay any applicable fee to be determined by the commissioner by rule. Notification must include an acknowledgement by the life insurance agent that the agent will operate as a broker in accordance with this chapter.

(e) An insurer that issued a policy that is the subject of a life settlement contract is not responsible for any act or omission of a broker or provider or purchaser arising out of or in connection with the life settlement transaction, unless the insurer receives compensation for the placement of a life settlement contract from the provider, purchaser, or broker in connection with the life settlement contract.

(f) A person licensed as an attorney, certified public accountant, or financial planner accredited by a nationally recognized accreditation agency, who is retained to represent the owner and whose compensation is not paid directly or indirectly by the provider or purchaser, may negotiate life settlement contracts for the owner without having to obtain a license as a broker.

(g) A license expires on the second anniversary of the date of issuance. A license holder may renew the license on payment of a renewal fee. As specified by Subsection (b), the renewal fee for a provider license may not exceed a reasonable fee.

(h) An applicant shall provide the information that the commissioner requires on forms adopted by the commissioner. The commissioner may, at any time, require an applicant to fully disclose the identity of its stockholders, except stockholders owning fewer than 10 percent of the shares of an applicant whose shares are publicly traded, partners, officers and employees, and the commissioner may, in the exercise of the commissioner's sole discretion, refuse to issue a license in the name of any person if the commissioner is not satisfied that an officer, an employee, a stockholder, or a partner of the applicant who may materially influence the applicant's conduct meets the standards of Sections 1111A.001 to 1111A.018.

(i) A license issued to a partnership, corporation, or other entity authorizes each member, officer, and designated employee named

in the application and any supplement to the application to act as a license holder under the license.

(j) After the filing of an application and the payment of the license fee, the commissioner shall investigate each applicant and may issue a license if the commissioner finds that the applicant:

- (1) if a provider, has provided a detailed plan of operation;
- (2) is competent and trustworthy and intends to transact business in good faith;
- (3) has a good business reputation and has had experience, training, or education to qualify in the business for which the license is applied;
- (4) if the applicant is a legal entity, is formed or organized under the laws of this state or is a foreign legal entity authorized to transact business in this state, or provides a certificate of good standing from the state of its domicile; and
- (5) has provided to the commissioner an antifraud plan that meets the requirements of Section 1111A.022 and includes:
 - (A) a description of the procedures for detecting and investigating possible fraudulent acts and procedures for resolving material inconsistencies between medical records and insurance applications;
 - (B) a description of the procedures for reporting fraudulent insurance acts to the commissioner;
 - (C) a description of the plan for antifraud education and training of its underwriters and other personnel; and
 - (D) a written description or chart outlining the arrangement of the antifraud personnel who are responsible for the investigation and reporting of possible fraudulent insurance acts and the investigation of unresolved material inconsistencies between medical records and insurance applications.

(k) The commissioner may not issue a license to a nonresident applicant unless a written designation of an agent for service of process is filed and maintained with the department or unless the applicant has filed with the department the applicant's written irrevocable consent that any action against the applicant may be commenced by service of process on the commissioner.

(l) A license holder shall file with the department not later than March 1 of each year an annual statement containing the information as the commissioner by rule prescribes.

(m) A provider may not allow any person to perform the functions of a broker unless the person holds a current, valid license as a broker, and as provided in this section.

(n) A broker may not allow any person to perform the functions of a provider unless the person holds a current, valid license as a provider, and as provided in this section.

(o) A provider or broker shall provide to the commissioner new or revised information about officers, stockholders described by Subsection (h), partners, directors, members, or designated employees within 30 days of the change.

(p) An individual licensed as a broker shall complete on a biennial basis 15 hours of training related to life settlements and life settlement transactions, as required by the commissioner. A life insurance agent who is operating as a broker under this section is not subject to the requirements of this subsection.

(q) The business of life settlements constitutes the business of insurance.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1156 (H.B. [2277](#)), Sec. 3, eff. September 1, 2011.

Sec. 1111A.004. LICENSE SUSPENSION, REVOCATION, OR REFUSAL TO RENEW. (a) The commissioner may suspend, revoke, or refuse to renew the license of a license holder if the commissioner finds that:

(1) there was a material misrepresentation in the application for the license;

(2) the license holder or an officer, partner, member, or director of the license holder has been guilty of fraudulent or dishonest practices, is subject to a final administrative action, or is otherwise shown to be untrustworthy or incompetent to act as a license holder;

(3) the license holder is a provider and demonstrates a pattern of unreasonably withholding payments to policy owners;

(4) the license holder no longer meets the requirements for initial licensure;

(5) the license holder or any officer, partner, member, or director of the license holder has been convicted of a felony, or of any misdemeanor with respect to which criminal fraud is an element, or has pleaded guilty or nolo contendere with respect to a felony or

a misdemeanor with respect to which criminal fraud or moral turpitude is an element, regardless of whether a judgment of conviction has been entered by the court;

(6) the license holder is a provider and has entered into a life settlement contract using a form that has not been approved under this chapter;

(7) the license holder is a provider and has failed to honor contractual obligations in a life settlement contract;

(8) the license holder is a provider and has assigned, transferred, or pledged a settled policy to a person other than a provider licensed in this state, a purchaser, an accredited investor or qualified institutional buyer as defined respectively in 17 C.F.R. Section 230.144A, as amended, a financing entity, a special purpose entity, or a related provider trust; or

(9) the license holder or any officer, partner, member, or key management personnel of the license holder has violated this chapter.

(b) The commissioner may deny a license application or suspend, revoke, or refuse to renew the license of a license holder in accordance with Chapter 2001, Government Code.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1156 (H.B. [2277](#)), Sec. 3, eff. September 1, 2011.

Sec. 1111A.005. REQUIREMENTS FOR CONTRACT FORMS, DISCLOSURE FORMS, AND ADVERTISEMENTS. (a) A person may not use any form of life settlement contract in this state unless the form has been filed with and approved, if required, by the commissioner in a manner that conforms with the filing procedures and any time restrictions or deeming provisions for life insurance forms, policies, and contracts.

(b) An insurer may not, as a condition of responding to a request for verification of coverage or in connection with the transfer of a policy pursuant to a life settlement contract, require that the owner, insured, provider, or broker sign any form, disclosure, consent, waiver, or acknowledgment that has not been expressly approved by the commissioner for use in connection with life settlement contracts.

(c) A person may not use a life settlement contract form or provide to an owner a disclosure statement form unless the form is

first filed with and approved by the commissioner. The commissioner shall disapprove a life settlement contract form or disclosure statement form if, in the commissioner's opinion, the contract or contract provisions fail to meet the requirements of Sections 1111A.011, 1111A.012, 1111A.014, and 1111A.023(b), or are unreasonable, contrary to the interests of the public, or otherwise misleading or unfair to the owner.

(d) At the commissioner's discretion, the commissioner may require the submission of advertisements.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1156 (H.B. [2277](#)), Sec. 3, eff. September 1, 2011.

Sec. 1111A.006. REPORTING REQUIREMENTS AND PRIVACY. (a) For a policy settled not later than the fifth anniversary of the date of policy issuance, each provider shall file with the commissioner not later than March 1 of each year an annual statement containing the information that the commissioner prescribes by rule. In addition to any other requirements, the annual statement must specify the total number, aggregate face amount, and life settlement proceeds of policies settled during the immediately preceding calendar year, together with a breakdown of the information by policy issue year. The annual statement must also include the names of each insurance company whose policies have been settled and the brokers that have settled the policies.

(b) The information required under Subsection (a) is limited to only those transactions in which the insured is a resident of this state and may not include individual transaction data regarding the business of life settlements or information if there is a reasonable basis to find that the information could be used to identify the owner or the insured.

(c) A provider that wilfully fails to file an annual statement as required in this section, or wilfully fails to reply not later than the 30th day after the date the provider receives a written inquiry from the department about the filing of the annual statement, shall, in addition to other penalties provided by this chapter, after notice and opportunity for hearing be subject to a penalty of up to \$250 for each day of delay, not to exceed \$25,000 in the aggregate, for the failure to file or respond.

(d) Except as otherwise allowed or required by law, a provider, broker, insurance company, insurance agent, information bureau, rating agency or company, or any other person with actual knowledge of an insured's identity, may not disclose the identity of an insured or information that there is a reasonable basis to believe could be used to identify the insured or the insured's financial or medical information to any other person unless the disclosure is:

(1) necessary to effect a life settlement contract between the owner and a provider and the owner and insured have provided prior written consent to the disclosure;

(2) necessary to effectuate the sale of a life settlement contract, or interests in the contract, as an investment, provided the sale is conducted in accordance with applicable state and federal securities law and provided further that the owner and the insured have both provided prior written consent to the disclosure;

(3) provided in response to an investigation or examination by the commissioner or another governmental officer or agency or under Section 1111A.018;

(4) a term or condition of the transfer of a policy by one provider to another licensed provider, in which case the receiving provider shall comply with the confidentiality requirements of this subsection;

(5) necessary to allow the provider or broker or the provider's or broker's authorized representative to make contact for the purpose of determining health status provided that in this subdivision, authorized representative does not include a person who has or may have a financial interest in the settlement contract other than a provider, licensed broker, financing entity, related provider trust, or special purpose entity and that the provider or broker requires the authorized representative to agree in writing to adhere to the privacy provisions of this chapter; or

(6) required to purchase stop loss coverage.

(e) Nonpublic personal information solicited or obtained in connection with a proposed or actual life settlement contract is subject to the provisions applicable to financial institutions under the federal Gramm-Leach-Bliley Act (Pub. L. No. 106-102), and any other state and federal laws relating to confidentiality of nonpublic personal information.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1156 (H.B. [2277](#)), Sec. 3,

eff. September 1, 2011.

Sec. 1111A.007. EXAMINATION. Subchapter B, Chapter 401, applies to a person engaged in the business of life settlements.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1156 (H.B. 2277), Sec. 3, eff. September 1, 2011.

Sec. 1111A.008. IMMUNITY FROM LIABILITY. (a) No cause of action shall arise nor shall any liability be imposed against the commissioner, the commissioner's authorized representatives, or any examiner appointed by the commissioner for a statement made or conduct performed in good faith while carrying out this chapter.

(b) No cause of action shall arise, nor shall any liability be imposed against any person for the act of communicating or delivering information to the commissioner or the commissioner's authorized representative or examiner pursuant to an examination made under this chapter, if the act of communication or delivery was performed in good faith and without fraudulent intent or the intent to deceive. This subsection does not abrogate or modify in any way any common law or statutory privilege or immunity enjoyed by any person identified in Subsection (a).

Added by Acts 2011, 82nd Leg., R.S., Ch. 1156 (H.B. 2277), Sec. 3, eff. September 1, 2011.

Sec. 1111A.009. INVESTIGATIVE AUTHORITY OF THE COMMISSIONER. The commissioner may investigate a suspected fraudulent life settlement act and a person engaged in the business of life settlements.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1156 (H.B. 2277), Sec. 3, eff. September 1, 2011.

Sec. 1111A.010. COST OF EXAMINATIONS. The reasonable and necessary cost of an examination under this chapter is to be assessed against the person being examined in accordance with Section 751.208.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1156 (H.B. 2277), Sec. 3, eff. September 1, 2011.

Sec. 1111A.011. ADVERTISING. (a) A broker or provider licensed pursuant to this chapter may conduct or participate in an advertisement in this state. The advertisement must comply with all advertising and marketing laws under Chapter 541 and rules adopted by the commissioner that are applicable to life insurers or to license holders under this chapter.

(b) Advertisements shall be accurate, truthful, and not misleading in fact or by implication.

(c) A person may not:

(1) market, advertise, solicit, or otherwise promote the purchase of a policy for the sole purpose of or with an emphasis on settling the policy; or

(2) use the words "free," "no cost," or words of similar import in the marketing, advertising, or soliciting of, or otherwise promoting, the purchase of a policy.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1156 (H.B. 2277), Sec. 3, eff. September 1, 2011.

Sec. 1111A.012. DISCLOSURES TO OWNERS. (a) The broker, or the provider if no broker is involved in the application, shall provide in writing, in a separate document that is signed by the owner, the following information to the owner not later than the date of application for a life settlement contract:

(1) the fact that possible alternatives to life settlement contracts exist, including accelerated benefits offered by the issuer of the life insurance policy;

(2) the fact that some or all of the proceeds of a life settlement contract may be taxable and that assistance should be sought from a professional tax advisor;

(3) the fact that the proceeds from a life settlement contract could be subject to the claims of creditors;

(4) the fact that receipt of proceeds from a life settlement contract may adversely affect the recipients' eligibility for public assistance or other government benefits or entitlements

and that advice should be obtained from the appropriate agency;

(5) the fact that the owner has a right to terminate a life settlement contract within 15 days of the date the contract is executed by all parties and the owner has received the disclosures described in this section, that rescission, if exercised by the owner, is effective only if both notice of the rescission is given and the owner repays all proceeds and any premiums, loans, and loan interest paid on account of the provider during the rescission period, and that if the insured dies during the rescission period, the contract is considered rescinded subject to repayment by the owner or the owner's estate of all proceeds and any premiums, loans, and loan interest to the provider;

(6) the fact that proceeds will be sent to the owner within three business days after the provider has received the insurer or group administrator's acknowledgement that ownership of the policy or interest in the certificate has been transferred and the beneficiary has been designated in accordance with the terms of the life settlement contract;

(7) the fact that entering into a life settlement contract may cause the owner to forfeit other rights or benefits, including conversion rights and waiver of premium benefits that may exist under the policy or certificate of a group policy, and that assistance should be sought from a professional financial advisor;

(8) the amount and method of calculating the compensation, including anything of value, paid or given, or to be paid or given, to the broker, or any other person acting for the owner in connection with the transaction;

(9) the date by which the funds will be available to the owner and the identity of the transmitter of the funds;

(10) the fact that the commissioner requires delivery of a buyer's guide or a similar consumer advisory package in the form prescribed by the commissioner to owners during the solicitation process;

(11) the following language: "All medical, financial, or personal information solicited or obtained by a provider or broker about an insured, including the insured's identity or the identity of family members or a spouse or a significant other, may be disclosed as necessary to effect the life settlement contract between the owner and provider. If you are asked to provide this information, you will be asked to consent to the disclosure. The information may be

provided to someone who buys the policy or provides funds for the purchase. You may be asked to renew your permission to share information every two years.";

(12) the fact that the commissioner requires providers and brokers to print separate signed fraud warnings on the applications and on the life settlement contracts as follows: "Any person who knowingly presents false information in an application for insurance or a life settlement contract is guilty of a crime and may be subject to fines and confinement in prison.";

(13) the fact that the insured may be contacted by either the provider or broker or an authorized representative of the provider or broker for the purpose of determining the insured's health status or to verify the insured's address and that this contact is limited to once every three months if the insured has a life expectancy of more than one year, and not more than once per month if the insured has a life expectancy of one year or less;

(14) the affiliation, if any, between the provider and the issuer of the insurance policy to be settled;

(15) that a broker represents exclusively the owner, and not the insurer or the provider or any other person, and owes a fiduciary duty to the owner, including a duty to act according to the owner's instructions and in the best interest of the owner;

(16) the name, address, and telephone number of the provider;

(17) the name, business address, and telephone number of the independent third party escrow agent, and the fact that the owner may inspect or receive copies of the relevant escrow or trust agreements or documents; and

(18) the fact that a change of ownership could in the future limit the insured's ability to purchase future insurance on the insured's life because there is a limit to how much coverage insurers will issue on one life.

(b) The written disclosures described by Subsection (a) must be conspicuously displayed in a life settlement contract furnished to the owner by a provider, including any affiliations or contractual arrangements between the provider and the broker.

(c) A broker shall provide the owner and the provider with at least the following disclosures not later than the date on which the life settlement contract is signed by all parties and which must be conspicuously displayed in the life settlement contract or in a

separate document signed by the owner:

(1) the name, business address, and telephone number of the broker;

(2) a full, complete, and accurate description of all the offers, counter-offers, acceptances, and rejections relating to the proposed life settlement contract;

(3) a written disclosure of any affiliations or contractual arrangements between the broker and any person making an offer in connection with the proposed life settlement contract;

(4) the name of each broker who receives compensation and the amount of compensation, including anything of value, paid or given to the broker in connection with the life settlement contract; and

(5) a complete reconciliation of the gross offer or bid by the provider to the net amount of proceeds or value to be received by the owner.

(d) For the purpose of this section, "gross offer or bid" means the total amount or value offered by the provider for the purchase of one or more life insurance policies, inclusive of commissions and fees.

(e) The failure to provide the disclosures or rights described in this section is an unfair method of competition or an unfair or deceptive act or practice.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1156 (H.B. [2277](#)), Sec. 3, eff. September 1, 2011.

Sec. 1111A.013. DISCLOSURE TO INSURER. (a) Without limiting the ability of an insurer to assess the insurability of a policy applicant and to determine whether to issue the policy, and in addition to other questions an insurance carrier may lawfully pose to a life insurance applicant, an insurer may inquire in the application for insurance whether the proposed owner intends to pay premiums with the assistance of financing from a lender that will use the policy as collateral to support the financing.

(b) If, as described in Sections 1111A.002(11) and (11-A), the loan provides funds that can be used for a purpose other than paying for the premiums, costs, and expenses associated with obtaining and maintaining the life insurance policy and loan, and notwithstanding

any other law, the application must be rejected as a violation of Section 1111A.017.

(c) If the financing does not violate Section 1111A.017, the insurance carrier:

(1) may make disclosures, not later than the date of the delivery of the policy, to the applicant and the insured, either on the application or on an amendment to the application that include the following or substantially similar statements:

"If you have entered into a loan arrangement in which the policy is used as collateral, and the policy does change ownership at some point in the future in satisfaction of the loan, the following may be true:

(A) a change of ownership could lead to a stranger owning an interest in the insured's life;

(B) a change of ownership could in the future limit your ability to purchase future insurance on the insured's life because there is a limit to how much coverage insurers will issue on one life;

(C) should there be a change of ownership and you wish to obtain more insurance coverage on the insured's life in the future, the insured's higher issue age, a change in health status, or other factors may reduce the ability to obtain coverage or may result in significantly higher premiums; and

(D) you should consult a professional advisor, since a change in ownership in satisfaction of the loan may result in tax consequences to the owner, depending on the structure of the loan.";

(2) may require certifications, such as the following, from the applicant or the insured:

(A) "I have not entered into any agreement or arrangement providing for the future sale of this life insurance policy";

(B) "My loan arrangement for this policy provides funds sufficient to pay for some or all of the premiums, costs, and expenses associated with obtaining and maintaining my life insurance policy, but I have not entered into any agreement by which I am to receive consideration in exchange for procuring this policy"; and

(C) "The borrower has an insurable interest in the insured."

Added by Acts 2011, 82nd Leg., R.S., Ch. 1156 (H.B. [2277](#)), Sec. 3,

eff. September 1, 2011.

Sec. 1111A.014. GENERAL RULES. (a) Before entering into a life settlement contract with an owner of a policy with respect to which the insured is terminally or chronically ill, the provider must obtain:

(1) if the owner is the insured, a written statement from a licensed attending physician that the owner is of sound mind and under no constraint or undue influence to enter into a settlement contract; and

(2) a document in which the insured consents to the release of medical records to a provider, settlement broker, or insurance agent and, if the policy was issued less than two years after the date of application for a settlement contract, to the insurance company that issued the policy.

(b) An insurer shall respond to a request for verification of coverage submitted by a provider, settlement broker, or life insurance agent not later than the 30th calendar day after the date the request is received. The request for verification of coverage must be made on a form approved by the commissioner. The insurer shall complete and issue the verification of coverage or indicate in which respects the insurer is unable to respond. In the response, the insurer shall indicate whether at the time of the response, based on the medical evidence and documents provided, the insurer intends to pursue an investigation about the validity of the insurance contract.

(c) On or before the date of execution of the life settlement contract, the provider shall obtain a witnessed document in which the owner consents to the settlement contract, represents that the owner has a full and complete understanding of the settlement contract and of the benefits of the policy, acknowledges that the owner is entering into the settlement contract freely and voluntarily, and, for persons with a terminal or chronic illness or condition, acknowledges that the insured has a terminal or chronic illness and that the terminal or chronic illness or condition was diagnosed after the policy was issued.

(d) The insurer may not unreasonably delay effecting change of ownership or beneficiary with any life settlement contract lawfully entered into in this state or with a resident of this state.

(e) If a settlement broker or life insurance agent performs any of these activities required of the provider, the provider is deemed to have fulfilled the requirements of this section.

(f) If a broker performs the verification of coverage activities required of the provider, the provider is deemed to have fulfilled the requirements of Section 1111A.012.

(g) Not later than the 20th day after the date that an owner executes the life settlement contract, the provider shall give written notice to the insurer that issued that insurance policy that the policy has become subject to a life settlement contract. The notice shall be accompanied by the documents required by Section 1111A.013(c).

(h) Medical information solicited or obtained by a license holder is subject to the applicable provision of state law relating to confidentiality of medical information, if not otherwise provided in this chapter.

(i) A life settlement contract entered into in this state must provide that the owner may rescind the contract on or before 15 days after the date the contract is executed by all parties to the contract. Rescission, if exercised by the owner, is effective only if notice of the rescission is given and the owner repays all proceeds and any premiums, loans, and loan interest paid on account of the provider within the rescission period. If the insured dies during the rescission period, the contract is rescinded subject to repayment by the owner or the owner's estate of all proceeds and any premiums, loans, and loan interest to the provider.

(j) Not later than the third business day after the date the provider receives from the owner the documents to effect the transfer of the insurance policy, the provider shall pay the proceeds of the settlement into an escrow or trust account managed by a trustee or escrow agent in a state or federally chartered financial institution pending acknowledgement of the transfer by the issuer of the policy. The trustee or escrow agent shall transfer to the owner the proceeds due to the owner not later than the third business day after the date the trustee or escrow officer receives from the insurer acknowledgment of the transfer of the insurance policy.

(k) Failure to tender the life settlement contract proceeds to the owner on or before the date disclosed to the owner renders the contract voidable by the owner for lack of consideration until the time the proceeds are tendered to and accepted by the owner. A

failure to give written notice of the right of rescission under this subsection tolls the right of rescission for 30 days after the date the written notice of the right of rescission has been given.

(l) A fee paid by a provider, an owner, or other person to a broker in exchange for services provided to the owner pertaining to a life settlement contract must be computed as a percentage of the offer obtained, not the face value of the policy. Nothing in this section prohibits a broker from voluntarily reducing the broker's fee to less than a percentage of the offer obtained.

(m) A broker shall disclose to the owner anything of value paid or given to a broker that relates to a life settlement contract.

(n) A person, at any time prior to or at the time of the application for, or issuance of, a policy, or during a two-year period beginning on the date of issuance of the policy, may not enter into a life settlement contract regardless of the date the compensation is to be provided and regardless of the date the assignment, transfer, sale, devise, bequest, or surrender of the policy is to occur. This prohibition does not apply if:

(1) the owner certifies to the provider that the policy was issued on the owner's exercise of conversion rights arising out of a group or individual policy, provided the total of the time covered under the conversion policy plus the time covered under the prior policy is at least 24 months; or

(2) the owner submits independent evidence to the provider that one or more of the following conditions have been met during the two-year period described by this subsection:

(A) the owner or insured is terminally or chronically ill;

(B) the owner or insured disposes of the owner's or insured's ownership interests in a closely held corporation, pursuant to the terms of a buyout or other similar agreement in effect at the time the insurance policy was initially issued;

(C) the owner's spouse dies;

(D) the owner divorces the owner's spouse;

(E) the owner retires from full-time employment;

(F) the owner becomes physically or mentally disabled and a physician determines that the disability prevents the owner from maintaining full-time employment; or

(G) a final order, judgment, or decree is entered by a court of competent jurisdiction, on the application of a creditor of

the owner, adjudicating the owner bankrupt or insolvent, or approving a petition seeking reorganization of the owner or appointing a receiver, trustee, or liquidator to all or a substantial part of the owner's assets.

(o) For the purposes of Subsection (n)(1), time covered under a group policy must be calculated without regard to a change in insurance carriers, provided the coverage has been continuous and under the same group sponsorship.

(p) Copies of the independent evidence described by Subsection (n)(2) must be submitted to the insurer at the time the provider submits a request to the insurer for verification of coverage. The copies must be accompanied by a letter of attestation from the provider that the copies are true and correct copies of the documents received by the provider. This section does not prohibit an insurer from exercising its right to contest the validity of a policy.

(q) If the provider submits to the insurer a copy of independent evidence provided for Subsection (n)(2)(A) at the time the provider submits a request to the insurer to effect the transfer of the policy to the provider, the copy is deemed to establish that the settlement contract satisfies the requirements of this section.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1156 (H.B. [2277](#)), Sec. 3, eff. September 1, 2011.

Sec. 1111A.015. AUTHORITY TO ADOPT RULES. (a) The commissioner may adopt rules implementing this chapter and regulating the activities and relationships of providers, brokers, insurers, and their authorized representatives.

(b) The commissioner may not adopt a rule establishing a price or fee for the sale or purchase of a life settlement contract. This subsection does not prohibit the commissioner from adopting a rule relating to an unjust price or fee for the sale or purchase of a life settlement contract.

(c) The commissioner may not adopt a rule that regulates the actions of an investor providing money to a life or viatical settlement company.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1156 (H.B. [2277](#)), Sec. 3, eff. September 1, 2011.

Sec. 1111A.016. CONFLICT OF LAWS. (a) If there is more than one owner on a single policy, and the owners are residents of different states, the life settlement contract is governed by the law of the state in which the owner having the largest percentage ownership resides or, if the owners hold equal ownership, the state of residence of one owner agreed on in writing by all of the owners. The law of the state of the insured shall govern in the event that equal owners fail to agree in writing on a state of residence for jurisdictional purposes.

(b) A provider licensed in this state who enters into a life settlement contract with an owner who is a resident of another state that has enacted statutes or adopted rules governing life settlement contracts is governed in the effectuation of that life settlement contract by the statutes and rules of the owner's state of residence. If the state in which the owner is a resident has not enacted statutes or adopted rules governing life settlement contracts, the provider shall give the owner notice that neither state regulates the transaction on which the owner is entering. For transactions in those states, however, the provider shall maintain all records required by this chapter if the transactions were executed in this state. The forms used in those states need not be approved by the department.

(c) If there is a conflict in the laws that apply to an owner and a purchaser in any individual transaction, the laws of the state that apply to the owner shall take precedence and the provider shall comply with those laws.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1156 (H.B. [2277](#)), Sec. 3, eff. September 1, 2011.

Sec. 1111A.017. PROHIBITED PRACTICES. (a) A person may not:

(1) enter into a life settlement contract if the person knows or reasonably should have known that the life insurance policy was obtained by means of a false, deceptive, or misleading application for the policy;

(2) engage in a transaction, practice, or course of business if the person knows or reasonably should have known that the intent of engaging in the transaction, practice, or course of business is to avoid the notice requirements of this chapter;

(3) engage in a fraudulent act or practice in connection with a transaction relating to any settlement involving an owner who is a resident of this state;

(4) issue, solicit, market, or otherwise promote the purchase of an insurance policy for the purpose of, or with an emphasis on, settling the policy;

(5) if providing premium financing, receive any proceeds, fee, or other consideration from the policy or owner in addition to the amounts required to pay principal, interest, and any reasonable costs or expenses incurred by the lender or borrower in connection with the premium finance agreement, except in event of a default, unless either the default on the loan or transfer of the policy occurs pursuant to an agreement or understanding with any other person for the purpose of evading regulation under this chapter;

(6) with respect to any settlement contract or insurance policy and to a broker, knowingly solicit an offer from, effectuate a life settlement contract with, or make a sale to any provider, financing entity, or related provider trust that is controlling, controlled by, or under common control with the broker unless the relationship is fully disclosed to the owner;

(7) with respect to any life settlement contract or insurance policy and a provider, knowingly enter into a life settlement contract with an owner if, in connection with the life settlement contract, anything of value will be paid to a broker that is controlling, controlled by, or under common control with the provider or the financing entity or related provider trust that is involved in such settlement contract, unless the relationship is fully disclosed to the owner;

(8) with respect to a provider, enter into a life settlement contract unless the life settlement promotional, advertising, and marketing materials, as may be prescribed by rule, have been filed with the commissioner, provided that in no event may any marketing materials expressly reference that the insurance is free for any period of time; or

(9) with respect to any life insurance agent, insurance company, broker, or provider, make any statement or representation to the applicant or policyholder in connection with the sale or financing of a life insurance policy to the effect that the insurance is free or without cost to the policyholder for any period of time unless provided in the policy.

(b) A violation of this section is a fraudulent life settlement act.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1156 (H.B. 2277), Sec. 3, eff. September 1, 2011.

Sec. 1111A.018. FRAUD PREVENTION AND CONTROL. (a) A person may not commit a fraudulent life settlement act.

(b) A person may not interfere with the enforcement of this chapter or an investigation of a suspected or actual violation of this chapter.

(c) A person in the business of life settlements may not knowingly or intentionally permit a person convicted of a felony involving dishonesty or breach of trust to participate in the business of life settlements.

(d) A life settlement contract and an application for a life settlement contract, regardless of the form of transmission, must contain the following, or a substantially similar, statement: "Any person who knowingly presents false information in an application for insurance or a life settlement contract is guilty of a crime and may be subject to fines and confinement in prison."

(e) The failure to include a statement as required in Subsection (d) is not a defense in any prosecution for a fraudulent life settlement act.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1156 (H.B. 2277), Sec. 3, eff. September 1, 2011.

Sec. 1111A.019. MANDATORY REPORTING OF FRAUDULENT LIFE SETTLEMENT ACTS. A person engaged in the business of life settlements has a duty under Section 701.051 to report a fraudulent life settlement act.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1156 (H.B. 2277), Sec. 3, eff. September 1, 2011.

Sec. 1111A.020. CONFIDENTIALITY. (a) The documents and evidence obtained by the commissioner in an investigation of a

suspected or an actual fraudulent life settlement act are privileged and confidential, are not a public record, and are not subject to discovery or subpoena in a civil or criminal action.

(b) Subsection (a) does not prohibit release by the commissioner of documents and evidence obtained in an investigation of a suspected or an actual fraudulent life settlement act:

(1) in an administrative or judicial proceeding to enforce a provision of this code or another insurance law of this state;

(2) to a federal, state, or local law enforcement or regulatory agency, to an organization established for the purpose of detecting and preventing a fraudulent life settlement act, or to the National Association of Insurance Commissioners; or

(3) at the discretion of the commissioner, to a person in the business of life settlements that is aggrieved by a fraudulent life settlement act.

(c) Release of documents and evidence under Subsection (b) does not abrogate or modify the privilege granted in Subsection (a).

Added by Acts 2011, 82nd Leg., R.S., Ch. 1156 (H.B. [2277](#)), Sec. 3, eff. September 1, 2011.

Sec. 1111A.021. OTHER LAW ENFORCEMENT OR REGULATORY AUTHORITY. This chapter does not:

(1) preempt the authority or relieve the duty of another law enforcement or regulatory agency to investigate, examine, and prosecute a suspected violation of law;

(2) preempt, supersede, or limit any provision of any state securities law or any rule, order, or notice issued under the law;

(3) prevent or prohibit a person from disclosing voluntarily information concerning life settlement fraud to a law enforcement or regulatory agency other than the department; or

(4) limit the powers granted by the laws of this state to the commissioner or an insurance fraud unit to investigate and examine a possible violation of law and to take appropriate action against wrongdoers.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1156 (H.B. [2277](#)), Sec. 3, eff. September 1, 2011.

Sec. 1111A.022. LIFE SETTLEMENT ANTIFRAUD INITIATIVES. (a) A provider or broker shall implement antifraud initiatives reasonably calculated to detect, prosecute, and prevent fraudulent life settlement acts. At the discretion of the commissioner, the commissioner may order, or a license holder may request and the commissioner may grant, a modification of the following required initiatives as necessary to ensure an effective antifraud program. A modification granted under this section may be more or less restrictive than the required initiatives so long as the modification may reasonably be expected to accomplish the purpose of this section. Antifraud initiatives must include:

(1) fraud investigators, who may be provider or broker employees or independent contractors; and

(2) an antifraud plan, which must be submitted to the commissioner and must include:

(A) a description of the procedures for detecting and investigating possible fraudulent life settlement acts and procedures for resolving material inconsistencies between medical records and insurance applications;

(B) a description of the procedures for reporting possible fraudulent life settlement acts to the commissioner;

(C) a description of the plan for antifraud education and training of underwriters and other personnel; and

(D) a description or chart outlining the organizational arrangement of the antifraud personnel who are responsible for the investigation and reporting of possible fraudulent life settlement acts and investigating unresolved material inconsistencies between medical records and insurance applications.

(b) An antifraud plan submitted to the commissioner is privileged and confidential, is not subject to disclosure under Chapter 552, Government Code, and is not subject to discovery or subpoena in a civil action.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1156 (H.B. [2277](#)), Sec. 3, eff. September 1, 2011.

Sec. 1111A.023. INJUNCTION; CIVIL REMEDIES; CEASE AND DESIST ORDERS. (a) In addition to the penalties and other enforcement provisions of this chapter, if any person violates this chapter or

any rule implementing this chapter, the commissioner may seek an injunction in a court in the county where the person resides or has a principal place of business and may apply for temporary and permanent orders that the commissioner determines necessary to restrain the person from further committing the violation.

(b) The commissioner may issue a cease and desist order against a person who violates any provision of this chapter, any rule or order adopted by the commissioner, or any written agreement entered into with the commissioner, in accordance with Chapter 82.

(c) If the commissioner finds that an action in violation of this chapter presents an immediate danger to the public and requires an immediate final order, the commissioner may issue an emergency cease and desist order under Chapter 83.

(d) The provisions of this chapter may not be waived by agreement. No choice of law provision may prevent the application of this chapter to any settlement.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1156 (H.B. [2277](#)), Sec. 3, eff. September 1, 2011.

Sec. 1111A.024. PENALTIES. (a) It is a violation of this chapter for any person, provider, broker, or any other party related to the business of life settlements to commit a fraudulent life settlement act.

(b) A person who knowingly, recklessly, or intentionally commits a fraudulent life settlement act commits a criminal offense and is subject to penalties under Chapter 35, Penal Code.

(c) Subtitle B, Title 2, applies to a violation of this chapter.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1156 (H.B. [2277](#)), Sec. 3, eff. September 1, 2011.

Sec. 1111A.025. APPLICABILITY OF OTHER INSURANCE LAWS. The following laws apply to a person engaged in the business of life settlements:

(1) Chapters 82, 83, 84, 101, 481, and 701;

(2) Sections 31.002, 32.021, 32.023, 32.041, 38.001, 81.004, 86.001, 86.051, 86.052, 201.004, 401.051, 401.054,

401.151(a), 521.003, 521.004, 543.001(c), 801.056, and 862.052;

- (3) Subchapter A, Chapter 32;
- (4) Subchapter C, Chapter 36;
- (5) Subchapter B, Chapter 404; and
- (6) Subchapter B, Chapter 491.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1156 (H.B. 2277), Sec. 3, eff. September 1, 2011.

Sec. 1111A.026. APPLICABILITY OF CERTAIN PROVISIONS TO LIFE EXPECTANCY ESTIMATORS. (a) The following provisions do not apply to a broker who acts solely as a life expectancy estimator:

- (1) Section 1111A.003(p);
- (2) Section 1111A.012; and
- (3) Sections 1111A.014(l) and (m).

(b) The commissioner may exempt a broker who acts only as a life expectancy estimator from other provisions of this chapter if the commissioner finds that the application of those provisions to the broker is not necessary for the public welfare.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1156 (H.B. 2277), Sec. 3, eff. September 1, 2011.

CHAPTER 1112. CERTAIN GUARANTEES IN LIFE INSURANCE POLICIES

Sec. 1112.001. CERTAIN GUARANTEES NOT PROHIBITED. Section 841.253 does not prohibit the issuance of a life insurance policy that guarantees, by coupons or otherwise, definite payments or reductions in premiums.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1F.001, eff. April 1, 2009.

Sec. 1112.002. CERTAIN GUARANTEES CONSTITUTE DEFINITE CONTRACT BENEFIT; VALUATION OF BENEFIT. (a) Except as provided by Subsection (e), a guarantee described by Section 1112.001 that is in a policy or coupon issued after September 5, 1955, shall be treated as a definite contract benefit and valued according to this section and the reserve requirements of Chapter 425.

(b) Except as provided by Subsection (c), for a policy or coupon issued before the date determined under Section 1105.002(a) or (b), as applicable to the company, a contract benefit described by Subsection (a) shall be valued using the reserve valuation net premium for the benefits that is a uniform percentage of the gross premiums.

(c) A policy described by Subsection (b) that contains a contract benefit described by Subsection (a) may be valued on a basis that provides for not more than one year preliminary term insurance.

(d) For a policy or coupon issued on or after the date determined under Section 1105.002(a) or (b), as applicable to the company, a contract benefit described by Subsection (a) shall be valued using the commissioners reserve valuation method described by Section 425.064.

(e) A provision of this section relating to reserves does not apply to a policy issued before September 7, 1955.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1F.001, eff. April 1, 2009.

CHAPTER 1113. MANAGEMENT, CONTROL, AND DISPOSITION OF CERTAIN LIFE INSURANCE AND ANNUITY CONTRACTS

Sec. 1113.001. LIFE INSURANCE AND ANNUITY CONTRACTS OF SPOUSE. A spouse, without the joinder or consent of the other spouse, has management, control, and disposition of any contract of life insurance or annuity issued in the spouse's name or to the extent provided by the contract or any assignment of the contract, regardless of whether the contract was issued before, on, or after January 1, 1968.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1F.001, eff. April 1, 2009.

CHAPTER 1114. REPLACEMENT OF CERTAIN LIFE INSURANCE POLICIES AND ANNUITIES

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1114.001. PURPOSE. The purpose of this chapter is to:

(1) regulate the activities of insurers and agents with respect to the replacement of existing life insurance and annuities;

- (2) protect the interests of purchasers of life insurance or annuities by establishing minimum standards of conduct to be observed in replacement or financed purchase transactions;
- (3) ensure that purchasers receive information with which a decision in the purchaser's best interest may be made;
- (4) reduce the opportunity for misrepresentation and incomplete disclosure; and
- (5) establish penalties for failure to comply with the requirements adopted under this chapter.

Added by Acts 2007, 80th Leg., R.S., Ch. 904 (H.B. 2762), Sec. 1, eff. September 1, 2007.

Sec. 1114.002. GENERAL DEFINITIONS. In this chapter:

- (1) "Agent" means an individual who holds a license under Chapter 4054 and who sells, solicits, or negotiates life insurance or annuities in this state.
- (2) "Direct-response solicitation" means a solicitation made:
 - (A) by a sponsoring or endorsing entity or individually; and
 - (B) solely through mails, telephone, the Internet, or other mass communication media.
- (3) "Existing insurer" means the insurer, the policy or contract of which is or will be changed or affected by a replacement.
- (4) "Existing policy or contract" means an individual life insurance policy or annuity contract that is in force, including a policy under a binding or conditional receipt or a policy or contract that is within an unconditional refund period.
- (5) "Financed purchase" means the purchase of a new policy that involves the actual or intended use of funds to pay all or part of any premium due on the new policy obtained by:
 - (A) the withdrawal or surrender of an existing policy; or
 - (B) borrowing from values of an existing policy.
- (6) "Illustration" means a presentation or depiction that includes nonguaranteed elements of a life insurance policy over a period of years.
- (7) "Registered contract" means a variable annuity contract

or variable life insurance policy subject to the prospectus delivery requirements of the Securities Act of 1933 (15 U.S.C. Section 77a et seq.).

(8) "Replacement" means a transaction under which a new policy or contract is to be purchased, and for which it is known or should be known to the proposing agent or proposing insurer that, by reason of the transaction, an existing policy or contract has been or is to be:

(A) lapsed, forfeited, surrendered or partially surrendered, assigned to a replacing insurer, or otherwise terminated;

(B) converted to reduced paid-up insurance, continued as extended term insurance, or otherwise reduced in value by the use of nonforfeiture benefits or other policy values;

(C) amended so as to effect a reduction in benefits or in the term for which coverage would otherwise remain in force or for which benefits would be paid;

(D) reissued with any reduction in cash value; or

(E) used in a financed purchase.

(9) "Replacing insurer" means the insurer that issues or proposes to issue a new policy or contract that:

(A) replaces an existing policy or contract; or

(B) is a financed purchase.

(10) "Sales material" means a sales illustration and any other written, printed, or electronically presented information:

(A) created or completed or provided by the insurer or agent; and

(B) used in the presentation to the policy or contract owner relating to the policy or contract purchased.

Added by Acts 2007, 80th Leg., R.S., Ch. 904 (H.B. [2762](#)), Sec. 1, eff. September 1, 2007.

Sec. 1114.003. DEFINITION OF POLICY SUMMARY. (a) For purposes of this chapter, "policy summary" has the meaning assigned by this section.

(b) For a policy or contract other than a universal life insurance policy, "policy summary" means a written statement regarding the policy or contract that at minimum contains, to the

extent applicable, the following information:

- (1) the current death benefit;
- (2) the annual contract premium;
- (3) the current cash surrender value;
- (4) the current dividend;
- (5) the application of the current dividend; and
- (6) the amount of any outstanding loan.

(c) For a universal life insurance policy, "policy summary" means a written statement that contains, at minimum, the following information:

- (1) the beginning and ending date of the current reporting period;
- (2) the policy value at the end of the previous reporting period and at the end of the current reporting period;
- (3) the total amounts that have been credited or debited to the policy value during the current reporting period, identifying each by type, including interest, mortality, expense, and riders;
- (4) the current death benefit at the end of the current reporting period on each life covered by the policy;
- (5) the net cash surrender value of the policy as of the end of the current reporting period; and
- (6) the amount of any outstanding loans as of the end of the current reporting period.

Added by Acts 2007, 80th Leg., R.S., Ch. 904 (H.B. [2762](#)), Sec. 1, eff. September 1, 2007.

Sec. 1114.004. APPLICABILITY; EXEMPTIONS. (a) Except as otherwise specifically provided by this chapter, this chapter does not apply to transactions involving:

- (1) credit life insurance;
- (2) group life insurance or group annuities for which there is no direct solicitation of individuals by an agent;
- (3) life insurance and annuities used to fund prepaid funeral benefits contracts, as defined by Chapter 154, Finance Code;
- (4) an application to:
 - (A) exercise a contractual change or a conversion privilege made to the insurer that issued the existing policy or contract;

(B) replace an existing policy or contract by the insurer that issued the existing policy or contract under a program filed with and approved by the commissioner; or

(C) exercise a term conversion privilege among corporate affiliates;

(5) life insurance proposed to replace life insurance under a binding or conditional receipt issued by the same insurer;

(6) a policy or contract used to fund:

(A) an employee pension benefit plan or employee welfare benefit plan that is covered by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.);

(B) a plan described by Section 401(a), 401(k), or 403(b), Internal Revenue Code of 1986, if established or maintained by an employer;

(C) a government or church plan, as defined by Section 414, Internal Revenue Code of 1986, a government or church welfare benefit plan, or a deferred compensation plan of a state or local government or tax exempt organization described under Section 457, Internal Revenue Code of 1986; or

(D) a nonqualified deferred compensation arrangement established or maintained by an employer or plan sponsor;

(7) new coverage provided under a life insurance policy or contract if the cost is borne wholly by the insured's employer or by an association of which the insured is a member;

(8) an existing life insurance policy that is a nonconvertible term life insurance policy scheduled to expire in five years or less and that cannot be renewed;

(9) immediate annuities purchased with proceeds from an existing contract; or

(10) structured settlements.

(b) Notwithstanding Subsection (a)(6), this chapter applies to policies or contracts used to fund any plan or arrangement that is funded solely by contributions an employee elects to make, whether on a pre-tax or after-tax basis, if:

(1) the insurer has been notified that plan participants may choose from among two or more insurers; and

(2) there is a direct solicitation of an individual employee by an insurance agent for the purchase of a contract or policy.

(c) Group life insurance or group annuity certificates marketed

through direct response solicitation are subject to Section 1114.055.

(d) Notwithstanding Subsection (a)(9), immediate annuities purchased with proceeds from an existing policy are not exempted from the requirements of this chapter.

(e) For the purpose of Subsections (a), (b), and (c), "direct solicitation" does not include a group meeting held by an insurance agent solely for the purpose of:

(1) educating or enrolling individuals; or

(2) if initiated by an individual member of the group, assisting with the selection of investment options offered by a single insurer in connection with enrolling that individual.

Added by Acts 2007, 80th Leg., R.S., Ch. 904 (H.B. 2762), Sec. 1, eff. September 1, 2007.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 1156 (H.B. 2277), Sec. 4, eff. September 1, 2011.

Sec. 1114.005. FINANCED PURCHASE. (a) If a withdrawal, surrender, or borrowing involving the policy values of an existing policy is used to pay premiums on a new policy that is owned by the same policyholder and is issued by the same insurer not earlier than four months before the effective date of the new policy or 13 months after the effective date of the new policy, it is deemed prima facie evidence of the policyholder's intent to finance the purchase of the new policy with existing policy values.

(b) Subsection (a) applies only to regulatory review of an individual transaction.

(c) The prima facie standard under Subsection (a) is not intended to increase or decrease the monitoring obligations contained in Section 1114.052(g).

Added by Acts 2007, 80th Leg., R.S., Ch. 904 (H.B. 2762), Sec. 1, eff. September 1, 2007.

Sec. 1114.006. CONSUMER NOTICE DOCUMENTS. (a) The commissioner by rule shall adopt or approve model documents to be used for consumer notices under this chapter.

(b) The department may develop model documents under this

section, or the commissioner may approve model documents developed by insurers or published by national organizations recognized by the commissioner.

Added by Acts 2007, 80th Leg., R.S., Ch. 904 (H.B. 2762), Sec. 1, eff. September 1, 2007.

Sec. 1114.007. RULES. The commissioner may adopt reasonable rules in the manner prescribed by Subchapter A, Chapter 36, to accomplish and enforce the purpose of this chapter.

Added by Acts 2007, 80th Leg., R.S., Ch. 904 (H.B. 2762), Sec. 1, eff. September 1, 2007.

SUBCHAPTER B. DUTIES OF INSURERS AND AGENTS

Sec. 1114.051. DUTIES OF AGENT; NOTICE. (a) An agent who initiates an application for a life insurance policy or annuity contract shall submit to the insurer, with or as part of the application, a statement signed by both the applicant and the agent as to whether the applicant has existing policies or contracts.

(b) If the applicant states that the applicant does not have existing policies or contracts, the agent's duties, after compliance with Subsection (a), with respect to replacement are complete.

(c) If the applicant states that the applicant does have existing policies or contracts, the agent shall present and read to the applicant, not later than at the time of taking the application, a notice regarding replacements as provided by Subsection (d).

(d) Except as provided by Subsection (e), the notice required by this section must be given in a form adopted or approved by the commissioner. The notice shall be signed by both the applicant and the agent attesting that the notice has been read aloud by the agent or that the applicant did not wish the notice to be read aloud, in which case the agent is not required to read the notice aloud. The notice must be left with the applicant unless it is presented to the applicant by electronic means and signed electronically, in which case the insurer shall mail the applicant a copy of the notice not later than the third business day after the date the application is received by the insurer. The notice must list all life insurance policies or annuities proposed to be replaced, properly identified by

the name of the insurer, the name of the insured or annuitant, and the policy or contract number if available, and include a statement as to whether each policy or contract will be replaced or whether a policy will be used as a source of financing for the new policy or contract. If a policy or contract number has not been issued by the existing insurer, alternative identification, such as an application or receipt number, must be listed.

(e) Commissioner approval of a notice is not required if a notice adopted or approved by the commissioner is used and amendments to that notice are limited to the omission of references not applicable to the product being sold or replaced.

(f) In connection with a replacement transaction, the agent shall leave with the applicant, at the time an application for a new policy or contract is completed, the original of all sales material or a copy of that material. Electronically presented sales material must be provided to the policy or contract owner in printed form not later than the date that the policy or contract is delivered.

(g) Except as provided by Section 1114.053(g), in connection with a replacement transaction, the agent shall submit to the insurer to which an application for a policy or contract is presented:

- (1) a copy of each document required by this section;
- (2) a statement identifying any preprinted or electronically presented insurer-approved sales materials used; and
- (3) copies of any individualized sales materials, including any illustrations related to the specific policy or contract purchased.

Added by Acts 2007, 80th Leg., R.S., Ch. 904 (H.B. [2762](#)), Sec. 1, eff. September 1, 2007.

Sec. 1114.052. DUTIES OF INSURERS THAT USE AGENTS. (a) An insurer that uses an agent shall comply with this section.

(b) Each insurer shall maintain a system of supervision and control to ensure compliance with the requirements of this chapter. Under the system, the insurer must, at minimum:

- (1) inform its agents of the requirements of this chapter and incorporate the requirements of this chapter into all relevant agent training manuals prepared by the insurer;
- (2) provide each agent a written statement of the insurer's

position with respect to the acceptability of replacements and provide guidance to the agent as to the appropriateness of these transactions;

(3) review the appropriateness of each replacement transaction that the agent does not indicate is in accord with Subdivision (2);

(4) implement procedures to confirm that the requirements of this chapter have been met; and

(5) implement procedures to detect transactions that are replacements of existing policies or contracts by the existing insurer but that have not been reported as such by the applicant or agent.

(c) Compliance with Subsection (b)(5) may include systematic customer surveys, interviews, confirmation letters, or programs of internal monitoring.

(d) Each insurer must have the capacity to monitor each agent's life insurance policy and annuity contract replacements for that insurer. The insurer shall maintain records regarding the monitoring and shall produce and make the records available to the department on request. The capacity to monitor under this subsection must include the ability to produce records for:

(1) each agent's life insurance replacements, including financed purchases, as a percentage of the agent's total annual sales for life insurance;

(2) the number of lapses of policies by the agent as a percentage of the agent's total annual sales for life insurance;

(3) each agent's annuity contract replacements as a percentage of the agent's total annual annuity contract sales;

(4) the number of transactions that are unreported replacements of existing policies or contracts by the existing insurer detected by the insurer's monitoring system as required by Subsection (b)(5); and

(5) replacements, indexed by replacing agent and existing insurer.

(e) Each insurer shall require, with or as a part of each application for life insurance or an annuity, a signed statement by both the applicant and the agent as to whether the applicant has existing policies or contracts.

(f) Each insurer shall require, with each application for life insurance or an annuity that indicates an existing policy or

contract, a completed notice regarding replacements.

(g) If the applicant has existing policies or contracts, each insurer must be able to produce, for at least five years after the date of termination or expiration of the proposed policy or contract, copies of any sales material required by Section 1114.051(g), the basic illustration and any supplemental illustrations related to the specific policy or contract that is purchased, and the agent's and applicant's signed statements with respect to financing and replacement.

(h) The insurer shall ascertain that the sales material and illustrations required by Section 1114.051(g) meet the requirements of this chapter and are complete and accurate for the proposed policy or contract.

(i) If an application does not meet the requirements of this chapter, the insurer shall notify the agent and applicant and fulfill the outstanding requirements.

(j) The insurer shall maintain records required by this section in paper, photographic, microprocess, magnetic, mechanical, or electronic media or by any process that accurately reproduces the actual document.

Added by Acts 2007, 80th Leg., R.S., Ch. 904 (H.B. 2762), Sec. 1, eff. September 1, 2007.

Sec. 1114.053. DUTIES OF REPLACING INSURERS THAT USE AGENTS.

(a) If a transaction under this chapter involves a replacement, the replacing insurer shall comply with this section.

(b) The replacing insurer shall verify that the required forms are received and are in compliance with this chapter.

(c) The replacing insurer shall:

(1) notify any existing insurer that may be affected by the proposed replacement not later than the fifth business day after:

(A) the date of receipt of a completed application indicating replacement; or

(B) the date that replacement is identified if it is not indicated on the application; and

(2) mail a copy of the available illustration or policy summary for the proposed policy or available disclosure document for the proposed contract to the existing insurer not later than the

fifth business day after the date of a request from the existing insurer.

(d) The replacing insurer must be able to produce copies of the notification regarding replacement required by Section 1114.051(d), indexed by agent, until the later of:

(1) the fifth anniversary of the date of the notification; or

(2) the date of the replacing insurer's next regular examination by the insurance regulatory authority of the insurer's state of domicile.

(e) The replacing insurer shall provide to the policy or contract owner notice of the owner's right to return the policy or contract within 30 days of the delivery of the policy or contract and to receive an unconditional full refund of all premiums or considerations paid on the policy or contract, including any policy fees or charges or, in the case of a variable or market value adjustment policy or contract, a payment of the cash surrender value provided under the policy or contract plus the fees and other charges deducted from the gross premiums or considerations or imposed under the policy or contract. The notice may be combined with other notices required under this chapter in accordance with rules of the commissioner.

(f) In transactions in which the replacing insurer and the existing insurer are the same or are subsidiaries or affiliates under common ownership or control, the replacing insurer shall allow credit for the period that has elapsed under the replaced policy's or contract's incontestability and suicide period up to the face amount of the existing policy or contract. With regard to financed purchases, the credit may be limited to the amount that the face amount of the existing policy is reduced by the use of existing policy values to fund the new policy or contract.

(g) If an insurer prohibits the use of sales material other than that approved by the insurer, as an alternative to the requirements under Section 1114.051(g), the insurer shall:

(1) require with each application a statement signed by the agent that:

(A) represents that the agent used only insurer-approved sales material; and

(B) states that copies of all sales material were left with the applicant in accordance with Section 1114.051(f);

(2) not later than the 10th day after the date of issuance of the policy or contract:

(A) notify the applicant by sending a letter, or by verbal communication with the applicant by a person whose duties are separate from the marketing area of the insurer, that the agent has represented that copies of all sales material have been left with the applicant in accordance with Section 1114.051(f);

(B) provide the applicant with a toll-free telephone number to contact the insurer's personnel involved in the compliance function if copies of all sales material have not been left with the applicant in accordance with Section 1114.051(f); and

(C) stress the importance of retaining copies of the sales material for future reference; and

(3) be able to produce a copy of the letter or other verification in the policy file until the fifth anniversary of the date of termination or expiration of the policy or contract.

Added by Acts 2007, 80th Leg., R.S., Ch. 904 (H.B. [2762](#)), Sec. 1, eff. September 1, 2007.

Sec. 1114.054. DUTIES OF EXISTING INSURER. (a) If a transaction involves a replacement, the existing insurer shall comply with this section.

(b) The existing insurer shall retain and be able to produce all replacement notifications received, indexed by the replacing insurer, until the later of:

(1) the fifth anniversary of the date of receipt of the notification; or

(2) the date of conclusion of the next regular examination conducted by the insurance regulatory authority of the existing insurer's state of domicile.

(c) The existing insurer shall send a letter to the policy or contract owner regarding the owner's right to receive information regarding the existing policy or contract values. The letter must include, if available, an in force illustration or, if an in force illustration cannot be produced not later than the fifth business day after the date of receipt of a notice that an existing policy or contract is being replaced, a policy summary. The information must be provided not later than the fifth business day after the date of

receipt of the request from the policy or contract owner.

(d) On receipt of a request to borrow, surrender, or withdraw any policy values, the existing insurer shall send a notice advising the policy owner that the release of policy values may affect the guaranteed elements, nonguaranteed elements, face amount, or surrender value of the policy from which the values are released. The notice must be sent separately from the payment if the payment is sent to any person other than the policy owner. In the case of consecutive automatic premium loans, the insurer is only required to send the notice at the time of the first loan.

Added by Acts 2007, 80th Leg., R.S., Ch. 904 (H.B. 2762), Sec. 1, eff. September 1, 2007.

Sec. 1114.055. DUTIES OF INSURERS REGARDING DIRECT RESPONSE SOLICITATIONS. (a) In the case of an application initiated as a result of a direct response solicitation, the insurer shall require submission of a statement asking whether the applicant, by applying for the proposed policy or contract, intends to replace, discontinue, or change an existing policy or contract. The statement may be included with, or submitted as part of, each completed application for a policy or contract. If the applicant indicates a replacement or change is not intended or if the applicant fails to respond to the statement, the insurer shall send the applicant, with the policy or contract, a notice, in a form adopted or approved by the commissioner, regarding replacement.

(b) If the insurer has proposed the replacement or if the applicant indicates a replacement is intended and the insurer continues with the replacement, the insurer shall:

(1) provide to the applicant or prospective applicant, with the policy or contract, a notice adopted or approved by the commissioner; and

(2) comply with the requirements of:

(A) Section 1114.053(c), if the applicant furnishes the names of the existing insurers; and

(B) Sections 1114.053(d), (e), and (f).

(c) In a situation described by Subsection (b)(1), the insurer may use a notice that deletes references to the agent, including the agent's signature, and references not applicable to the product being

sold or replaced, without having to obtain prior approval of the notice from the commissioner. The insurer's obligation to obtain the applicant's signature is satisfied if the insurer can demonstrate that the insurer has made a diligent effort to secure a signed copy of the notice. The requirement to make a diligent effort is deemed satisfied if the insurer includes in the mailing a self-addressed postage prepaid envelope with instructions for the return of the signed notice.

Added by Acts 2007, 80th Leg., R.S., Ch. 904 (H.B. 2762), Sec. 1, eff. September 1, 2007.

Sec. 1114.056. REGISTERED CONTRACTS. A registered contract is exempt from the requirements of Sections 1114.053(c) and 1114.054(c) with respect to the provision of illustrations or policy summaries, but must provide instead premium or contract contribution amounts and identification of the appropriate prospectus or offering circular.

Added by Acts 2007, 80th Leg., R.S., Ch. 904 (H.B. 2762), Sec. 1, eff. September 1, 2007.

Sec. 1114.057. DISCLOSURE OF AVAILABILITY OF WAIVER OF SURRENDER CHARGES. An insurer that offers to waive surrender charges as described by Section 541.058(b)(4) shall provide reasonable notice of that offer to the insurer's prospective or current contract holders. The notice may be provided by any available means, including a disclosure document or by display on a link that is prominently placed on the insurer's Internet website.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1156 (H.B. 2277), Sec. 5, eff. September 1, 2011.

SUBCHAPTER C. ENFORCEMENT

Sec. 1114.101. UNFAIR METHOD OF COMPETITION; SANCTIONS AND PENALTIES. (a) A failure by an insurer or agent to comply with this chapter constitutes a violation of Chapter 541 and is subject to sanctions and penalties as provided by that chapter. For purposes of this section, examples of violations include:

(1) deceptive or misleading information set forth in any sales material;

(2) failing to ask the applicant in completing the application the pertinent questions regarding the possibility of financing or replacement;

(3) intentionally recording an answer incorrectly;

(4) advising an applicant to respond negatively to any question regarding replacement in order to prevent notice to the existing insurer; or

(5) advising a policy or contract owner to contact the insurer directly in such a way as to attempt to obscure the identity of the replacing agent or insurer.

(b) A policy or contract owner has the right to replace an existing life insurance policy or annuity contract after indicating in or as a part of applications for new coverage that replacement is not the intention. However, patterns of that action by policy or contract owners of the same agent shall be deemed prima facie evidence of the agent's knowledge that replacement was intended in connection with the identified transactions, and those patterns of action shall be deemed prima facie evidence of the agent's intent to violate this chapter.

(c) If it is determined that the requirements of this chapter have not been met, the replacing insurer shall provide to the policy owner:

(1) an in force illustration or, if an in force illustration is not available, a policy summary for the replacement policy or an available disclosure document for the replacement contract; and

(2) the appropriate notice regarding replacements.

Added by Acts 2007, 80th Leg., R.S., Ch. 904 (H.B. [2762](#)), Sec. 1, eff. September 1, 2007.

Sec. 1114.102. ADDITIONAL SANCTIONS. (a) In addition to sanctions and penalties under Chapter 541 as provided by Section 1114.101, an insurer or agent that violates this chapter is subject to sanctions as provided by Chapter 82, which may include:

(1) the revocation or suspension of the agent's license or the insurer's certificate of authority;

(2) administrative penalties under Chapter 84; and
 (3) forfeiture of any commissions or other compensation paid to an agent as a result of the transaction in connection with which the violations occurred.

(b) In addition, if the commissioner has determined that the violations of this chapter were material to the sale, the insurer may be required to:

(1) make restitution in the manner provided by Section 82.053;
 (2) restore policy or contract values; and
 (3) pay interest at the rate set by Section 84.050 on the amount refunded in cash.

Added by Acts 2007, 80th Leg., R.S., Ch. 904 (H.B. 2762), Sec. 1, eff. September 1, 2007.

CHAPTER 1115. SUITABILITY OF CERTAIN ANNUITY TRANSACTIONS
SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1115.001. PURPOSE. The purpose of this chapter is to require an agent to act in the best interest of the consumer when making a recommendation of an annuity and to require insurers to establish and maintain a system to supervise those recommendations so that the insurance needs and financial objectives of the consumer as of the time of the transaction are effectively addressed.

Added by Acts 2007, 80th Leg., R.S., Ch. 736 (H.B. 2761), Sec. 1, eff. September 1, 2007.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 1156 (H.B. 2277), Sec. 6, eff. September 1, 2011.

Acts 2021, 87th Leg., R.S., Ch. 262 (H.B. 1777), Sec. 2, eff. September 1, 2021.

Sec. 1115.002. DEFINITIONS. In this chapter:

(1) "Agent" means an individual who holds a license under Chapter 4054 and who sells, solicits, or negotiates insurance or annuity contracts in this state.

(2) "Annuity" means an annuity that is an insurance product under the laws of this state that is individually solicited, whether

the product is classified as an individual annuity or group annuity.

(2-a) "Cash compensation" means a discount, concession, fee, service fee, commission, sales charge, loan, override, or cash benefit received by an agent from an insurer, intermediary, or consumer in connection with the recommendation or sale of an annuity.

(2-b) "Consumer profile information" means information that is reasonably appropriate to determine whether a recommendation addresses the consumer's financial situation, insurance needs, and financial objectives, including the following:

- (A) age;
- (B) annual income;
- (C) existing assets and financial products, including investment, annuity, and insurance holdings;
- (D) financial situation and needs, including debts and other obligations;
- (E) financial experience;
- (F) financial objectives;
- (G) financial resources used to fund the annuity;
- (H) financial time horizon;
- (I) insurance needs;
- (J) intended use of the annuity;
- (K) liquid net worth;
- (L) liquidity needs;
- (M) risk tolerance, including willingness to accept non-guaranteed elements in the annuity; and
- (N) tax status.

(2-c) "Continuing education provider" means a person authorized to offer continuing education courses under Chapter 4004.

(3) "Insurer" means a company authorized to engage in the business of life insurance and annuities in this state, and includes a fraternal benefit society operating under Chapter 885.

(3-a) "Intermediary" means an entity contracted directly with an insurer or with another entity contracted with an insurer to facilitate the sale of the insurer's annuities by agents.

(3-b) "Material conflict of interest" means a financial interest of an agent in the sale of an annuity that a reasonable person would expect to influence the impartiality of a recommendation. The term does not include cash or noncash compensation paid to an agent.

(3-c) "Noncash compensation" means any form of compensation

that is not cash compensation, including health insurance, office rent, office support, and retirement benefits.

(3-d) "Non-guaranteed element" means a premium, credited interest rate, including any bonus, benefit, value, dividend, non-interest based credit, or charge, or an element of a formula used to determine any of those elements, that is determined at the discretion of the insurer and is not guaranteed at issue. The term includes an element that is calculated using an element that is determined at the discretion of the insurer and is not guaranteed at issue.

(4) "Recommendation" means advice provided by an agent, or an insurer if no agent is involved, to an individual consumer that is intended to result or does result in a purchase, exchange, or replacement of an annuity made in accordance with that advice. The term does not include a general communication to the public, any generalized customer service assistance or administrative support, any general educational information or tools, a prospectus, or any other product or sales material.

(5) "Replacement" means a transaction in which a new annuity is to be purchased and the proposing agent, or the proposing insurer regardless of whether an agent is involved, knows or should know that, by reason of the transaction, an existing annuity or other insurance policy has been or is to be:

(A) lapsed, forfeited, surrendered or partially surrendered, assigned to the replacing insurer, or otherwise terminated;

(B) converted to reduced paid-up insurance, continued as extended term insurance, or otherwise reduced in value by the use of nonforfeiture benefits or other policy values;

(C) amended so as to effect either a reduction in benefits or in the term for which coverage would otherwise remain in force or for which benefits would be paid;

(D) reissued with any reduction in cash value; or

(E) used in a financed purchase.

(6) Repealed by Acts 2021, 87th Leg., R.S., Ch. 262 (H.B. [1777](#)), Sec. 18(1), eff. September 1, 2021.

Added by Acts 2007, 80th Leg., R.S., Ch. 736 (H.B. [2761](#)), Sec. 1, eff. September 1, 2007.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 1156 (H.B. [2277](#)), Sec. 7, eff.

September 1, 2011.

Acts 2021, 87th Leg., R.S., Ch. 262 (H.B. 1777), Sec. 3, eff. September 1, 2021.

Acts 2021, 87th Leg., R.S., Ch. 262 (H.B. 1777), Sec. 18(1), eff. September 1, 2021.

Sec. 1115.003. APPLICABILITY; EXEMPTIONS. (a) This chapter applies to any sale of an annuity.

(b) Unless otherwise specifically included, this chapter does not apply to transactions involving:

(1) direct response solicitations if there is no recommendation based on information collected from the consumer under this chapter;

(2) contracts used to fund:

(A) an employee pension benefit plan or employee welfare benefit plan covered by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.);

(B) a plan described by Section 401(a), 401(k), 403(b), 408(k), or 408(p), Internal Revenue Code of 1986, if established or maintained by an employer;

(C) a government or church plan, as defined by Section 414, Internal Revenue Code of 1986, a government or church welfare benefit plan, or a deferred compensation plan of a state or local government or tax exempt organization described under Section 457, Internal Revenue Code of 1986; or

(D) a nonqualified deferred compensation arrangement established or maintained by an employer or plan sponsor;

(3) settlements of or assumptions of liabilities associated with personal injury litigation or any dispute or claim resolution process; or

(4) prepaid funeral benefits contracts, as defined by Chapter 154, Finance Code.

Added by Acts 2007, 80th Leg., R.S., Ch. 736 (H.B. 2761), Sec. 1, eff. September 1, 2007.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 1156 (H.B. 2277), Sec. 8, eff. September 1, 2011.

Acts 2021, 87th Leg., R.S., Ch. 262 (H.B. 1777), Sec. 4, eff.

September 1, 2021.

Sec. 1115.004. NO CAUSE OF ACTION CREATED. This chapter may not be construed to create or imply a private cause of action against an agent or insurer or to subject an agent or insurer to civil liability for a violation of:

- (1) this chapter or a rule adopted under this chapter; or
- (2) a standard governing the conduct of a fiduciary or a fiduciary relationship.

Added by Acts 2007, 80th Leg., R.S., Ch. 736 (H.B. 2761), Sec. 1, eff. September 1, 2007.

Amended by:

Acts 2021, 87th Leg., R.S., Ch. 262 (H.B. 1777), Sec. 5, eff. September 1, 2021.

Sec. 1115.005. RULES. The commissioner may adopt reasonable rules in the manner prescribed by Subchapter A, Chapter 36, to accomplish and enforce the purpose of this chapter.

Added by Acts 2007, 80th Leg., R.S., Ch. 736 (H.B. 2761), Sec. 1, eff. September 1, 2007.

SUBCHAPTER B. DUTIES OF INSURERS AND AGENTS

Sec. 1115.0505. AGENTS EXERCISING MATERIAL CONTROL. (a) This subchapter applies to each agent who:

- (1) exercises material control or influence in making a recommendation or sale; and
- (2) receives direct compensation as a result of the recommendation or sale, regardless of whether the agent has direct contact with the consumer.

(b) Activities that do not constitute material control or influence include providing or delivering marketing or educational materials, product wholesaling or other back office product support, general supervision of an agent, and similar activities.

Added by Acts 2021, 87th Leg., R.S., Ch. 262 (H.B. 1777), Sec. 6, eff. September 1, 2021.

Sec. 1115.0506. TRANSACTIONS NOT BASED ON RECOMMENDATION; CERTAIN EXEMPTIONS FROM SUBCHAPTER. An agent does not have an obligation to a consumer under Section 1115.0513 if:

- (1) the agent does not make a recommendation;
- (2) the agent makes a recommendation based on materially inaccurate information provided by the consumer;
- (3) the consumer refuses to provide consumer profile information; or
- (4) the consumer enters into an annuity transaction that is not based on the recommendation from the agent or the insurer.

Added by Acts 2021, 87th Leg., R.S., Ch. 262 (H.B. 1777), Sec. 6, eff. September 1, 2021.

Sec. 1115.0507. INSURER OBLIGATIONS. (a) Notwithstanding Section 1115.0506, an insurer's issuance of an annuity must be reasonable under the circumstances known to the insurer at the time the annuity is issued.

(b) If there is no agent involved in an annuity transaction, the obligations described in this subchapter apply to the insurer that recommends or sells the annuity in the same way those obligations would apply to an agent.

Added by Acts 2021, 87th Leg., R.S., Ch. 262 (H.B. 1777), Sec. 6, eff. September 1, 2021.

Sec. 1115.0508. ADDITIONAL LICENSURE NOT REQUIRED. Nothing in this subchapter may be construed to require an agent to obtain a license other than the license described by Chapter 4054.

Added by Acts 2021, 87th Leg., R.S., Ch. 262 (H.B. 1777), Sec. 6, eff. September 1, 2021.

Sec. 1115.051. BEST-INTEREST OBLIGATION. (a) When making a recommendation of an annuity, an agent shall act in the best interest of the consumer under the circumstances known to the agent at the

time the recommendation is made, without placing the agent's or the insurer's financial interest ahead of the consumer's interest.

(b) An agent is presumed to act in the best interest of the consumer if the agent satisfies the care, disclosure, conflict of interest, and documentation obligations described by this subchapter.

(c) Repealed by Acts 2021, 87th Leg., R.S., Ch. 262 (H.B. 1777), Sec. 18(2), eff. September 1, 2021.

(d) Repealed by Acts 2021, 87th Leg., R.S., Ch. 262 (H.B. 1777), Sec. 18(2), eff. September 1, 2021.

(e) Repealed by Acts 2021, 87th Leg., R.S., Ch. 262 (H.B. 1777), Sec. 18(2), eff. September 1, 2021.

(f) Repealed by Acts 2021, 87th Leg., R.S., Ch. 262 (H.B. 1777), Sec. 18(2), eff. September 1, 2021.

Added by Acts 2007, 80th Leg., R.S., Ch. 736 (H.B. 2761), Sec. 1, eff. September 1, 2007.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 1156 (H.B. 2277), Sec. 9, eff. September 1, 2011.

Acts 2021, 87th Leg., R.S., Ch. 262 (H.B. 1777), Sec. 7, eff. September 1, 2021.

Acts 2021, 87th Leg., R.S., Ch. 262 (H.B. 1777), Sec. 8, eff. September 1, 2021.

Acts 2021, 87th Leg., R.S., Ch. 262 (H.B. 1777), Sec. 18(2), eff. September 1, 2021.

Sec. 1115.0513. CARE OBLIGATION. (a) In making a recommendation, an agent shall exercise reasonable diligence, care, and skill to:

(1) obtain consumer profile information from the consumer before making the recommendation of an annuity;

(2) know the consumer's financial situation, insurance needs, and financial objectives;

(3) understand the available recommendation options available to the agent;

(4) consider the types of products the agent is authorized and licensed to recommend or sell that address the consumer's financial situation, insurance needs, and financial objectives;

(5) have a reasonable basis to believe the recommendation

addresses the consumer's financial situation, insurance needs, and financial objectives over the life of the product, in light of the consumer profile information;

(6) have a reasonable basis to believe the consumer would benefit from certain features of the annuity, such as annuitization, a death or living benefit, or other insurance-related feature; and

(7) communicate the basis of the recommendation.

(b) Subsection (a) does not require:

(1) analysis or consideration of a product outside the authority and license of the agent;

(2) analysis or consideration of a product or strategy that is an alternative to an annuity;

(3) recommendation of the annuity with the lowest one-time or multiple occurrence compensation structure; or

(4) ongoing monitoring of the consumer's financial situation.

(c) The agent shall consider consumer profile information, characteristics of the insurer, and product costs, rates, benefits, and features in determining whether an annuity effectively addresses the consumer's financial situation, insurance needs, and financial objectives. The agent may place varying levels of importance on each of those factors based on the facts and circumstances of a particular case, but may not consider one factor in isolation.

(d) In the case of an exchange or replacement of an annuity, the agent shall consider the whole transaction, including whether:

(1) the consumer will incur a surrender charge, be subjected to the commencement of a new surrender period, lose existing benefits such as death, living, or other contractual benefits, or be subject to increased fees, investment advisory fees, or charges for riders and similar product enhancements;

(2) the replacing product would substantially benefit the consumer in comparison to the replaced product over the life of the product; and

(3) the consumer has had an annuity exchange or replacement in the preceding 60 months.

(e) This section applies to an annuity as a whole, including:

(1) underlying subaccounts to which money is allocated at the time of the purchase or exchange of an annuity; and

(2) any riders and similar product enhancements.

(f) An agent shall be held to standards applicable to an agent

with similar authority and licensure with respect to the requirements of this section. This section does not create a fiduciary obligation or relationship and only creates a regulatory obligation. This section does not affect any ongoing monitoring obligation an agent may have under a fiduciary, consulting, investment advising, or financial planning agreement between the consumer and the agent.

Added by Acts 2021, 87th Leg., R.S., Ch. 262 (H.B. 1777), Sec. 9, eff. September 1, 2021.

Sec. 1115.0514. DISCLOSURE OBLIGATION. (a) Before the recommendation or sale of an annuity, an agent shall provide a disclosure to the consumer on a form prescribed by the commissioner by rule.

(b) The prescribed form must be substantially similar to the National Association of Insurance Commissioners Insurance Agent Disclosure for Annuities form. The form must include:

(1) a description of the scope and terms of the agent's relationship with the consumer and role in the transaction;

(2) an affirmative statement on whether the agent is licensed and authorized to sell:

- (A) fixed annuities;
- (B) fixed indexed annuities;
- (C) variable annuities;
- (D) life insurance;
- (E) mutual funds;
- (F) stocks and bonds; or
- (G) certificates of deposit;

(3) a statement describing the insurers for whom the agent is authorized, contracted or appointed, or otherwise able to sell insurance products, described as follows:

- (A) one insurer;
- (B) two or more insurers; or
- (C) two or more insurers though primarily contracted with one insurer;

(4) a description of the sources and types of cash compensation and noncash compensation to be received by the agent, including whether the agent is to be compensated for the sale of a recommended annuity by commission as part of premium or other

remuneration received from the insurer, intermediary, or other agent or by fee as a result of a contract for advice or consulting services; and

(5) a notice of the consumer's right to request additional information regarding cash compensation under Subsection (c).

(c) On request of the consumer or the consumer's designated representative, an agent shall disclose:

(1) a reasonable estimate of the amount of cash compensation to be received by the agent, which may be stated as a range of amounts or percentages; and

(2) whether the cash compensation is a one-time or multiple occurrence amount, and if a multiple occurrence amount, the frequency and amount of occurrence, which may be stated as a range of amounts or percentages.

(d) Prior to or at the time of the recommendation or sale of an annuity, the agent must have a reasonable basis to believe the consumer has been informed of the features of the annuity, including:

- (1) the potential surrender period and surrender charge;
- (2) the potential tax penalty if the consumer sells exchanges, surrenders, or annuitizes the annuity;
- (3) mortality and expense fees;
- (4) investment advisory fees;
- (5) annual fees;
- (6) potential charges for and features of riders or other options of the annuity;
- (7) limitations on interest returns;
- (8) potential changes in non-guaranteed elements of the annuity;
- (9) insurance and investment components; and
- (10) market risk.

Added by Acts 2021, 87th Leg., R.S., Ch. 262 (H.B. [1777](#)), Sec. 9, eff. September 1, 2021.

Sec. 1115.0515. CONFLICT OF INTEREST OBLIGATION. (a) An agent shall take reasonable steps to discover a material conflict of interest, including a material conflict of interest related to an ownership interest.

(b) An agent shall:

- (1) identify and avoid a material conflict of interest; or
- (2) reasonably manage and disclose the conflict.

Added by Acts 2021, 87th Leg., R.S., Ch. 262 (H.B. 1777), Sec. 9, eff. September 1, 2021.

Sec. 1115.0516. DOCUMENTATION OBLIGATION. At the time of the recommendation or sale, an agent shall:

(1) make a written record of the recommendation and the basis for the recommendation;

(2) if applicable, obtain a statement signed by the consumer on a form prescribed by the commissioner by rule that is substantially similar to the National Association of Insurance Commissioners Consumer Refusal to Provide Information form documenting:

(A) a consumer's refusal to provide consumer profile information; and

(B) a consumer's understanding of the ramifications of failing to provide consumer profile information or providing insufficient consumer profile information; and

(3) if a consumer decides to enter into an annuity transaction that is not based on the agent's recommendation, obtain a statement signed by the consumer on a form prescribed by the commissioner by rule that is substantially similar to the National Association of Insurance Commissioners Consumer Decision to Purchase an Annuity Not Based on a Recommendation, acknowledging that the annuity transaction is not recommended.

Added by Acts 2021, 87th Leg., R.S., Ch. 262 (H.B. 1777), Sec. 9, eff. September 1, 2021.

Sec. 1115.052. SUPERVISION SYSTEM. (a) Except as provided in Section 1115.0506, an insurer may not issue an annuity recommended to a consumer unless there is a reasonable basis to believe the annuity would effectively address the consumer's financial situation, insurance needs, and financial objectives based on the consumer's consumer profile information.

(b) Each insurer shall establish and maintain a supervision system that is reasonably designed to achieve the insurer's and the

insurer's agent's compliance with this chapter, including:

(1) establishing and maintaining reasonable procedures to inform the insurer's agents of the requirements of this chapter and incorporating the requirements of this chapter into relevant agent training manuals;

(2) establishing and maintaining standards for agent product training and establishing and maintaining reasonable procedures to require the insurer's agents to comply with the requirements of Section 1115.056;

(3) providing product-specific training and training materials that explain all material features of the insurer's annuity products to the insurer's agents;

(4) establishing and maintaining procedures to review each recommendation electronically, physically, or otherwise before the issuance of an annuity that:

(A) are designed to ensure that there is a reasonable basis to determine that the recommended annuity would effectively address the consumer's financial situation, insurance needs, and financial objectives; and

(B) may:

(i) include the application of a screening system to identify selected transactions for additional review; and

(ii) be designed to require additional review only of those transactions identified for additional review by the selection criteria;

(5) establishing and maintaining reasonable procedures, such as confirmation of consumer profile information, systematic customer surveys, agent and consumer interviews, confirmation letters, agent statements or attestations, and programs of internal monitoring, to detect recommendations that are not in compliance with Sections 1115.0505 through 1115.051 and Sections 1115.0521 and 1115.054, which may include applying sampling procedures or confirming consumer profile information after the issuance or delivery of the annuity;

(6) establishing and maintaining reasonable procedures to assess, before or on issuance or delivery of an annuity, whether an agent has provided to the consumer the information required to be provided under this subchapter;

(7) establishing and maintaining reasonable procedures to identify and address suspicious consumer refusals to provide consumer

profile information;

(8) establishing and maintaining reasonable procedures to identify and eliminate sales contests, sales quotas, bonuses, or noncash compensation that are based on the sale of specific annuities within a limited period of time; and

(9) annually providing a written report to the insurer's senior management, including to the senior manager responsible for audit functions, that details a review, with appropriate testing, reasonably designed to determine the effectiveness of the supervision system, the exceptions found, and any corrective action taken or recommended.

(b-1) Subsection (b)(8) does not prohibit the receipt by employees of health insurance, office rent, office support, retirement benefits, or other employee benefits so long as those benefits are not based on the volume of sales of a specific annuity within a limited period of time.

(c) This subsection and Subsection (c-1) do not prohibit an insurer from contracting for the performance of a function, including maintenance of procedures, required by Subsection (b). An insurer is responsible for taking appropriate corrective action and may be subject to sanctions and penalties under Section 1115.102 regardless of whether the insurer contracts for performance of a function and regardless of whether the insurer complies with Subsection (c-1).

(c-1) An insurer's supervision system under Subsection (b) must include the supervision of contractual performance under this subsection that includes, at a minimum:

(1) annually obtaining certification that complies with Section 1115.053 from a senior manager who represents that the contracted function is properly performed; and

(2) monitoring and, as appropriate, conducting audits to ensure that the contracted function is properly performed.

(d) An insurer is not required by this section to include in the supervision system:

(1) an agent's recommendations to consumers of products other than the annuities offered by the insurer; or

(2) consideration of or comparison to options available to the agent or compensation relating to those options other than annuities or other products offered by the insurer.

(e) Repealed by Acts 2021, 87th Leg., R.S., Ch. 262 (H.B. 1777), Sec. 18(3), eff. September 1, 2021.

Added by Acts 2007, 80th Leg., R.S., Ch. 736 (H.B. 2761), Sec. 1, eff. September 1, 2007.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 1156 (H.B. 2277), Sec. 10, eff. September 1, 2011.

Acts 2021, 87th Leg., R.S., Ch. 262 (H.B. 1777), Sec. 10, eff. September 1, 2021.

Acts 2021, 87th Leg., R.S., Ch. 262 (H.B. 1777), Sec. 18(3), eff. September 1, 2021.

Sec. 1115.0521. PROHIBITED PRACTICES. An agent or insurer may not dissuade or attempt to dissuade a consumer from:

- (1) truthfully responding to an insurer's request for confirmation of consumer profile information;
- (2) filing a complaint; or
- (3) cooperating with the investigation of a complaint.

Added by Acts 2021, 87th Leg., R.S., Ch. 262 (H.B. 1777), Sec. 11, eff. September 1, 2021.

Sec. 1115.053. CERTIFICATION REQUIREMENTS. A person may not provide a certification under Section 1115.052(c-1)(1) unless the person:

- (1) is a senior manager with responsibility for the delegated functions; and
- (2) has a reasonable basis for making the certification.

Added by Acts 2007, 80th Leg., R.S., Ch. 736 (H.B. 2761), Sec. 1, eff. September 1, 2007.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 1156 (H.B. 2277), Sec. 11, eff. September 1, 2011.

Acts 2021, 87th Leg., R.S., Ch. 262 (H.B. 1777), Sec. 12, eff. September 1, 2021.

Sec. 1115.054. SAFE HARBOR. (a) Recommendations and sales of annuities made in compliance with comparable standards satisfy the requirements of this chapter. This section applies to

recommendations and sales of annuities made by a financial professional in compliance with business rules, controls, and procedures that satisfy a comparable standard even if such standard would not otherwise apply to the product or recommendation at issue.

(b) This section does not affect or limit the commissioner's ability to enforce or investigate under this chapter.

(c) This section does not limit the insurer's obligation to comply with Section 1115.052(a), although the insurer may base its analysis on information received from either the financial professional or the entity supervising the financial professional.

(d) Subsection (a) applies only if the insurer:

(1) using information collected in the normal course of the insurer's business, monitors the relevant conduct of the financial professional or the entity responsible for supervising the financial professional, such as the financial professional's broker-dealer or an investment adviser registered under federal or state securities laws; and

(2) provides to the entity responsible for supervising the financial professional, such as the financial professional's broker-dealer or investment adviser registered under federal or state securities laws, information and reports that are reasonably appropriate to assist the entity in maintaining the entity's supervision system.

(e) For purposes of this section, "financial professional" means an agent that is regulated and acting as:

(1) a broker-dealer registered under federal or state securities laws or a registered representative of a broker-dealer;

(2) an investment adviser registered under federal or state securities laws or an investment adviser representative associated with the federal or state registered investment adviser; or

(3) a plan fiduciary under Section 3(21), Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1002(21)) or a fiduciary under Section 4975(e)(3), Internal Revenue Code of 1986.

(f) For purposes of this section, "comparable standards" means:

(1) with respect to a broker-dealer or a registered representative of a broker-dealer, applicable rules of the Financial Industry Regulatory Authority (FINRA) or a successor agency and the United States Securities and Exchange Commission pertaining to best interest obligations and supervision of annuity recommendations and

sales, including Regulation Best Interest (17 C.F.R. Section 240.151-1), including subsequent amendments or successor regulations;

(2) with respect to an investment adviser registered under federal or state securities laws or an investment adviser representative, the fiduciary duties and all other requirements imposed on those investment advisers or investment adviser representatives by contract or under the Investment Advisers Act of 1940 (15 U.S.C. Section 80b-1 et seq.) or applicable state securities law or regulations, including Form ADV (17 C.F.R. Section 279.1), and interpretations; and

(3) with respect to a plan fiduciary or a fiduciary, the duties, obligations, prohibitions, and all other requirements attendant to that status under the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.) or the Internal Revenue Code of 1986.

Added by Acts 2007, 80th Leg., R.S., Ch. 736 (H.B. [2761](#)), Sec. 1, eff. September 1, 2007.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1043 (H.B. [4492](#)), Sec. 1, eff. September 1, 2009.

Acts 2011, 82nd Leg., R.S., Ch. 1156 (H.B. [2277](#)), Sec. 12, eff. September 1, 2011.

Acts 2021, 87th Leg., R.S., Ch. 262 (H.B. [1777](#)), Sec. 13, eff. September 1, 2021.

Sec. 1115.055. RECORDKEEPING REQUIREMENTS. (a) Each agent, general agent, independent agency, and insurer shall maintain, or otherwise be able to make available to the commissioner, records of the information collected from the consumer, disclosures made to the consumer, including summaries of oral disclosures, and other information used in making a recommendation that was the basis for an insurance transaction subject to this chapter until the fifth anniversary of the date on which the transaction is completed by the insurer.

(b) An insurer may, but is not required to, maintain documentation on behalf of an agent.

(c) Records required to be maintained under this section may be maintained in paper, photographic, microprocess, magnetic,

mechanical, or electronic media by any process that accurately reproduces the actual document.

Added by Acts 2007, 80th Leg., R.S., Ch. 736 (H.B. 2761), Sec. 1, eff. September 1, 2007.

Amended by:

Acts 2021, 87th Leg., R.S., Ch. 262 (H.B. 1777), Sec. 14, eff. September 1, 2021.

Sec. 1115.056. AGENT TRAINING REQUIREMENTS. (a) An agent may not solicit the sale of an annuity product unless the agent has adequate knowledge of the product to recommend the annuity and the agent is in compliance with the insurer's standards for product training. An agent may rely on insurer-provided, product-specific training standards and materials to comply with this subsection.

(b) An agent who engages in the sale of annuity products must complete a one-time four-credit training course approved by the department and provided by a continuing education provider.

(c) The training required by Subsection (b) must be of a length sufficient to qualify for at least four continuing education credits, as determined by the commissioner in accordance with Chapter 4004 and any rules adopted under that chapter, but may be longer. The training required by Subsection (b) may be used to satisfy the continuing education requirements under Subchapters B and E, Chapter 4004, and is not in addition to the continuing education requirements in Section 4004.202.

(d) The training required by Subsection (b) must include information on the following topics:

- (1) the types of annuities and various classifications of annuities;
- (2) identification of the parties to an annuity;
- (3) how product-specific annuity features affect consumers;
- (4) the application of income taxation of qualified and nonqualified annuities;
- (5) the primary uses of annuities; and
- (6) appropriate standard of conduct sales practices, replacement, and disclosure requirements.

(e) A provider of a course intended to comply with Subsection (b) must cover all topics listed in Subsection (d) and may not

present any marketing information, provide training on sales techniques, or provide specific information about a particular insurer's products. Additional topics may be offered in conjunction with and in addition to the required topics.

(f) A provider of an annuity training course intended to comply with Subsection (b) must register as a continuing education provider in this state and comply with the rules and guidelines applicable to agent continuing education courses provided by Chapter 4004.

(g) An annuity training course may be conducted and completed by classroom or self-study methods in accordance with Chapter 4004.

(h) A provider of annuity training under Subsection (b) must comply with the reporting requirements and issue certificates of completion in accordance with Chapter 4004.

(i) The satisfaction of the training requirements of another state that are substantially similar to the provisions of this section is considered to satisfy the training requirements of this section.

(i-1) A course that is substantially similar to a course required by this section satisfies the requirement.

(j) An insurer must verify that an agent has completed the annuity training course required by this section before allowing the agent to sell an annuity product for that insurer. An insurer may satisfy the insurer's responsibility under this section by:

- (1) obtaining a certificate of completion of the training course or obtaining an appropriate report provided by the department;
- (2) using a department-sponsored database or vendor; or
- (3) using a reasonably reliable commercial database vendor that has a reporting arrangement with approved insurance education providers.

Added by Acts 2009, 81st Leg., R.S., Ch. 362 (H.B. [1294](#)), Sec. 1.001, eff. September 1, 2009.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 1156 (H.B. [2277](#)), Sec. 13, eff. September 1, 2011.

Acts 2021, 87th Leg., R.S., Ch. 262 (H.B. [1777](#)), Sec. 15, eff. September 1, 2021.

SUBCHAPTER C. MITIGATION; ENFORCEMENT

Sec. 1115.101. MITIGATION. An insurer is responsible for compliance with this chapter. If a violation occurs because of the action or inaction of the insurer or the insurer's agent, the commissioner may:

(1) order:

(A) the insurer to take reasonable appropriate corrective action for any consumer harmed by a failure to comply with this chapter by the insurer, the insurer's agent, or an entity contracted to perform the insurer's supervisory duties; or

(B) a general agency, independent agency, or the agent to take reasonably appropriate corrective action for any consumer harmed by the agent's violation of this chapter; and

(2) impose appropriate sanctions as provided by Section 1115.102.

Added by Acts 2007, 80th Leg., R.S., Ch. 736 (H.B. 2761), Sec. 1, eff. September 1, 2007.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 1156 (H.B. 2277), Sec. 14, eff. September 1, 2011.

Acts 2021, 87th Leg., R.S., Ch. 262 (H.B. 1777), Sec. 17, eff. September 1, 2021.

Sec. 1115.102. SANCTIONS. (a) The commissioner may impose sanctions as provided by Chapter 82 for a violation of this chapter.

(b) The commissioner shall reduce or eliminate a sanction for a violation of this chapter otherwise applicable if:

(1) corrective action for the consumer was taken promptly by the agent or insurer after a violation was discovered; or

(2) the violation was not part of a pattern or practice.

Added by Acts 2007, 80th Leg., R.S., Ch. 736 (H.B. 2761), Sec. 1, eff. September 1, 2007.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 1156 (H.B. 2277), Sec. 15, eff. September 1, 2011.

CHAPTER 1116. REQUIRED PROVISIONS FOR ANNUITY CONTRACT

Sec. 1116.001. DEFINITION. In this chapter, "annuity" means a

fixed, variable, or modified guaranteed annuity that is individually solicited, whether classified as an individual annuity or group annuity.

Added by Acts 2011, 82nd Leg., R.S., Ch. 77 (H.B. 1032), Sec. 1, eff. September 1, 2011.

Sec. 1116.002. RESCISSION PERIOD REQUIRED. (a) A fixed annuity contract must provide that, for a period of at least 20 days after the date the contract is delivered, the purchaser may rescind the contract and receive an unconditional refund of premiums paid for the contract, including any contract fees or charges.

(b) Except as provided by Subsection (c), a variable or modified guaranteed annuity contract must provide that, for a period of at least 20 days after the date the contract is delivered, the purchaser may rescind the contract and receive an unconditional refund that is equal to the cash surrender value provided in the contract plus any fees or charges deducted from the premiums or imposed under the contract.

(c) Subsection (b) does not apply to an annuity contract if the prospective owner is an accredited investor, as defined by 17 C.F.R. Section 230.501(a) as adopted by the United States Securities and Exchange Commission.

Added by Acts 2011, 82nd Leg., R.S., Ch. 77 (H.B. 1032), Sec. 1, eff. September 1, 2011.

Sec. 1116.003. RULEMAKING AUTHORITY FOR CONTINGENT DEFERRED ANNUITY CONTRACTS. (a) In this section, "contingent deferred annuity contract" means an annuity contract in which a life insurer makes periodic payments for the annuitant's lifetime beginning when a designated investment that is not owned or held by the insurer is depleted to an amount specified by the contract due to contractually permitted withdrawals, market performance, fees, or other charges.

(b) The commissioner by rule may adopt reasonable standards for contingent deferred annuity contracts, including standards for:

(1) the procedures for department review and approval of contingent deferred annuity contracts and the criteria the department will use in approving the contracts;

(2) replacement, suitability, and disclosure requirements that are consistent with applicable model regulations developed by the National Association of Insurance Commissioners; and

(3) advertising of contingent deferred annuity contracts that are consistent with applicable model regulations developed by the National Association of Insurance Commissioners.

Added by Acts 2015, 84th Leg., R.S., Ch. 375 (S.B. [1107](#)), Sec. 2, eff. June 9, 2015.

**CHAPTER 1117. USE OF SENIOR-SPECIFIC CERTIFICATIONS OR
PROFESSIONAL DESIGNATIONS**

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1117.001. PURPOSE. The purpose of this chapter is to establish standards to protect consumers from misleading and fraudulent marketing practices with respect to the use of certain senior-specific certifications and professional designations in soliciting the sale or purchase of, or providing advice made concerning, life insurance or annuity products.

Added by Acts 2009, 81st Leg., R.S., Ch. 362 (H.B. [1294](#)), Sec. 2.001, eff. September 1, 2009.

Sec. 1117.002. DEFINITIONS. In this chapter:

(1) "Insurance agent" means an agent licensed under this code to sell, solicit the sale of, or negotiate a life insurance or annuity product.

(2) "Senior-specific certification or professional designation" means a certification or designation that implies that an insurance agent holds a special certification or has specialized training in advising or servicing seniors regarding purchasing or selling a life insurance or annuity product.

Added by Acts 2009, 81st Leg., R.S., Ch. 362 (H.B. [1294](#)), Sec. 2.001, eff. September 1, 2009.

Sec. 1117.003. APPLICABILITY OF CHAPTER; CONSTRUCTION WITH OTHER LAW. (a) This chapter applies to any solicitation, sale or

purchase of, or advice made in connection with, a life insurance or annuity product by an insurance agent.

(b) Nothing in this chapter may be construed to limit the commissioner's authority to enforce any other provision of this code or another law.

Added by Acts 2009, 81st Leg., R.S., Ch. 362 (H.B. 1294), Sec. 2.001, eff. September 1, 2009.

SUBCHAPTER B. USE OF SENIOR-SPECIFIC CERTIFICATIONS AND PROFESSIONAL DESIGNATIONS

Sec. 1117.051. CERTAIN USES OF SENIOR-SPECIFIC CERTIFICATIONS AND DESIGNATIONS PROHIBITED. (a) An insurance agent may not, directly or indirectly, use a senior-specific certification or professional designation in such a way as to mislead a purchaser or prospective purchaser that the agent has special certification or training in advising or servicing seniors in connection with the solicitation, sale, or purchase of a life insurance or annuity product or in the provision of advice as to the value of or the advisability of purchasing or selling a life insurance or annuity product:

(1) through any writing or other publication; or
 (2) by issuing or disseminating analyses or reports related to a life insurance or annuity product.

(b) Subsection (a) prohibits the use of a senior-specific certification or professional designation only by an insurance agent using:

(1) a certification or professional designation that the agent has not actually earned or for which the agent is ineligible;

(2) a nonexistent or self-conferred certification or professional designation;

(3) a certification or professional designation that indicates or implies a level of occupational qualification obtained through education, training, or experience that the agent has not obtained; and

(4) a certification or professional designation that was obtained from an organization that:

(A) is primarily engaged in the business of instruction in sales or marketing;

(B) does not have reasonable standards or procedures for:

(i) assuring the competency of individuals granted a certification or designation by the organization; or

(ii) monitoring and disciplining individuals granted a certification or designation by the organization for improper or unethical conduct; or

(C) does not have reasonable continuing education requirements in order to maintain the certification or designation for individuals granted a certification or designation by the organization.

(c) A rebuttable presumption exists that a certification or professional designation granted by an organization described by Subsection (b)(4) is not prohibited under Subsection (a) if the certification or designation issued by the organization does not primarily apply to sales or marketing and if the organization or the certification or designation has been accredited by:

(1) the American National Standards Institute;

(2) the National Commission for Certifying Agencies;

(3) any organization that is included in "Accrediting Agencies Recognized for Title IV Purposes" published by the U.S. Department of Education; or

(4) any other national accrediting organization recognized by the commissioner.

(d) In determining whether a word, a combination of words, or an acronym constitutes a senior-specific certification or professional designation, the commissioner shall consider:

(1) the use of one or more words such as "senior," "retirement," "elder," or similar words combined with one or more words such as "certified," "registered," "chartered," "advisor," "specialist," "consultant," "planner," or similar words, in the name of the certification or professional designation; and

(2) the manner in which those words are combined.

Added by Acts 2009, 81st Leg., R.S., Ch. 362 (H.B. [1294](#)), Sec. 2.001, eff. September 1, 2009.

Sec. 1117.052. APPLICABILITY TO CERTAIN FINANCIAL SERVICES.

(a) Notwithstanding Section 1117.003, for purposes of this chapter,

a job title used within an organization that is licensed or registered by a state or federal financial services regulatory agency and that indicates seniority or standing within the organization, or that specifies an individual's area of specialization within the organization, is not a senior-specific certification or professional designation unless the title is used in a manner that is likely to confuse or mislead a reasonable consumer.

(b) For purposes of Subsection (a), "financial services regulatory agency" includes an agency that regulates insurers, insurance producers, broker-dealers, investment advisers, or investment companies, as defined by the Investment Company Act of 1940 (15 U.S.C. Section 80a-1 et seq.).

Added by Acts 2009, 81st Leg., R.S., Ch. 362 (H.B. [1294](#)), Sec. 2.001, eff. September 1, 2009.

SUBTITLE B. GROUP LIFE INSURANCE

CHAPTER 1131. GROUP LIFE INSURANCE AND WHOLESALE, FRANCHISE, OR EMPLOYEE LIFE INSURANCE

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1131.001. DEFINITION. In this chapter, "wholesale, franchise, or employee life insurance" means a term life insurance plan under which a number of individual term life insurance policies are issued to a selected group at a rate that is lower than the rate shown in the issuing insurer's manual for an individually issued policy of the same type issued to an insured of the same class.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1131.002. CERTAIN GROUP LIFE INSURANCE AUTHORIZED. A group life insurance policy may be delivered in this state only if the policy:

- (1) covers a group described by Subchapter B; and
- (2) complies with this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1131.003. CERTAIN WHOLESALE, FRANCHISE, OR EMPLOYEE LIFE

INSURANCE AUTHORIZED. A wholesale, franchise, or employee life insurance policy may be issued or delivered in this state only if the policy:

- (1) covers a group described by Section 1131.065; and
- (2) complies with Subchapter P.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1131.004. FORFEITURE OF CERTIFICATE OF AUTHORITY FOR UNAUTHORIZED GROUP LIFE INSURANCE CONTRACT. The certificate of authority to engage in the business of insurance in this state of an insurer that enters into a group life insurance contract other than as authorized by this chapter may be forfeited by an action brought for that purpose by the attorney general at the department's request.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1131.005. GUARANTEEING ISSUANCE OF LIFE INSURANCE POLICY WITHOUT EVIDENCE OF INSURABILITY. (a) In this section, "qualified pension or profit-sharing plan" means a plan that meets the requirements of:

(1) Section 401 or 403, Internal Revenue Code of 1986, and their subsequent amendments; or

(2) any corresponding provisions of prior or subsequent United States revenue laws.

(b) This code does not prohibit a life insurance company authorized to engage in the business of insurance in this state from guaranteeing to issue individual life insurance policies insuring participants in a qualified pension or profit-sharing plan on other than the term plan without evidence of insurability.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1131.006. ASSIGNMENT OF BENEFITS. (a) Subject to the terms of a group life insurance policy, an insured under the policy may make to any individual, firm, corporation, association, trust, or other legal entity, other than the insured's employer, an absolute or collateral assignment of all rights and benefits conferred on the

insured by the policy or by Subchapter C.

(b) Subsection (a) applies without regard to the date a policy is issued.

(c) Subject to the terms of the policy, an assignment by an insured before September 1, 1969, is valid for the purpose of vesting in the assignee all assigned rights and privileges but without prejudice to the insurer because of any payment the insurer makes or individual policy the insurer issues before receiving notice of the assignment.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1131.007. POLICY FORM. A policy of group life insurance is subject to Chapter 1701.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2F.007, eff. April 1, 2009.

**SUBCHAPTER B. GROUP AND WHOLESALE, FRANCHISE, OR EMPLOYEE LIFE
INSURANCE: ELIGIBLE POLICYHOLDERS**

Sec. 1131.051. EMPLOYERS. (a) A group life insurance policy may be issued to an employer or to trustees of a fund established by an employer to insure the employer's employees for the benefit of persons other than the employer.

(b) A policy to which this section applies may provide that "employee" includes:

(1) an individual proprietor or partner, if the employer is an individual proprietorship or partnership;

(2) an employee of a subsidiary corporation of the employer;

(3) an employee, individual proprietor, or partner of an affiliated corporation, proprietorship, or partnership, if the business of the employer and the affiliated corporation, proprietorship, or partnership is under common control through stock ownership, contract, or otherwise; or

(4) a retired employee.

(c) The employer or the trustees of a fund established by an

employer are the policyholder under a policy to which this section applies.

(d) A policy to which this section applies is subject to Subchapter E.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1131.052. LABOR UNIONS. (a) A group life insurance policy may be issued to a labor union to insure the union's members who are actively engaged in the same occupation.

(b) For purposes of this chapter:

- (1) a labor union is considered to be an employer; and
- (2) a member of a labor union is considered to be an employee of the union.

(c) The labor union is the policyholder under a policy to which this section applies.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1131.053. FUNDS ESTABLISHED BY EMPLOYERS OR LABOR UNIONS.

(a) A group life insurance policy that insures the employers' employees or the unions' members for the benefit of persons other than the employers or unions may be issued to the trustees of a fund established or adopted by two or more employers in the same industry or by one or more labor unions, by one or more employers in the same industry and one or more labor unions, or by one or more employers and one or more labor unions whose members are in the same or related occupations or trades.

(b) A policy to which this section applies may provide that "employee" includes:

- (1) an individual proprietor or partner, if the employer is an individual proprietorship or partnership;
- (2) a trustee, an employee of the trustee, or both, if the person's duties are principally connected with the trusteeship; or
- (3) a retired employee.

(c) The trustees are the policyholder under a policy to which this section applies.

(d) A policy may not be issued under this section to insure employees of:

(1) an employer whose eligibility to participate in the fund as an employer arises out of considerations directly related to the employer being a commercial correspondent or business client or patron of another employer, without regard to whether the other employer participates in the fund; or

(2) an employer that is not located in this state, unless:

(A) the majority of the employers whose employees are to be insured are located in this state; or

(B) the policy is issued to the trustees of a fund established or adopted by one or more labor unions.

(e) A policy to which this section applies is subject to Subchapter F.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.
Amended by:

Acts 2009, 81st Leg., R.S., Ch. 689 (H.B. 2690), Sec. 1, eff. September 1, 2009.

Sec. 1131.054. GOVERNMENTAL ENTITIES OR ASSOCIATIONS OF PUBLIC EMPLOYEES. (a) In this section, "employee" includes an elected or appointed officer of the state.

(b) A group life insurance policy may be issued to a governmental entity or an association of public employees listed in Subsection (c) to insure the governmental entity's employees or the association's members for the benefit of persons other than the governmental entity or association.

(c) This section authorizes issuance of a group life insurance policy to:

(1) a municipality, independent school district, or common school district;

(2) a department of state government;

(3) a state college or university; or

(4) an association of public employees, including an association of:

(A) employees of the United States government, if the majority of the members of the association reside in this state;

(B) state employees; or

(C) any combination of state, county, and municipal employees.

(d) The governmental entity or association is the policyholder under a policy to which this section applies.

(e) A policy to which this section applies is subject to Subchapter G.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1131.055. SPOUSES AND CHILDREN OF EMPLOYEES OF UNITED STATES GOVERNMENT. (a) A group term life insurance policy may be extended, in the form of group term life insurance only, to insure the spouse and natural or adopted minor children of an insured employee of the United States government if:

(1) the policy constitutes a part of the employee benefit program established for the benefit of employees of the United States government; and

(2) the spouse or children of other employees covered by the same employee benefit program in other states are or may be covered by group term life insurance.

(b) A policy to which this section applies is subject to Subchapter H.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1131.056. PRINCIPALS. (a) In this section, "agent" includes a general agent or a salesperson.

(b) A group life insurance policy may be issued to a principal, or if the principal is a life, life and accident, or life, accident, and health insurer, by or to the principal, to insure the principal's agents for the benefit of persons other than the principal.

(c) A policy to which this section applies is subject to Subchapter I.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Amended by:

Acts 2021, 87th Leg., R.S., Ch. 355 (H.B. 4030), Sec. 6, eff. September 1, 2021.

Sec. 1131.057. CREDITORS. (a) A group life insurance policy

may be issued to a creditor to insure the creditor's debtors.

(b) The creditor is the policyholder under a policy to which this section applies.

(c) A policy to which this section applies is subject to Subchapter J.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1131.058. VETERANS' LAND BOARD. (a) A group life insurance policy may be issued to the Veterans' Land Board to insure persons purchasing land under the Veterans' Land Program as provided by Subchapter I, Chapter 161, Natural Resources Code.

(b) The Veterans' Land Board is the policyholder under a policy to which this section applies.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1131.059. ASSOCIATIONS OR TRUSTS FOR PAYMENT OF FUNERAL EXPENSES. A group life insurance policy may be issued to an association or trust for a group of individuals for the payment of future funeral expenses.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1131.060. NONPROFIT ORGANIZATIONS OR ASSOCIATIONS. (a) A group life insurance policy may be issued to a nonprofit service, civic, fraternal, or community organization or association to insure the organization's or association's members and employees for the benefit of persons other than the organization or association or an officer of the organization or association.

(b) To be eligible to obtain a group life insurance policy under this section, an organization or association must:

(1) have a constitution or bylaws;
(2) have actively existed for at least two years; and
(3) have been formed for purposes other than that of obtaining insurance.

(c) The organization or association is the policyholder under a policy to which this section applies.

(d) A policy to which this section applies is subject to Subchapter K.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1131.064. OTHER GROUPS. (a) A group life insurance policy may be issued to cover a group other than a group described by Sections 1131.051-1131.060 if the commissioner finds that:

- (1) the issuance of the policy is not contrary to the best interest of the public;
- (2) the issuance of the policy would result in economies of acquisition or administration; and
- (3) the benefits are reasonable in relation to the premiums charged.

(b) Group life insurance coverage may not be offered under this section in this state by an insurer under a policy issued in another state unless this state or another state having requirements substantially similar to those prescribed by Subsections (a)(1)-(3) has determined that those requirements have been met.

(c) A policy to which this section applies is subject to Subchapter O.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1131.065. WHOLESALE, FRANCHISE, OR EMPLOYEE LIFE INSURANCE. (a) Policies of wholesale, franchise, or employee life insurance may be issued to:

- (1) the employees of a common employer or employers;
- (2) the members of one or more labor unions; or
- (3) the members of one or more credit unions.

(b) A policy to which this section applies is subject to Subchapter P.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

SUBCHAPTER C. GROUP LIFE INSURANCE: REQUIRED PROVISIONS

Sec. 1131.101. REQUIRED PROVISIONS. (a) A group life insurance policy may not be delivered in this state unless the policy

contains in substance the provisions prescribed by this subchapter or provisions in relation to provisions prescribed by this subchapter that, in the opinion of the commissioner, are:

- (1) more favorable to an insured under the policy; or
- (2) at least as favorable to an insured under the policy and more favorable to the policyholder.

(b) The standard provisions required for individual life insurance policies do not apply to group life insurance policies.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1131.102. NONFORFEITURE. (a) A group life insurance policy other than a group term life insurance policy must contain nonforfeiture provisions that, in the commissioner's opinion, are equitable to the insured and the policyholder.

(b) This section does not require that a group life insurance policy contain the same nonforfeiture provisions as required for an individual life insurance policy.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1131.103. GRACE PERIOD. (a) A group life insurance policy must provide that the policyholder or premium payor is entitled to a grace period of 31 days for the payment of any premium, other than the first, due under the policy. During the grace period, the death benefit coverage continues in force unless the policyholder or premium payor gives the insurer written notice of discontinuance before the date of discontinuance and in accordance with the policy.

(b) The policy may provide that the policyholder or premium payor is liable to the insurer for payment of a pro rata premium for the time the policy was in force during a grace period.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1131.104. INCONTESTABILITY OF POLICY. A group life insurance policy must provide that:

- (1) the validity of the policy may not be contested, except for nonpayment of premiums, after the policy has been in force for

two years after its date of issue; and

(2) a statement made by any insured under the policy relating to the insured's insurability may not be used in contesting the validity of the insurance with respect to which the statement was made after the insurance has been in force before the contest for a period of two years from its date of issue during the insured's lifetime and unless the statement is contained in a written instrument signed by the insured making the statement.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1131.105. APPLICATION FOR POLICY; STATEMENTS OF INSURED. A group life insurance policy must provide that:

(1) a copy of any application for the policy by the policyholder must be attached to the policy when issued;

(2) a statement made by the policyholder or an insured is considered a representation and not a warranty; and

(3) a statement made by an insured may not be used in any contest under the policy unless a copy of the instrument containing the statement is or has been furnished to the person or the person's beneficiary.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1131.106. EVIDENCE OF INSURABILITY. A group life insurance policy must state the conditions, if any, under which the insurer reserves the right to require an individual eligible for insurance to furnish evidence of individual insurability satisfactory to the insurer as a condition of obtaining part or all of the coverage.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1131.107. ADJUSTMENT OF PREMIUMS OR BENEFITS IF AGE OF INSURED IS MISSTATED. (a) A group life insurance policy must specify an equitable adjustment of premiums, benefits, or both, to be made if the age of an insured has been misstated.

(b) The provision required by Subsection (a) must contain a

clear statement of the method of adjustment to be used.

(c) This section does not apply to a policy to which Section 1131.703 applies.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1131.108. INSURANCE CERTIFICATE. (a) A group life insurance policy must provide that the insurer will issue to the policyholder for delivery to each insured an individual certificate stating:

- (1) the insurance protection to which the insured is entitled;
- (2) to whom the insurance benefits are payable; and
- (3) the rights and conditions specified by Sections 1131.110-1131.112.

By agreement between the insurer and the policyholder, the certificate of insurance may be delivered electronically.

(b) This section does not apply to:

- (1) a policy issued to a creditor to insure the creditor's debtors; or
- (2) a policy to which Section 1131.703 applies.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1075, Sec. 1, eff. Sept. 1, 2003.

Sec. 1131.109. PERSON TO WHOM BENEFITS ARE PAYABLE. (a) A group life insurance policy must provide that any amount due because of an insured's death must be paid to the beneficiary designated by the insured or the beneficiary's assignee, subject to:

- (1) the provisions of the policy, if the designated beneficiary as to all or any part of the amount is not living at the time the insured dies; and
- (2) any right reserved by the insurer in the policy and stated in the certificate to pay at the insurer's option a portion of the amount not to exceed \$250 to any person the insurer determines is equitably entitled to the portion because of having incurred funeral or other expenses incident to the last illness or death of the insured.

(b) This section does not apply to:

- (1) a policy issued to a creditor to insure the creditor's debtors; or
- (2) a policy to which Section 1131.703 applies.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1131.110. RIGHT TO INDIVIDUAL POLICY ON TERMINATION OF EMPLOYMENT OR MEMBERSHIP. (a) A group life insurance policy must provide that if any portion of the insurance on an individual insured under the policy ceases because the individual's employment or membership in the class or classes eligible for coverage under the policy terminates, the individual is entitled to have the insurer issue to the individual an individual life insurance policy without disability or other supplementary benefits.

(b) An individual must apply for an individual policy and pay the first premium to the insurer not later than the 31st day after the date the individual's employment or membership terminates.

(c) An individual policy under this section must be issued without evidence of insurability.

(d) The insured may select any individual policy, other than a term life insurance policy, customarily issued by the insurer for an individual of the insured's age and for the amount requested.

(e) Except as provided by Subsection (f), the individual policy must be in an amount not to exceed the amount of life insurance that ceases because of the termination of employment or membership.

(f) For purposes of Subsection (e), any amount of insurance that, on or before the date of the termination of employment or membership, has matured as an endowment payable to the insured is not included in the amount that is considered to cease because of the termination. This subsection applies without regard to whether the endowment is payable in full, in installments, or in the form of an annuity.

(g) The premium on an individual policy must be at the insurer's then customary rate applicable to:

- (1) the form and amount of the individual policy;
- (2) the class of risk to which the insured then belongs;

and

- (3) the insured's age on the effective date of the

individual policy.

(h) This section does not apply to:

- (1) a policy issued to a creditor to insure the creditor's debtors; or
- (2) a policy to which Section 1131.703 applies.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1131.111. RIGHT TO INDIVIDUAL POLICY ON TERMINATION OF COVERAGE UNDER GROUP POLICY. (a) A group life insurance policy must provide that if the policy terminates or is amended so as to terminate the insurance of a class of insured individuals, each individual insured under the policy on the date of the termination or amendment whose insurance terminates and who has been insured under the policy for at least five years before the date of the termination or amendment is entitled to have the insurer issue to the individual an individual life insurance policy, subject to the conditions and limitations provided by Section 1131.110.

(b) Notwithstanding Section 1131.110(e), a group life insurance policy may provide that the amount of an individual policy issued under this section may not exceed the lesser of:

- (1) the amount of the individual's life insurance coverage that ceases because of the termination or amendment of the group policy, less the amount of any life insurance for which the individual is or becomes eligible under any group policy issued or reinstated by the same or another insurer not later than the 31st day after the date of the termination or amendment; or
- (2) \$2,000.

(c) This section does not apply to:

- (1) a policy issued to a creditor to insure the creditor's debtors; or
- (2) a policy to which Section 1131.703 applies.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1131.112. PAYMENT OF BENEFITS ON DEATH OF INSURED BEFORE INDIVIDUAL POLICY BECOMES EFFECTIVE. (a) A group life insurance policy must provide that if an individual insured under the group policy dies during the period within which the individual would have

been entitled to have an individual policy issued as provided by Section 1131.110 or 1131.111 and before such an individual policy takes effect, the amount of life insurance that the individual would have been entitled to have issued to the individual under the individual policy is payable as a claim under the group policy.

(b) This section applies without regard to whether:

(1) the application for the individual policy has been made; or

(2) the first premium for the individual policy has been paid.

(c) This section does not apply to:

(1) a policy issued to a creditor to insure the creditor's debtors; or

(2) a policy to which Section 1131.703 applies.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

SUBCHAPTER D. GROUP LIFE INSURANCE: OPTIONAL PROVISIONS

Sec. 1131.151. CONTINUATION OF BENEFITS FOR FAMILY MEMBERS AFTER DEATH OF INSURED. (a) A group life insurance policy that provides for the insurer to pay benefits for members of the family or dependents of an individual in the insured group may provide for a continuation of any part of those benefits after the death of the individual in the insured group.

(b) Any amounts of insurance provided by benefits under Subsection (a) are not considered to be life insurance for the purpose of determining the maximum amount of term insurance that may be issued on any one life.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

SUBCHAPTER E. GROUP LIFE INSURANCE POLICIES ISSUED TO EMPLOYERS: ADDITIONAL REQUIREMENTS

Sec. 1131.201. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a group life insurance policy issued to a group described by Section 1131.051.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1131.202. ELIGIBLE EMPLOYEES. All employees of the employer, or all of any class or classes of employees determined by conditions relating to their employment, are eligible for insurance under the policy.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1131.203. PAYMENT OF PREMIUMS. The policyholder must pay the premium for the policy:

(1) wholly from the employer's fund or funds contributed by the employer;

(2) partly from funds described by Subdivision (1) and partly from funds contributed by the insured employees; or

(3) wholly from funds contributed by the insured employees.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Amended by:

Acts 2005, 79th Leg., Ch. 1073 (H.B. 1571), Sec. 1, eff. June 18, 2005.

Acts 2005, 79th Leg., Ch. 1073 (H.B. 1571), Sec. 2, eff. June 18, 2005.

Sec. 1131.204. MINIMUM ENROLLMENT. (a) The policy must cover at least two employees on the date the policy is issued.

(b) Repealed by Acts 2005, 79th Leg., Ch. 1073, Sec. 2, eff. June 18, 2005.

(c) A policy as to which the insured employees do not pay any part of the premium must insure:

(1) all eligible employees; or

(2) all eligible employees except any employees as to whom evidence of individual insurability is not satisfactory to the insurer.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Amended by:

Acts 2005, 79th Leg., Ch. 2 (S.B. 88), Sec. 1, eff. September 1, 2005.

Acts 2005, 79th Leg., Ch. 1073 (H.B. 1571), Sec. 2, eff. June 18, 2005.

Sec. 1131.205. AMOUNTS OF INSURANCE. (a) The amounts of insurance under the policy must be based on a plan that precludes individual selection by the employees or by the employer or trustees.

(b) Repealed by Acts 2005, 79th Leg., Ch. 496, Sec. 2(1), eff. June 17, 2005.

(c) Repealed by Acts 2005, 79th Leg., Ch. 496, Sec. 2(1), eff. June 17, 2005.

(d) Repealed by Acts 2005, 79th Leg., Ch. 496, Sec. 2(1), eff. June 17, 2005.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Amended by:

Acts 2005, 79th Leg., Ch. 496 (H.B. 526), Sec. 2(1), eff. June 17, 2005.

**SUBCHAPTER F. GROUP LIFE INSURANCE POLICIES ISSUED TO FUNDS
ESTABLISHED BY EMPLOYERS OR LABOR UNIONS: ADDITIONAL REQUIREMENTS**

Sec. 1131.251. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a group life insurance policy issued to a group described by Section 1131.053.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1131.252. ELIGIBLE EMPLOYEES OR MEMBERS. (a) The individuals eligible for insurance under the policy are:

(1) all employees of the employers and the employees of the trade association of those employers;

(2) all members of the labor union; or

(3) all of any class or classes of employees or members determined by conditions relating to their employment, to their membership in the unions, or both.

(b) A director of a corporate employer is not eligible for insurance under the policy unless the person is otherwise eligible as a bona fide employee of the corporation by performing services other than the usual duties of a director.

(c) An individual proprietor or partner is not eligible for insurance under the policy unless the person is actively engaged in

and devotes a substantial part of the person's time to conducting the business of the proprietorship or partnership.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1131.253. PAYMENT OF PREMIUMS. (a) Subject to Subsection (b), the policyholder must pay the premium for the policy:

(1) wholly from funds contributed by the employer or employers, the labor union or unions, or both; or

(2) partly from funds described by Subdivision (1) and partly from funds contributed by the insureds.

(b) An insured's contribution toward the cost of the insurance may not exceed 40 cents per month for each \$1,000 of insurance coverage.

(c) The policy may provide that a participating employer or labor union may pay the premium directly to the insurer for the policy issued to the trustee. If payment is made as provided by this subsection, the employer or labor union is the premium payor for the insured employees or union members for that employer unit.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1131.254. MINIMUM ENROLLMENT. (a) The policy must cover at least 100 individuals on the date the policy is issued unless the policy is issued to the trustees of a fund established by:

(1) employers that have assumed obligations through a collective bargaining agreement and are participating in the fund to:

(A) comply with those obligations with regard to one or more classes of their employees who are covered by the collective bargaining agreement; or

(B) provide insurance benefits for other classes of their employees; or

(2) one or more labor unions.

(b) A policy as to which the insureds are to pay part of the premium from funds contributed specifically for their insurance may take effect only if at least 75 percent of the individuals of each participating employer unit who are eligible on the date the policy takes effect, excluding any individuals as to whom evidence of insurability is not satisfactory to the insurer, elect to make the

required contributions.

(c) A policy as to which the insureds do not pay any part of the premium must insure:

(1) all eligible individuals; or

(2) all eligible individuals except any individuals as to whom evidence of individual insurability is not satisfactory to the insurer.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1131.255. AMOUNTS OF INSURANCE. (a) The amounts of insurance under the policy must be based on a plan that precludes individual selection by the insureds or by the policyholder or employer.

(b) Repealed by Acts 2005, 79th Leg., Ch. 496, Sec. 2(2), eff. June 17, 2005.

(c) Repealed by Acts 2005, 79th Leg., Ch. 496, Sec. 2(2), eff. June 17, 2005.

(d) Repealed by Acts 2005, 79th Leg., Ch. 496, Sec. 2(2), eff. June 17, 2005.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.
Amended by:

Acts 2005, 79th Leg., Ch. 496 (H.B. 526), Sec. 2(2), eff. June 17, 2005.

SUBCHAPTER G. GROUP LIFE INSURANCE POLICIES ISSUED TO GOVERNMENTAL ENTITIES OR ASSOCIATIONS OF PUBLIC EMPLOYEES: ADDITIONAL REQUIREMENTS

Sec. 1131.301. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a group life insurance policy issued to a group described by Section 1131.054.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1131.302. ELIGIBLE EMPLOYEES OR MEMBERS. All employees of the employer or all members of the association are eligible for insurance under the policy.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1131.303. PAYMENT OF PREMIUMS. (a) The premium for the policy may be paid wholly or partly from funds contributed by:

- (1) the employer;
- (2) the individuals insured under the policy; or
- (3) the insured employees who are members of the

association of employees.

(b) Any money or credits received by or allowed to the policyholder under any participation agreement contained in or issued in connection with the policy must be applied to the payment of future premiums and to the pro rata abatement of the insured employees' contribution for future premiums.

(c) The employer may deduct from an employee's salary the employee's contribution for the premiums if authorized to do so in writing by that employee.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1131.304. MINIMUM ENROLLMENT. (a) The policy must cover at least 10 employees or members on the date the policy is issued.

(b) A policy as to which the insured employees or members pay part of the premium may take effect only if at least 75 percent of the employees or members eligible on the date the policy takes effect, excluding any employees or members as to whom evidence of individual insurability is not satisfactory to the insurer, elect to make the required contributions.

(c) A group policy issued before September 1, 1969, to a group described by Section 1131.054 that was in existence on that date continues in force without regard to whether the number of the employees or members insured under the policy was less than 75 percent of the employees or members eligible on that date.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

SUBCHAPTER H. GROUP TERM LIFE INSURANCE POLICIES EXTENDED TO SPOUSES AND CHILDREN OF EMPLOYEES OF UNITED STATES: ADDITIONAL REQUIREMENTS

Sec. 1131.351. APPLICABILITY OF SUBCHAPTER. This subchapter

applies only to a group term life insurance policy extended to a group described by Section 1131.055.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1131.352. PAYMENT OF PREMIUMS. The policyholder must pay the premium for the group term life insurance solely from funds contributed by the insured employees.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1131.353. AMOUNTS OF INSURANCE. (a) The amounts of insurance under the policy must be based on a plan that precludes individual selection by the insured employees or by the policyholder.

(b) Group term life insurance on the life of an employee's spouse may not exceed the lesser of:

(1) \$10,000; or

(2) one-half of the amount of insurance on the life of the insured employee under the group policy.

(c) Group term life insurance on the life of an employee's minor child may not exceed \$2,000.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1131.354. CONVERSION RIGHTS. On termination of group term life insurance coverage for a spouse insured under this subchapter because the insured employee's employment terminates or the employee dies, or because the group contract terminates, the spouse has the same conversion rights as to the group term life insurance on the spouse's life as the employee.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1131.355. CERTIFICATE OF INSURANCE. Only one certificate of insurance issued for delivery to an insured employee is required if the certificate includes a statement concerning any dependent's coverage.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

**SUBCHAPTER I. GROUP LIFE INSURANCE POLICIES ISSUED TO PRINCIPALS:
ADDITIONAL REQUIREMENTS**

Sec. 1131.401. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a group life insurance policy issued to a group described by Section 1131.056.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1131.402. ELIGIBLE AGENTS. Agents who are under contract to provide personal services for the principal for a commission or other fixed or ascertainable compensation, or any class or classes of those agents determined by conditions relating to the services the agents provide to the principal, are eligible for insurance under the policy.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1131.403. PAYMENT OF PREMIUMS. The premium for the policy must be paid:

- (1) wholly by the principal; or
- (2) partly from funds contributed by the principal and partly from funds contributed by the insured agents.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1131.404. MINIMUM ENROLLMENT. (a) The policy must cover at least 10 agents on the date the policy is issued.

(b) Subject to Subsection (c), a policy as to which the insured agents pay part of the premium must cover, on the date the policy is issued, at least:

- (1) 75 percent of the eligible agents; or
- (2) 75 percent of any class or classes of eligible agents, determined by conditions relating to the services the agents provide to the principal.

(c) Benefits may be extended to another class of agents if 75

percent of the class request coverage.

(d) A policy as to which the insured agents do not pay any part of the premium must insure:

(1) all eligible agents; or

(2) all of any class or classes of eligible agents

determined by conditions relating to the services the agents provide to the principal.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1131.405. AMOUNTS OF INSURANCE. (a) The amounts of insurance under the policy must be based on a plan that precludes individual selection by the agents or by the principal.

(b) Repealed by Acts 2005, 79th Leg., Ch. 496, Sec. 2(3), eff. June 17, 2005.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Amended by:

Acts 2005, 79th Leg., Ch. 496 (H.B. 526), Sec. 2(3), eff. June 17, 2005.

**SUBCHAPTER J. GROUP LIFE INSURANCE POLICIES ISSUED TO CREDITORS:
ADDITIONAL REQUIREMENTS**

Sec. 1131.451. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a group life insurance policy issued to a group described by Section 1131.057.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1131.452. ELIGIBLE DEBTORS. All individuals who become borrowers, or purchasers of securities, merchandise, or other property, under an agreement to pay the borrowed amount or to pay the balance of the price of the securities, merchandise, or other property purchased, are eligible for insurance under the policy.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1131.453. PAYMENT OF PREMIUMS. The policyholder must pay the premium for the policy from:

- (1) the creditor's funds;
- (2) charges collected from the insured debtors; or
- (3) both the creditor's funds and charges collected from the insured debtors.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1131.454. MINIMUM ENROLLMENT. The policy must cover at least 50 debtors at all times.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1131.455. AMOUNT OF INSURANCE. (a) Except as otherwise provided by this section, the amount of insurance on a debtor's life under the policy may not exceed the amount of the debtor's indebtedness.

(b) Subject to Subsections (c) and (d), the face amount of any loan or loan commitment, totally or partially executed, made to a debtor for educational purposes or to a debtor with seasonal income by a creditor in good faith for general agricultural or horticultural purposes, secured or unsecured, under which the debtor becomes personally liable for the payment of the loan, may be insured in an initial amount of insurance not to exceed the total amount payable under the contract of indebtedness.

(c) If indebtedness described by Subsection (b) is payable in substantially equal installments, the amount of insurance may not at any time exceed the greater of the scheduled or actual amount of unpaid indebtedness.

(d) Insurance on a loan commitment described by Subsection (b) that does not exceed one year in duration may be written up to the amount of the loan commitment on a nondecreasing or level term plan.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Amended by:

Acts 2005, 79th Leg., Ch. 496 (H.B. 526), Sec. 1, eff. June 17, 2005.

Sec. 1131.456. PAYMENT OF PROCEEDS. (a) The proceeds of the insurance must be payable to the policyholder.

(b) Payment to the policyholder reduces or extinguishes the debtor's unpaid indebtedness to the extent of the payment. In the case of a debtor under a loan or loan commitment described by Section 1131.455(b), any insurance proceeds in excess of the indebtedness to the creditor are payable:

- (1) to the debtor's estate; or
- (2) under a facility of payment clause.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1131.457. ANNUITIES AND ENDOWMENT INSURANCE PROHIBITED. The insurance issued may not include annuities or endowment insurance.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

SUBCHAPTER K. GROUP LIFE INSURANCE POLICIES ISSUED TO NONPROFIT ORGANIZATIONS OR ASSOCIATIONS: ADDITIONAL REQUIREMENTS

Sec. 1131.501. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a group life insurance policy issued to a group described by Section 1131.060.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1131.502. ELIGIBLE MEMBERS. All members of the organization or association, or all of any class of members determined by conditions relating to their membership in the organization or association, are eligible for insurance under the policy.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1131.503. PAYMENT OF PREMIUMS. (a) The policyholder must pay the premium from:

- (1) the policyholder's funds;

(2) funds contributed by the employees or members specifically for their insurance; or

(3) both the policyholder's funds and funds contributed by the employees or members.

(b) The policy may provide that the premium may be paid directly to the insurer by individual employees or members from their own funds. If the premium is paid as provided by this subsection, the respective employees or members become the premium payor for that particular certificate.

(c) For purposes of Sections 222.002, 257.001, and 281.004, only the final retrospectively determined premium amount remitted to the issuer by the group policyholder is taxable as gross premiums, without regard to whether membership contributions, fees, assessments, dues, revenues, or other considerations in excess of that final amount are also collected from members. This subsection applies only to a nonprofit membership association that:

(1) qualifies under Section 501(c)(9), Internal Revenue Code of 1986;

(2) has been in existence for at least 50 years;

(3) limits association membership to:

(A) members of the uniformed services of the United States serving on active duty;

(B) members of the ready reserve forces of the United States, including the Army and Air National Guard;

(C) retirees and separatees of:

(i) the uniformed services of the United States; or

(ii) the ready reserve forces of the United States, including the Army and Air National Guard;

(D) cadets and midshipmen in the service academies of the United States and other officer candidates;

(E) federal employees and contractors who are employed by the United States government or other related governmental entities or retired with pay from that employment;

(F) employees or members of any state, county, municipal, or other local governmental body or other organized governmental entity who are involved in homeland defense and homeland security operations; and

(G) any other category of membership established by the governing body of the association that falls within the scope of permissible membership authorized by Section 501(c)(9), Internal

Revenue Code of 1986;

(4) has no separate membership enrollment or application requirement;

(5) collects member contributions, fees, or dues, including funds contributed specifically for insurance and remitted by the group policyholder to the issuer following a retrospective premium determination; and

(6) provides insurance and noninsurance membership benefits.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 1252 (H.B. 2718), Sec. 1, eff. June 15, 2007.

Sec. 1131.504. MINIMUM ENROLLMENT. The policy must cover at least 25 individuals on the date the policy is issued.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1131.505. AMOUNTS OF INSURANCE. The amounts of insurance under the policy must be based on a plan that precludes individual selection by the insured members or by the organization or association.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

**SUBCHAPTER O. GROUP LIFE INSURANCE POLICIES ISSUED TO OTHER GROUPS:
ADDITIONAL REQUIREMENTS**

Sec. 1131.701. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a group life insurance policy issued to a group described by Section 1131.064.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1131.702. PAYMENT OF PREMIUMS. The premium for the policy must be paid from:

- (1) the policyholder's funds;
- (2) funds contributed by the insureds; or
- (3) both the policyholder's funds and funds contributed by the insureds.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1131.703. INSURANCE FOR LIABILITIES RELATED TO FRINGE BENEFITS. (a) Notwithstanding any other law, an employer may insure the lives of the employer's officers, directors, employees, and retired employees under Section 1131.064 to and in an amount necessary to provide funds to offset liabilities related to fringe benefits.

(b) An employer shall submit evidence of the purpose of the policy to the commissioner.

(c) A policy issued for the purpose described by this section does not reduce any other life insurance benefits offered or provided by the employer.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

**SUBCHAPTER P. WHOLESALE, FRANCHISE, OR EMPLOYEE LIFE INSURANCE
POLICIES: ADDITIONAL REQUIREMENTS**

Sec. 1131.751. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a wholesale, franchise, or employee life insurance policy issued as provided by Section 1131.065.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1131.752. PAYMENT OF PREMIUMS. (a) The premium for the policy must be paid:

(1) wholly from funds contributed by the employer or employers of the insureds;

(2) wholly from funds contributed by the labor or credit union or unions; or

(3) partly from funds described by Subdivision (1) or (2) and partly from funds contributed by the insureds.

(b) An insured's contribution toward the cost of the insurance

may not exceed 40 cents per month for each \$1,000 of insurance coverage.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1131.753. MINIMUM ENROLLMENT. A policy of wholesale, franchise, or employee life insurance must cover at least five employees or members of a labor union or credit union on the date the policy is issued.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1131.755. INDIVIDUAL APPLICATION REQUIRED. (a) An insurer must take an individual application for each policy of wholesale, franchise, or employee life insurance.

(b) Repealed by Acts 2005, 79th Leg., Ch. 496, Sec. 2(5), eff. June 17, 2005.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Amended by:

Acts 2005, 79th Leg., Ch. 496 (H.B. 526), Sec. 2(5), eff. June 17, 2005.

Sec. 1131.756. RIGHT TO INDIVIDUAL POLICY ON TERMINATION OF EMPLOYMENT OR MEMBERSHIP. (a) A policy of wholesale, franchise, or employee life insurance must contain in substance the provisions prescribed by this section.

(b) The policy must provide that, subject to Subsections (c) and (d), if the insurance on an individual insured under the policy ceases because the individual's employment or membership in the labor or credit union terminates, the individual is entitled to have the insurer issue to the individual an individual life insurance policy without disability or other supplementary benefits.

(c) An individual policy under this section must be issued without evidence of insurability.

(d) An individual must apply for an individual policy and pay the first premium to the insurer not later than the 31st day after the date the individual's employment or membership terminates.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1131.757. OPTIONAL POLICY PROVISIONS. A policy of wholesale, franchise, or employee life insurance may contain in substance provisions under which:

- (1) the policy is renewable at the option of the insurer only;
- (2) coverage by the insurer terminates on termination of employment or membership by the insured employee or member; or
- (3) an individual eligible for insurance must furnish evidence of individual insurability satisfactory to the insurer as a condition to coverage.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1131.758. CERTAIN POLICIES AND PLANS UNAFFECTED. This subchapter does not impair or otherwise affect:

- (1) a policy issued before August 28, 1961;
- (2) a plan of wholesale, franchise, or employee life insurance in effect before August 28, 1961, if the plan was legal on the date policies were issued under the plan; or
- (3) a policy issued on a salary savings franchise plan, bank deduction plan, pre-authorized check plan, or similar plan of premium collection.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

SUBCHAPTER Q. EXTENSION OF GROUP LIFE INSURANCE TO SPOUSES AND CHILDREN

Sec. 1131.801. APPLICABILITY OF SUBCHAPTER. This subchapter applies to any group life insurance policy issued and delivered under the laws of this state other than a policy issued and delivered to a creditor as provided by Section 1131.057 or other law providing for credit life insurance.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1131.802. EXTENSION OF GROUP LIFE INSURANCE TO SPOUSES AND CHILDREN; ELIGIBLE CHILDREN. Insurance under a group life insurance policy may be extended to cover:

- (1) the spouse of each individual eligible to be insured under the policy;
- (2) a natural or adopted child of each individual eligible to be insured under the policy if the child is:
 - (A) younger than 25 years of age or an older age stated in the policy; or
 - (B) physically or mentally disabled and under the parents' supervision; or
- (3) a natural or adopted grandchild of each individual eligible to be insured under the policy if the child is younger than 25 years of age or an older age stated in the policy.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 1243 (H.B. 2549), Sec. 1, eff. September 1, 2007.

Acts 2011, 82nd Leg., R.S., Ch. 1000 (H.B. 2172), Sec. 1, eff. September 1, 2011.

Sec. 1131.803. PAYMENT OF PREMIUMS. The premium for group life insurance extended to cover a spouse or child may be paid by:

- (1) the group policyholder;
- (2) the insured under the policy; or
- (3) the group policyholder and the insured jointly.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1131.804. AMOUNTS OF INSURANCE. (a) The amounts of insurance under the policy must be based on a plan that precludes individual selection by the insured or the policyholder.

(b) The amount of insurance on the life of the spouse or a child may not exceed the amount of insurance for which the insured is eligible under the policy.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1131.805. CONVERSION RIGHTS. On termination of group life insurance coverage for a spouse insured under this subchapter because the insured's employment terminates, the insured's eligibility for insurance terminates, or the insured dies, or because the group life insurance policy terminates, the spouse has the same conversion rights as to the group life insurance on the spouse's life as the insured.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1131.806. CERTIFICATE OF INSURANCE. Only one certificate of insurance issued for delivery to an insured is required if the certificate includes a statement concerning any spouse's or child's coverage.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

**SUBCHAPTER R. CONTINUATION OF CERTAIN GROUP LIFE INSURANCE DURING
LABOR DISPUTE**

Sec. 1131.851. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a group life insurance policy that is delivered or issued for delivery in this state and as to which any part of the premium is paid or is to be paid by an employer under the terms of a collective bargaining agreement.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1131.852. CONTINUATION OF GROUP LIFE INSURANCE DURING LABOR DISPUTE REQUIRED FOR CERTAIN POLICIES. An insurer may not deliver or issue for delivery a policy subject to this subchapter unless the policy provides that if the employees covered by the policy stop work because of a labor dispute, coverage continues under the policy, on timely payment of the premium, for each employee who:

- (1) is covered under the policy on the date the work stoppage begins;
 - (2) continues to pay the employee's individual contribution, subject to the conditions provided by this subchapter;
- and

(3) assumes and pays during the work stoppage the contribution due from the employer, subject to the conditions provided by this subchapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1131.853. CONTRIBUTIONS IF POLICYHOLDER IS TRUSTEE. (a) An employee's contribution for purposes of a policy as to which the policyholder is a trustee or the trustees of a fund established or maintained wholly or partly by the employer is the amount the employee and employer would have been required to contribute to the fund for the employee if:

- (1) the work stoppage had not occurred; and
- (2) the agreement requiring the employer to make contributions to the fund were in effect.

(b) The policy may provide that continuation of coverage is contingent on the collection of individual contributions by the policyholder or the policyholder's agent.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1131.854. CONTRIBUTIONS IF POLICYHOLDER IS NOT TRUSTEE.

(a) A policy as to which the policyholder is not a trustee or the trustees of a fund established or maintained in whole or in part by the employer must provide that the employee's individual contribution:

- (1) is the policy rate applicable:

- (A) on the date the work stoppage begins; and
- (B) to an individual in the class to which the employee belongs as provided by the policy; or

(2) if the policy does not provide for a rate applicable to an individual, is an amount equal to the amount determined by dividing:

(A) the total monthly premium in effect under the policy on the date the work stoppage begins; by

(B) the total number of insureds under the policy on that date.

(b) The policy may provide that continuation of coverage under this subchapter is contingent on the collection of individual

contributions by the union or unions representing the employees.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1131.855. PAYMENT OF CONTRIBUTION AND PREMIUM. A policy may provide that continuation of coverage for an employee under the policy is contingent on timely payment of:

- (1) contributions by the employee; and
- (2) the premium by the entity responsible for collecting the individual employee contributions.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1131.856. PAST DUE PREMIUM. (a) A policy may provide that the continuation of coverage is contingent on payment of any premium that:

- (1) is unpaid on the date the work stoppage begins; and
- (2) became due before the date the work stoppage begins.

(b) A premium described by Subsection (a) must be paid before the date the next premium becomes due under the policy.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1131.857. INDIVIDUAL PREMIUM RATE INCREASE. (a) A policy may provide that, during the period of a work stoppage, an individual premium rate may be increased by an amount not to exceed 20 percent of the amount shown in the policy, or a greater percentage as approved by the commissioner, to provide sufficient compensation to the insurer to cover increased:

- (1) administrative costs; and
- (2) mortality and morbidity.

(b) If a policy provides for a premium rate increase in accordance with this section, the amount of an employee's contribution must be increased by the same percentage.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1131.858. PREMIUM RATE CHANGE NOT LIMITED. (a) This subchapter does not limit any right of the insurer under a policy to increase or decrease a premium rate before, during, or after a work stoppage if the insurer would be entitled to increase the premium rate had a work stoppage not occurred.

(b) A change in a premium rate made in accordance with this section takes effect on a date that is determined by the insurer in accordance with the terms of the policy.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1131.859. LIMITATIONS ON CONTINUATION OF COVERAGE. This subchapter does not require the continuation of coverage under a policy for a period:

- (1) longer than six months after a work stoppage occurs;
- (2) beyond the time that 75 percent of the covered employees continue the coverage; or
- (3) as to an individual covered employee, beyond the time that the employee takes a full-time job with another employer.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1131.860. OTHER PROVISIONS; COMMISSIONER APPROVAL REQUIRED. A policy may contain any other provision relating to continuation of policy coverage during a work stoppage that the commissioner approves.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

CHAPTER 1132. NOTICE OF RATE INCREASE FOR GROUP LIFE INSURANCE

Sec. 1132.001. NOTICE OF RATE INCREASE. (a) In this section, "insurer" means:

- (1) a life insurance company;
- (2) an accident insurance company;
- (3) a general casualty insurance company;
- (4) a mutual life insurance company;
- (5) a mutual or natural premium life insurance company;
- (6) a fraternal benefit society; or

(7) a local mutual aid association.

(b) Not later than the 61st day before the date on which a premium rate increase takes effect on a group policy of life insurance delivered or issued for delivery in this state by an insurer, the insurer shall give written notice to the policyholder of:

- (1) the amount of the increase; and
- (2) the date on which the increase is to take effect.

(c) An insurer that issues a group policy described by Subsection (b) to a multiple employer trust shall give the notice required by that subsection to the trustee or group policyholder.

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

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

(f) An insurer may not require a policyholder or trustee 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 (b) is given.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Amended by Acts 2003, 78th Leg., ch. 222, Sec. 2, eff. Sept. 1, 2003.

SUBTITLE C. SPECIALIZED COVERAGES
CHAPTER 1151. INDUSTRIAL LIFE INSURANCE
SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1151.001. DEFINITION. In this chapter, "industrial life insurance" means life insurance under which the premiums are payable:

- (1) weekly; or
- (2) less often than weekly but at least monthly, if the face amount of insurance coverage provided by the policy is \$1,000 or less.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1151.002. GENERAL APPLICABILITY OF CHAPTER. (a) Except as provided by other law, this chapter controls the form and content

of an industrial life insurance policy delivered or issued for delivery in this state by an insurance company.

(b) This chapter does not control an industrial life insurance policy delivered or issued for delivery in this state by an association described by Section 1151.004.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1151.003. APPLICABILITY OF CHAPTER TO POLICY PROVIDING ACCIDENT AND HEALTH BENEFITS. Except as otherwise provided by this chapter, if an industrial life insurance policy provides accident and health benefits in addition to natural death benefits, this chapter applies only to the life insurance benefits provided by that policy.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1151.004. CERTAIN ASSOCIATIONS EXCEPTED. This chapter does not apply to any of the following associations operating under Chapter 886:

- (1) a local mutual aid association;
- (2) a statewide mutual life, health, and accident association; or
- (3) a burial association.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1151.005. CERTAIN NONPROFIT ORGANIZATIONS EXCEPTED. This chapter does not apply to:

- (1) an order, society, association, or labor organization that:
 - (A) admits to membership only persons engaged in one or more crafts or hazardous occupations in the same or similar lines of business; and
 - (B) does not operate for profit;
- (2) a ladies auxiliary to an order, society, association, or labor organization described by Subdivision (1); or
- (3) a fraternal order, association, or society.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

SUBCHAPTER B. REQUIRED POLICY PROVISIONS

Sec. 1151.051. POLICY TITLE. An industrial life insurance policy must contain a title on the face of the policy that:

- (1) briefly describes the form of the policy; and
- (2) includes the printed words "Industrial Policy."

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1151.052. ENTIRE CONTRACT. (a) An industrial life insurance policy must provide that the policy is the entire contract between the parties, except that at the option of the insurer, the insurer may make the policy and the policy application the entire contract between the parties.

(b) To make the policy application a part of the contract, a copy of the application must be endorsed on or attached to the policy at the time the policy is issued.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1151.053. AGENT UNAUTHORIZED TO WAIVE OR CHANGE TERMS. An industrial life insurance policy must provide that an agent may not waive or change the terms of an application or policy.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1151.054. STATEMENT MADE BY OR ON BEHALF OF INSURED. An industrial life insurance policy must provide that, in the absence of fraud, a statement made by the insured or on behalf of the insured is considered a representation and not a warranty.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1151.055. INCONTESTABILITY OF POLICY. An industrial life insurance policy must provide that, after the policy has been in

force for two years from its date of issue during the lifetime of the insured, the policy is incontestable except:

- (1) for nonpayment of a premium;
- (2) for violation of any policy condition relating to naval or military service in time of war; and
- (3) concerning a provision relating to:
 - (A) benefits in case of total or permanent disability as defined by the policy; or
 - (B) additional insurance:
 - (i) specifically against accidental death; or
 - (ii) against loss of, or loss of use of, specific parts of the body.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1151.056. ADJUSTMENT OF AMOUNT PAYABLE IF AGE OF INSURED IS MISSTATED. An industrial life insurance policy must provide that, if the age of the insured is misstated, the amount payable under the policy is the amount of insurance that the premium paid would have purchased if the insured's age had been stated correctly.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1151.057. GRACE PERIOD. (a) An industrial life insurance policy must provide that the insured is entitled to a grace period stated in the policy within which any premium after the first premium may be paid. The grace period must be at least a four-week period.

(b) During the grace period the policy continues in effect, but if an event under which the insurer may be liable under the policy occurs during the grace period and before the overdue premiums are paid, the amount of the overdue premiums may be deducted in a settlement made under the policy.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1151.058. NONFORFEITURE BENEFITS AND CASH SURRENDER VALUES IN GENERAL. An industrial life insurance policy must provide, in case of default in payment of premiums, nonforfeiture benefits and

cash surrender values in accordance with:

- (1) Sections 1151.152-1151.154; or
- (2) Chapter 1105, for a policy issued on or after the date determined under Section 1105.002(a) or (b), as applicable.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1151.059. SURPLUS. An industrial life insurance policy that is a participating policy must provide that the insurer shall annually determine and apportion any divisible surplus accruing on the policy.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1151.060. CLAIM BASED ON DEATH OF INSURED. An industrial life insurance policy must provide that if a claim arises as the result of the death of the insured, the insurer shall settle the claim not later than two months after the date the insurer receives at the insurer's home office:

- (1) proof of death satisfactory to the insurer; and
- (2) proof of the right of the claimant to the insurance proceeds.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1151.061. REINSTATEMENT OF POLICY. (a) An industrial life insurance policy must provide that unless the cash surrender value has been paid or the term of extended insurance has expired, the policy may be reinstated not later than the first anniversary of or, at the option of the insurer, not later than the 52nd week after the date of default in payment of premiums if the insured:

- (1) pays all overdue premiums;
- (2) pays or reinstates any other debt owed to the insurer on the policy; and
- (3) presents evidence of insurability satisfactory to the insurer.

(b) The insurer may impose on the overdue premiums interest at an annual rate specified in the policy, not to exceed six percent.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1151.062. EXCEPTION FOR POLICIES ISSUED OR GRANTED UNDER CERTAIN NONFORFEITURE PROVISIONS. This subchapter does not apply to a policy issued or granted under a nonforfeiture provision prescribed by Section 1151.058.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

SUBCHAPTER C. AUTHORIZED OR PROHIBITED POLICY PROVISIONS

Sec. 1151.101. AUTHORIZED PROVISIONS. In addition to the provisions required by Subchapter B and Section 1151.152, an industrial life insurance policy may:

(1) exclude liability or promise a benefit that is less than the full amount payable as a death benefit if the insured:

(A) dies by the insured's own hand, regardless of whether the insured is sane or insane; or

(B) dies as a result of engaging in a stated hazardous occupation;

(2) promise a benefit that is less than the full amount payable if the insured dies as a result of an aviation activity under a condition specified in the policy approved by the department as provided by Chapter 1701;

(3) limit the maximum amount payable on the death of a child younger than 15 years of age; and

(4) include any other provision not otherwise prohibited by this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2F.008, eff. April 1, 2009.

Sec. 1151.102. PROHIBITED PROVISIONS. (a) An industrial life insurance policy may not:

(1) require a cause of action based on the policy to be initiated before the second anniversary of the date the cause of action accrues; or

(2) except as otherwise provided by this subchapter, establish a method of settlement at maturity that provides less value than the face amount of insurance coverage provided by the policy and any dividend additions to the policy, less:

(A) any debt owed to the insurer on the policy; and

(B) any premium that may be deducted under the terms of the policy.

(b) Subsection (a)(2) does not prevent a limitation from being imposed on payment of an additional accidental death benefit in case of accidental death resulting from certain specified causes.

(c) A nonparticipating or term policy may not incorporate any part of a provision described by Subchapter B or Section 1151.152 that does not apply to that type of policy.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

SUBCHAPTER D. RIGHTS OF INSURED UNDER CERTAIN OLDER POLICIES

Sec. 1151.151. EXTENDED TERM OR PAID-UP INSURANCE FOR CERTAIN POLICIES. (a) This section applies only to a policy delivered or issued for delivery in this state before March 29, 1941, under former Article 3.43 of this code.

(b) An insured or a beneficiary of the insured is entitled to elect extended term or paid-up insurance under an industrial life insurance policy that does not by its terms provide a stipulated form of insurance to the insured or beneficiary on default in payment of premiums if:

(1) premiums have been paid on the policy for at least three years; and

(2) the insured or beneficiary gives written notice of the election to the insurer at the insurer's home office before the expiration of the term of extended insurance.

(c) An insured or beneficiary who does not make an election as provided by Subsection (b) is considered to have elected extended term insurance.

(d) The net value of extended term or paid-up insurance shall be determined as provided by Section 1151.153.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1151.152. PROVISIONS CONCERNING STIPULATED FORM OF INSURANCE OR SPECIFIED CASH SURRENDER VALUE IN CERTAIN POLICIES. (a) An industrial life insurance policy issued before the date described by Section 1151.058(2) must contain a provision substantially as follows:

(1) in case of default in payment of premiums:

(A) after premiums have been paid for three years, a stipulated form of insurance is available, effective from the due date of the defaulted premium; and

(B) after premiums have been paid for five years, the stipulated form of insurance described by Paragraph (A) or a specified cash surrender value is available, at the election of the insured; and

(2) the stipulated form of insurance takes effect unless the insured applies in writing for the specified cash surrender value within the grace period following the due date of the defaulted premium.

(b) The policy must:

(1) state the amount and term of the stipulated form of insurance, computed assuming that there is no debt owed on or dividend additions to the policy;

(2) specify the mortality table, the rate of interest, and the method of valuation, if a method of valuation other than net level premium is used, adopted for computing the reserve on the policy; and

(3) provide a table showing in numbers the nonforfeiture options available under the policy at the end of each year in case of default in payment of premiums.

(c) Subsections (a), (b)(1), and (b)(3) do not apply to a term insurance policy with a term of 20 years or less.

(d) The table described by Subsection (b)(3) must begin with the year in which the numbers on the nonforfeiture options become available and must cover not more than the first 20 years of the policy. On the expiration of the period for which the numbers are shown by the policy, the insurer shall provide an extension of the table on request.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1151.153. COMPUTATION OF NET VALUE OF STIPULATED FORM OF INSURANCE OR SPECIFIED CASH SURRENDER VALUE. (a) The net value of the stipulated form of insurance or the specified cash surrender value available under Section 1151.152 may not be less than the reserve on the policy at the end of the last completed quarter of the policy year for which premiums have been paid, less:

(1) an amount of not more than:

(A) 2-1/2 percent of the maximum amount insured under the policy and any dividend additions to the policy, if the age of the insured on the date the policy was issued is younger than 10 years; or

(B) 2-1/2 percent of the amount insured under the policy at the time the computation is made and any dividend additions to the policy, if the age of the insured on the date the policy was issued is 10 years or older; and

(2) any existing debt to the insurer on or secured under the policy.

(b) The reserve described by Subsection (a):

(1) includes:

(A) the reserve for any paid-up additions to the policy; and

(B) the amount of any dividends credited to the policy; and

(2) excludes any reserve on:

(A) total or permanent disability, as defined by the policy; and

(B) additional accidental death benefits.

(c) In computing the value of paid-up term insurance with any accompanying pure endowment, a rate of mortality may be assumed that is not more than:

(1) 130 percent of the rate of mortality according to the applicable table, if the 1941 Standard Industrial Mortality Table or the 1941 Sub-standard Industrial Mortality Table is adopted for computing the reserve; or

(2) the rate of mortality shown by:

(A) the Commissioners 1961 Industrial Extended Term Insurance Table, if the Commissioners 1961 Standard Industrial Mortality Table is adopted for computing the reserve; or

(B) any other mortality table specified by the insurer and approved by the department, if the policy is substandard.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1151.154. SURRENDER OF POLICY FOR SPECIFIED CASH SURRENDER VALUE. (a) An industrial life insurance policy issued before the date described by Section 1151.058(2) under which the insured applies for cash surrender value must be surrendered for the specified cash surrender value to the insurer at the insurer's home office within the grace period following the due date of the defaulted premium.

(b) The insurer may defer payment for a period of not more than six months after the date of application for the specified cash surrender value.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

CHAPTER 1152. SEPARATE ACCOUNTS, VARIABLE CONTRACTS, AND RELATED PRODUCTS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1152.001. APPLICABILITY OF CODE. (a) Except as provided by Subsection (b), this code applies to separate accounts described by this chapter and contracts relating to those accounts.

(b) The following sections do not apply to the separate accounts and contracts:

- (1) Sections 882.303 and 882.703;
- (2) Subchapters H and J, Chapter 882;
- (3) Sections 1101.002(b), 1101.005, 1101.009, 1101.012, 1101.052, 1101.055, and 1101.152-1101.156;
- (4) Chapter 1105; and
- (5) Section 1131.103.

(c) A separate account established under former Article 3.39 Part III, 3.72, or 3.73 is considered to be established under this chapter. A policy or other agreement issued before September 1, 1984, under one of those articles remains subject to the article, as the article existed immediately before September 1, 1984.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1152.002. RULES. The commissioner may adopt rules that are fair, reasonable, and appropriate to augment and implement this

chapter, including rules establishing requirements for:

- (1) agent licensing;
- (2) standard policy provisions; and
- (3) disclosure.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

SUBCHAPTER B. SEPARATE ACCOUNTS

Sec. 1152.051. ESTABLISHMENT OF SEPARATE ACCOUNTS. A domestic life insurance company may establish separate accounts under this subchapter and may allocate to each account amounts, including proceeds applied under optional modes of settlement or under dividend options, to:

- (1) provide for life insurance, an annuity, or a benefit incidental to the insurance or annuity, payable in a fixed amount, a variable amount, or both a fixed amount and a variable amount; or
- (2) fund a benefit for a pension, retirement, or profit sharing plan payable in a fixed amount, a variable amount, or both a fixed amount and a variable amount.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1152.052. OWNERSHIP OF AMOUNTS IN SEPARATE ACCOUNT. (a) An insurance company owns an amount allocated to a separate account under this subchapter.

(b) The company is not and may not represent itself as a trustee regarding an amount allocated to a separate account under this subchapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1152.053. TRANSFER OF ASSETS BETWEEN SEPARATE ACCOUNTS. (a) Except as provided by Subsection (b), an insurance company may not sell, exchange, or otherwise transfer an asset between the company's separate accounts or between any other investment account and a separate account unless:

- (1) in case of a transfer into a separate account, the transfer is made solely to establish the account or to support the

operation of a contract regarding the separate account to which the transfer was made; and

(2) the transfer, whether into or from a separate account, is made:

(A) by a transfer of cash; or

(B) by a transfer of securities if the securities have a readily determinable market value and the commissioner approves the transfer.

(b) The commissioner may approve a transfer between accounts other than a transfer described by Subsection (a) if, in the commissioner's opinion, the transfer would not be inequitable.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1152.054. COMPLIANCE WITH FEDERAL OR STATE LAW FOR SEPARATE ACCOUNT. (a) To comply with a federal or state law, an insurance company with respect to any separate account, including a separate account that is a management investment company or a unit investment trust, may, to the extent the company considers it necessary, provide:

(1) for appropriate voting and other rights for persons who have an interest in the account; and

(2) special rights and procedures to conduct the business of the account, including rights and procedures related to:

(A) investment policy;

(B) investment advisory services;

(C) selection of independent public accountants; and

(D) selection of a committee to manage the business of the account.

(b) The members of a committee selected under Subsection (a)(2)(D) are not required to be affiliated with the company.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1152.055. GUARANTEED BENEFITS AND MONEY RESTRICTION FOR SEPARATE ACCOUNTS. A domestic insurance company may not maintain a reserve for a benefit guaranteed as to dollar amount and duration or funds guaranteed as to principal amount or stated rate of interest in a separate account except with the commissioner's approval and under

conditions for investments, and other matters, that recognize the guaranteed nature of the benefits provided and that are prescribed by the department.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 412 (H.B. 1587), Sec. 2, eff. June 9, 2023.

Sec. 1152.056. INVESTMENT LIMITS NOT APPLICABLE TO SEPARATE ACCOUNT. Except as provided by Section 1152.055:

(1) an amount allocated to a separate account, including an accumulation on that amount, may be invested without regard to a law of this state governing a life insurance company investment; and

(2) an investment in a separate account may not be considered in applying an investment limit otherwise applicable to the insurance company.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1152.057. ALLOCATION OF INCOME, GAINS, OR LOSSES ON SEPARATE ACCOUNT. An insurance company shall credit to or charge against a separate account the income, gain, or loss, realized or unrealized, from an asset allocated to the account without regard to other income, gains, or losses of the insurance company.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1152.058. ASSET VALUATION IN SEPARATE ACCOUNT. An asset allocated to a separate account is valued:

(1) at its market value on the date of valuation;

(2) as provided under a contract, rule, or other written agreement applicable to the separate account, if a readily available market does not exist;

(3) as provided by the rules otherwise applicable to the insurance company's assets for any portion of the assets that is equal to the company's reserve liability with regard to the guaranteed benefits and funds under Section 1152.055; or

(4) under any other method approved by the commissioner.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1152.059. SEPARATE ACCOUNT NOT CHARGEABLE WITH OTHER LIABILITIES. To the extent provided under the applicable contracts, the portion of a separate account's assets equal to the reserves and other contract liabilities regarding that account is not chargeable with a liability arising out of any other business of the insurance company.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

SUBCHAPTER C. VARIABLE CONTRACTS

Sec. 1152.101. SOLE AUTHORITY TO REGULATE VARIABLE CONTRACTS. The commissioner has sole authority to regulate the issuance and sale of a variable contract under:

- (1) this chapter; and
- (2) rules adopted under Section 1152.002.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1152.102. AUTHORIZATION REQUIRED FOR VARIABLE CONTRACTS. (a) An insurance company may not deliver or issue for delivery a variable contract in this state unless authorized by the commissioner under this section.

(b) If the commissioner finds, after notice and hearing, that the company is qualified to issue, deliver, and use a variable contract under this chapter and rules adopted under Section 1152.002, the commissioner shall issue an order relating to the company's authority to issue, deliver, and use a variable contract in this state.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1152.103. CONSIDERATION OF COMPANY'S CONDITION OR METHOD OF OPERATION. (a) For purposes of this section, the domicile of an

alien company is its state of entry.

(b) In considering a company's condition or method of operation, the factors the commissioner shall consider must include:

(1) the company's history and financial condition;

(2) the character, responsibility, and fitness of the company's officers and directors;

(3) the law, including rules, under which the company is authorized to do business in the state of domicile to issue a variable contract; and

(4) whether the condition or method of operation in connection with the issuance of a variable contract will make the company's operation hazardous to the public or the company's policyholders in this state.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1152.104. AUTHORIZATION FOR SUBSIDIARY OR AFFILIATE OF AUTHORIZED LIFE INSURANCE COMPANY. The commissioner may determine, after notice and hearing, that a company that is a subsidiary of or affiliated with an authorized life insurance company through common management or ownership meets the requirements of this subchapter if either the company or the parent or affiliated company meets the requirements of this subchapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1152.105. WAIVER OF HEARING REQUIREMENT. (a) If a company, its parent, or a commonly controlled affiliate is an authorized life insurance company, the company may apply to the commissioner for a waiver of the hearing requirements under Section 1152.102 or 1152.104.

(b) The commissioner may waive the hearing requirement if the commissioner determines that a hearing is not necessary to find the company qualified under this subchapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1152.106. RESERVE LIABILITY FOR VARIABLE CONTRACT. The

reserve liability for a variable contract must be established under actuarial procedures that recognize:

- (1) the variable nature of the benefits provided; and
- (2) any mortality guarantees.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1152.107. SEPARATE ANNUAL STATEMENT REQUIRED. (a) An insurance company authorized under this subchapter to issue, deliver, or use a variable annuity contract or variable life contract shall file with the department a separate annual statement of its separate variable contract accounts.

(b) The company shall file the statement:

- (1) on a form prescribed or approved by the department;

and

(2) simultaneously with the annual statement required by Sections 841.255 and 882.003.

(c) The statement must:

(1) include details as to all income, disbursements, assets, and liability items associated with the separate variable contract accounts; and

- (2) be under oath of two company officers.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1152.108. GRACE, REINSTATEMENT, AND NONFORFEITURE PROVISIONS REQUIRED. (a) An individual variable life insurance or individual variable annuity contract delivered or issued for delivery in this state must contain grace, reinstatement, and nonforfeiture provisions appropriate to the contract.

(b) A group variable contract delivered or issued for delivery in this state must contain a grace period provision appropriate to the contract.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1152.109. VARIABLE BENEFITS PROVISIONS. (a) A contract providing benefits payable in variable amounts that is delivered or

issued for delivery in this state must state the essential features of the procedures the insurance company will follow in determining the dollar amount of the variable benefits.

(b) A contract under which the benefits vary to reflect investment experience, including a group contract and any certificate in evidence of variable benefits issued under that group contract, must state:

(1) on its first page, that the benefits under the contract are on a variable basis; and

(2) that the dollar amount will vary.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1152.110. PRIVATE PLACEMENT CONTRACTS. (a) In this section, "private placement contract" means a variable annuity contract or variable life insurance policy that is:

(1) issued exclusively to an accredited investor or qualified purchaser, as those terms are defined by the Securities Act of 1933 (15 U.S.C. Section 77a et seq.), the Investment Company Act of 1940 (15 U.S.C. Section 80a-1 et seq.), or the regulations promulgated under either of those acts; and

(2) offered for sale and sold in a transaction that is exempt from registration under the Securities Act of 1933 (15 U.S.C. Section 77a et seq.).

(b) A private placement contract may provide that the insurer issuing the contract may defer payments or advances for loans, cash surrender values, or death benefits until the separate account assets, or any portion of the separate account assets, comprising rights to loans, cash surrender values, or death benefits can be converted to cash under any applicable terms.

(c) Section 1103.104 does not apply to the computation of the interest on the proceeds of a private placement contract.

Added by Acts 2007, 80th Leg., R.S., Ch. 737 (H.B. [2765](#)), Sec. 1, eff. September 1, 2007.

SUBCHAPTER D. VARIABLE CONTRACT AGENTS

Sec. 1152.151. AGENT'S LICENSE REQUIRED. (a) A person may not sell or offer for sale in this state a variable contract, or act to

negotiate, make, or consummate a variable contract for another, unless the department has licensed the person under Chapter 4054 as a general life, accident, and health agent or a life agent.

(b) The licensing and regulation of a person acting as a variable contract agent is subject to the same provisions applicable to the licensing and regulation of other agents under Title 13.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.303(b), eff.

Sept. 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 548 (S.B. 1263), Sec. 2.11, eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2F.009, eff. April 1, 2009.

SUBCHAPTER E. MODIFIED GUARANTEED CONTRACTS

Sec. 1152.201. DEFINITION. In this subchapter, "modified guaranteed contract" means an individual life insurance policy or deferred annuity contract as to which:

(1) the underlying assets are held in a separate account; and

(2) the values are guaranteed if the policy or contract is held for a specified period.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1152.202. APPLICABILITY OF LAWS GOVERNING LIFE INSURANCE COMPANIES. Unless otherwise approved by the commissioner, the laws of this state governing the investments of life insurance companies apply to an asset held in a separate account that relates to a modified guaranteed contract that provides for nonforfeiture values that may vary based on a market-value adjustment formula.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1152.203. RULES. In addition to any rules adopted under Section 1152.002, the commissioner may adopt reasonable rules that

apply only to a modified guaranteed contract, to appropriately regulate:

- (1) a modified guaranteed contract under this chapter; and
- (2) the separate account maintained in relation to a modified guaranteed contract.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1152.204. NONFORFEITURE VALUES. (a) A modified guaranteed contract must contain nonforfeiture values that are based on a market-value adjustment formula if the contract is held for a period shorter than the period specified in the contract. The formula may or may not reflect the value of assets held in the separate account.

(b) A modified guaranteed contract must prominently state on its first page that the nonforfeiture values may increase or decrease based on the market-value formula specified in the contract.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1152.205. SEPARATE ACCOUNT STATEMENT. An insurance company that files a separate account statement under Section 1152.107 shall include in that statement a statement for each separate account that relates to a modified guaranteed contract.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

CHAPTER 1153. CREDIT LIFE INSURANCE AND CREDIT ACCIDENT AND HEALTH INSURANCE

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1153.001. SHORT TITLE. This chapter may be cited as the Act for the Regulation of Credit Life Insurance and Credit Accident and Health Insurance.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1153.002. PURPOSE; LEGISLATIVE INTENT; CONSTRUCTION.

(a) The purpose of this chapter is to promote the public welfare by regulating credit life insurance and credit accident and health insurance.

(b) This chapter is not intended to prohibit or discourage reasonable competition.

(c) This chapter shall be liberally construed.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1153.003. DEFINITIONS. In this chapter:

(1) "Credit accident and health insurance" means insurance to provide indemnity for payments that become due on a specific credit transaction of a debtor when the debtor is disabled, as defined in the insurance policy.

(2) "Credit life insurance" means insurance on the life of a debtor in connection with a specific credit transaction.

(3) "Credit transaction" includes the lending of money.

(4) "Creditor" means:

(A) a person who lends money or who sells or leases goods, services, property, rights, or privileges, for which the payment is arranged through a credit transaction;

(B) a successor to the right, title, or interest of a person described by Paragraph (A); or

(C) a person who is in any way associated with a person described by Paragraph (A) or (B), including a director, officer, employee, affiliate, associate, or subsidiary of the person described by Paragraph (A) or (B).

(5) "Debtor" means a person who borrows money or who purchases or leases goods, services, property, rights, or privileges, the payment for which is arranged through a credit transaction.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1153.004. APPLICABILITY OF CHAPTER. (a) This chapter applies to life insurance and accident and health insurance that is sold in connection with a credit transaction that is charged to or paid for by, in whole or part, the debtor, except insurance that is issued or sold:

(1) in connection with a credit transaction of more than 10

years' duration;

(2) in connection with a credit transaction that is:

(A) secured by a first mortgage or deed of trust; and

(B) made to:

(i) finance the purchase of commercial real property or the construction of or improvement to a building, other than a single-family dwelling, on the real property if the purchase, construction, or improvement is secured by a lien on the real property; or

(ii) refinance a credit transaction made for a purpose described by Subparagraph (i); or

(3) as an isolated transaction on the part of the insurer that is not related to an agreement or a plan for insuring debtors of the creditor.

(b) This chapter applies to insurance described by Subsection (a) regardless of the nature, kind, or plan of the credit insurance coverage or premium payment system and regardless of whether the credit insurance is charged to or paid for by the debtor directly or indirectly.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1153.005. RULES. After notice and a hearing, the commissioner may adopt rules to implement this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1153.006. FILING FEE. (a) The department shall set and collect a fee for a form or schedule filed under this chapter in an amount not to exceed \$200.

(b) Fees collected under this section shall be deposited in the Texas Department of Insurance operating account.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1153.007. GAIN OR ADVANTAGE FROM INSURANCE NOT PROHIBITED CHARGE. (a) The premium or cost of credit life insurance or credit accident and health insurance authorized under this chapter is not

considered to be interest, a charge, consideration, or an amount in excess of permitted charges in connection with the underlying credit transaction.

(b) Any benefit, return, or other gain or advantage to the creditor arising out of the sale or provision of the insurance under this chapter is not a violation of any law of this state.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

SUBCHAPTER B. FORMS

Sec. 1153.051. FILING OF FORM. (a) An insurer shall file with the commissioner the form of each policy, certificate of insurance, notice of proposed insurance, application for insurance, endorsement, and rider to which this chapter applies that is delivered or issued for delivery in this state.

(b) If a group policy of credit life insurance or credit accident and health insurance is delivered in another state, the insurer is required to file only the group certificate and notice of proposed insurance delivered or issued for delivery in this state, as specified in Section 1153.052.

(c) The commissioner shall approve a certificate filed under Subsection (b) if it conforms with the requirements provided by Section 1153.052 and if the schedule of premium rates applicable to the insurance evidenced by that certificate or notice does not exceed the presumptive premium rate established by the commissioner.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1153.052. REQUIREMENTS RELATING TO INSURANCE POLICY OR CERTIFICATE. (a) A policy or certificate of credit life insurance or credit accident and health insurance must:

(1) specify:

- (A) the name and home office address of the insurer;
- (B) the name of each debtor;
- (C) in the case of a certificate under a group policy, the identity, by name or otherwise, of each insured;
- (D) the full amount of premium or the total identifiable insurance charge, if any, to the debtor, separately for credit life insurance and credit accident and health insurance; and

(E) each exception or limitation to or restriction on the coverage;

(2) describe the coverage, including the amount and term of the coverage; and

(3) state that the benefits are to be paid to the creditor to reduce or extinguish the unpaid amount of the debt and that any amount of benefits that exceeds the unpaid debt is to be paid to a beneficiary, other than the creditor, named by the debtor or to the debtor's estate.

(b) The requirements of this section are in addition to the other requirements of law.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1153.053. DISAPPROVAL OF FORM. (a) Not later than the 60th day after the date an insurer files a form under Section 1153.051, the commissioner shall disapprove the form if:

(1) the benefits provided are not reasonable in relation to the premium charge; or

(2) the form contains a provision that:

(A) is unjust, unfair, inequitable, misleading, or deceptive;

(B) encourages misrepresentation of the coverage; or

(C) is contrary to this code or a rule adopted under this code.

(b) The commissioner shall specify in the notice of disapproval of a form the reason for the disapproval and state that, if the insurer delivers to the commissioner a written request for a hearing on the disapproval of the form, the hearing will be granted not later than the 20th day after the date of the request.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1153.054. WITHDRAWAL OF APPROVAL OF FORM. The commissioner may hold a hearing on the withdrawal of the approval of a form not earlier than the 21st day after the date written notice of the hearing is given to the insurer who submitted the form. The notice of the hearing must state the reason for the proposed withdrawal of approval. At any time after the hearing, the

commissioner may withdraw approval of the form for any ground provided by Section 1153.053(a).

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1153.055. PROHIBITIONS RELATING TO ISSUANCE OR USE OF FORM. (a) A policy, certificate of insurance, notice of proposed insurance, application for insurance, endorsement, or rider to which this chapter applies may not be issued or used before the 61st day after the date the form is filed with the commissioner under Section 1153.051, unless the commissioner gives prior written approval of the issuance or use of the form.

(b) An insurer who is notified by the commissioner that a form is disapproved may not issue or use that form.

(c) After the effective date of the withdrawal of the approval of a form under Section 1153.054, the insurer may not issue or use that form.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

SUBCHAPTER C. RATES

Sec. 1153.101. FILING OF SCHEDULE OF RATES. An insurer shall file with the commissioner each schedule of premium rates relating to a document required to be filed under Section 1153.051.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1153.102. REVISION OF SCHEDULE OF RATES. (a) An insurer may revise its schedules of premium rates for various classes of business.

(b) The insurer shall file the revised schedules and classes of business with the commissioner.

(c) An insurer may not issue a credit life insurance policy or credit accident and health insurance policy for which the premium rate exceeds the rate determined by using the appropriate schedule for that class of business that the insurer has on file with the commissioner.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1153.103. PRESUMPTIVE PREMIUM RATE. (a) After notice and a hearing, the commissioner by rule may adopt a presumptive premium rate for various classes of business and terms of coverage. An insurer that does not file a different rate under Section 1153.105 or 1153.106 shall file the presumptive rate adopted by the commissioner.

(b) Except as provided by this chapter, any hearing conducted or order adopting a presumptive rate under this subchapter shall be held in accordance with the rulemaking provisions of Chapter 2001, Government Code.

(c) In the commissioner's order adopting a presumptive rate, the commissioner shall set forth findings and conclusions on all material issues presented at the hearing.

(d) In determining the presumptive premium rate, the commissioner shall consider any relevant data, including reasonable acquisition costs, loss ratios, administrative expenses, reserves, loss settlement expenses, the type or class of business, the duration of various credit transactions, and reasonable and adequate profits to the insurers.

(e) In determining the presumptive premium rate, the commissioner may not set or limit the amount of compensation actually paid by a company to an agent but may request from an insurer or agent any relevant data relating to the presumptive premium rate, including information relating to compensation paid for the sale of credit insurance, expenses, losses, and profits. An insurer or agent shall provide the requested information to the commissioner in a timely manner.

(f) The commissioner may not adopt a presumptive premium rate that is unjust, unreasonable, inadequate, confiscatory, or excessive to the insureds, the insurers, or the agents.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.304(a), eff. Sept. 1, 2003.

Sec. 1153.104. APPEAL OF PRESUMPTIVE RATE. Any person who is aggrieved by any action of the commissioner taken in the setting of a

presumptive rate may, not later than the 30th day after the date the commissioner adopts a presumptive rate order, file a petition for judicial review in a district court in Travis County. Judicial review under this section is governed by Subchapter B, Chapter 2001, Government Code.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.304(a), eff. Sept. 1, 2003.

Sec. 1153.105. RATE WITHIN CERTAIN PERCENTAGES OF PRESUMPTIVE RATE. (a) An insurer electing to deviate from the presumptive rate shall file with the commissioner the insurer's proposed rate for credit life and credit accident and health insurance.

(b) On filing the rate with the commissioner, the insurer may use the filed rate until the insurer elects to file a different rate.

(c) Except as provided by Section 1153.106, an insurer may not use a rate that is more than 30 percent higher or more than 30 percent lower than the presumptive rate.

(d) Except as provided by this subchapter, a rate that complies with this section is valid and in compliance with the requirements of this subchapter and other applicable law.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.304(b), eff. Sept. 1, 2003.

Sec. 1153.106. RATE OUTSIDE CERTAIN PERCENTAGES OF PRESUMPTIVE RATE. (a) An insurer may file with the commissioner a proposed rate for credit life and credit accident and health insurance that is more than 30 percent higher or more than 30 percent lower than the presumptive rate adopted by the commissioner under this subchapter.

(b) The commissioner may disapprove a rate filed under this section on the ground that the rate is not actuarially justified.

(c) A rate filed under this section is considered approved and the insurer may use the rate if the rate is not disapproved by the commissioner before the 60th day after the date the insurer filed the rate.

(d) A hearing under this section is a contested case hearing conducted under Chapter 2001, Government Code. Judicial review of

any action of the commissioner under this section is governed by Subchapter D, Chapter 36.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.304(b), eff. Sept. 1, 2003.

Sec. 1153.107. RATE STANDARD. (a) A rate filed under this subchapter is not excessive unless the rate is unreasonably high for the coverage provided and a reasonable degree of competition does not exist with respect to the classification to which the rate is applicable.

(b) A rate filed under this subchapter is not inadequate unless the rate is insufficient to sustain projected losses and expenses or the rate substantially impairs, or is likely to substantially impair, competition with respect to the sale of the product.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.304(b), eff. Sept. 1, 2003.

SUBCHAPTER D. CREDIT INSURANCE REQUIREMENTS

Sec. 1153.151. FORMS OF CREDIT LIFE INSURANCE. Credit life insurance may be issued only as:

- (1) an individual policy of life insurance issued to a debtor on a term plan; or
- (2) a group policy of life insurance issued to a creditor on a term plan providing insurance on the lives of debtors.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1153.152. FORMS OF CREDIT ACCIDENT AND HEALTH INSURANCE. Credit accident and health insurance may be issued only as:

- (1) an individual policy of accident and health insurance issued to a debtor on a term plan;
- (2) a disability benefit provision in an individual policy of credit life insurance;
- (3) a group policy of accident and health insurance issued to a creditor on a term plan insuring debtors; or
- (4) a disability benefit provision in a group policy of

credit life insurance.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1153.153. EVIDENCE OF INSURANCE. Credit life insurance or credit accident and health insurance shall be evidenced by an individual policy or group certificate of insurance.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1153.154. REQUIREMENTS FOR DELIVERY OR ISSUANCE OF CREDIT INSURANCE POLICY. A policy of credit life insurance or credit accident and health insurance that is delivered or issued for delivery in this state may be delivered or issued for delivery only by an insurer authorized to engage in the business of insurance in this state and may be issued only through a holder of a license issued by the commissioner.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1153.155. LIMITS ON AMOUNT OF CREDIT LIFE INSURANCE. (a) The initial amount of credit life insurance on a debtor may not exceed the total amount of debt repayable under the contract that evidences the credit transaction.

(b) If the debt is repayable in substantially equal installments, the amount of insurance may not at any time exceed the greater of the scheduled or actual unpaid amount of the debt under the contract.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1153.156. LIMITS ON AMOUNT OF CREDIT ACCIDENT AND HEALTH INSURANCE. (a) The total amount of indemnity payable by credit accident and health insurance may not exceed the total amount of debt repayable under the contract that evidences the credit transaction.

(b) The amount of a periodic indemnity payment may not exceed the scheduled periodic installment payment on the debt.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1153.157. BEGINNING OF TERM OF CREDIT INSURANCE COVERAGE.

(a) Except as otherwise provided by this section, the term of credit life insurance or credit accident and health insurance begins, subject to acceptance by the insurer, on the date that the debtor becomes obligated to the creditor.

(b) With respect to an obligation that exists when a group policy takes effect, coverage begins on the later of the effective date of the policy or the date of enrollment for coverage under the policy.

(c) If evidence of insurability is required and is provided after the 30th day after the date the debtor becomes obligated to the creditor, the term of the insurance may begin on the date the insurance company determines that the evidence is satisfactory.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1153.158. DELIVERY OF EVIDENCE OF INSURANCE TO DEBTOR.

(a) At the time a debt for which credit insurance is sold is incurred:

- (1) the individual policy or group certificate of insurance, as appropriate, shall be delivered to the debtor; or
- (2) a copy of the application for the policy or certificate of insurance or a notice of proposed insurance that satisfies Section 1153.159 shall be delivered to the debtor.

(b) If delivery to the debtor is made under Subsection (a)(2), the insurer shall deliver the individual policy or group certificate of insurance to the debtor on acceptance of the insurance by the insurer and not later than the 45th day after the date the debt is incurred.

(c) If the insurer named in the application or notice under Subsection (a)(2) does not accept the risk, the debtor shall receive a policy or certificate of insurance that specifies the name and home office address of the substituted insurer and the amount of the premium to be charged for the insurance.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1153.159. REQUIREMENTS RELATING TO APPLICATION FOR INSURANCE OR NOTICE OF PROPOSED INSURANCE. A copy of an application for insurance or a notice of proposed insurance delivered under Section 1153.158 must:

- (1) be signed by the debtor;
- (2) specify:
 - (A) the name and home office address of the insurer;
 - (B) the name of each debtor;
 - (C) the full amount of the premium or the total identifiable insurance charge, if any, to be paid by the debtor, separately for credit life insurance and credit accident and health insurance; and
 - (D) the amount, term, and a brief description of the coverage to be provided;
- (3) refer exclusively to insurance coverage;
- (4) be separate from the instrument or agreement for the loan or sale or other credit statement of account, unless the information required by this section is prominently set forth in that instrument, agreement, or statement; and
- (5) provide that on acceptance by the insurer, the insurance becomes effective as provided by Section 1153.157.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1153.160. TERMINATION OF CREDIT INSURANCE. (a) The term of credit life insurance or credit accident and health insurance must end not later than the 15th day after the scheduled maturity date of the debt unless the coverage after that date is without additional cost to the debtor.

(b) If the debt is discharged by renewing or refinancing the debt before the scheduled maturity date, the insurance in force must terminate before new insurance may be issued in connection with the renewed or refinanced debt.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1153.161. INSURANCE MAY BE PROVIDED BY DEBTOR. If credit life insurance or credit accident and health insurance is required as additional security for a debt, the debtor, on request to the

creditor, may provide the required amount of insurance through:

- (1) an existing insurance policy owned or controlled by the debtor; or
- (2) an insurance policy obtained from an insurer authorized to engage in the business of insurance in this state.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

SUBCHAPTER E. CHARGES, REFUNDS, ADJUSTMENTS, AND CLAIMS

Sec. 1153.201. MAXIMUM AMOUNT OF INSURANCE CHARGE TO DEBTOR. A creditor may not charge a debtor for credit life or credit accident and health insurance issued to the debtor an amount that exceeds the amount of the premium that the insurer charges the creditor for that insurance, as computed at the time the charge to the debtor is determined.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1153.202. REFUND OF INSURANCE CHARGE ON TERMINATION OF DEBT OR INSURANCE; FILING OF FORMULA. (a) Each individual policy or group policy and group certificate must include a written notice stating that:

- (1) if the underlying debt or the insurance terminates before the originally scheduled termination date of the insurance, including the termination of a debt by renewing or refinancing the debt, the debtor shall be entitled to a refund of unearned premium; and

- (2) in the event that the underlying debt or the insurance terminates before the originally scheduled termination date of the insurance, including the termination of a debt by renewing or refinancing the debt, the person who is the holder of the underlying debt instrument on the date the debt terminates shall, no later than 60 days after the termination of the insurance, provide notice to the insurer of the termination of the debt, that includes the name and address of the insured and the payoff date of the underlying debt.

- (a-1) The refund of any amount of unearned premium paid by or charged to the debtor for insurance shall be paid or credited promptly to the person entitled to the refund no later than 30 days after receipt of the notice required to be sent to the insurer under

Subsection (a)(2).

(a-2) In any claim or action asserted by an insured against an insurer for failure to refund any unearned premium in accordance with this section, the insurer shall be entitled to indemnity from a holder who failed to provide the notice required under Subsection (a)(2).

(b) A refund is not required if the amount of the refund is less than \$3.

(c) The formula to be used in computing the refund of the amount paid by or charged to the debtor for insurance if the underlying debt or the insurance terminates before the scheduled maturity date of the debt must be filed with and approved by the commissioner.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 502 (S.B. 382), Sec. 1, eff. September 1, 2007.

Sec. 1153.203. CERTAIN REFUNDS OR ADJUSTMENTS REQUIRED. (a) If the beginning of the term of insurance is delayed under Section 1153.157(c), the charge to the debtor for insurance shall be adjusted or the appropriate amount shall be refunded to the debtor.

(b) If insurance is substituted under Section 1153.158(c) and the amount of premium for the substituted insurance is less than the amount specified in the application or notice of proposed insurance, the appropriate amount shall be refunded to the debtor.

(c) If a creditor requires a debtor to make any payment for credit life insurance or credit accident and health insurance and an individual policy or group certificate of insurance is not issued, the creditor shall:

- (1) immediately give written notice to the debtor; and
- (2) promptly make an appropriate credit to the debtor's account.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1153.204. CLAIM UNDER POLICY. (a) A claim for recovery under a policy to which this chapter applies shall be reported

promptly to the insurer or the insurer's designated claim representative.

(b) An insurer shall maintain adequate claim files.

(c) A claim shall be settled as soon as possible and in accordance with the insurance contract.

(d) A claim shall be paid by a draft drawn on the insurer or by check of the insurer to the order of the claimant to whom payment of the claim is due under the policy or on direction of the claimant to the person specified.

(e) A plan or arrangement may not be used to authorize an individual, firm, or corporation, other than the insurer or the insurer's designated claim representative, to settle or adjust a claim. The creditor may not be designated as claim representative for the insurer in settling or adjusting a claim. Notwithstanding this subsection, a group policyholder, under an arrangement with the group insurer, may draw drafts or checks in payment of claims due to the group policyholder subject to audit and review by the insurer.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

SUBCHAPTER O. ENFORCEMENT OF CHAPTER; PENALTY

Sec. 1153.701. COMPLIANCE ORDER. (a) If, after written notice to an insurer or other person who holds a license or other authorization issued by the commissioner and a hearing, the commissioner determines that a violation of this chapter or a rule adopted under this chapter has occurred, the commissioner shall issue the details of that determination and an order for compliance by a specified date.

(b) An order issued under this section is binding on the insurer or other person to whom it is issued on the date specified in the order unless:

(1) the order is withdrawn by the commissioner before that date; or

(2) the order is appealed under Subchapter D, Chapter 36.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1153.702. PENALTY. (a) An individual, firm, or corporation who violates a final order issued under this chapter is

liable to the state in a civil action for a penalty of not more than:

(1) \$250; or

(2) \$1,000, if the court finds the violation to be wilful.

(b) The penalty provided by this section is in addition to any other penalty provided by law.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

Sec. 1153.703. REVOCATION OR SUSPENSION OF AUTHORITY ON VIOLATION OF ORDER. After notice and a hearing, the commissioner may revoke or suspend the license or certificate of authority of an individual, firm, or corporation that violates an order issued under this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 2, eff. June 1, 2003.

**CHAPTER 1154. FUNDING AGREEMENTS, GUARANTEED INVESTMENT CONTRACTS,
AND SYNTHETIC GUARANTEED INVESTMENT CONTRACTS**

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1154.001. SHORT TITLE. This chapter may be cited as the Act for the Regulation of Funding Agreements, Guaranteed Investment Contracts, and Synthetic Guaranteed Investment Contracts.

Added by Acts 2015, 84th Leg., R.S., Ch. 1187 (S.B. [1196](#)), Sec. 2, eff. September 1, 2015.

Sec. 1154.002. PURPOSE; LEGISLATIVE INTENT; CONSTRUCTION. (a) The purpose of this chapter is to:

(1) promote the public welfare by regulating funding agreements, guaranteed investment contracts, and synthetic guaranteed investment contracts; and

(2) clarify and codify the existing law pertaining to funding agreements, guaranteed investment contracts, and synthetic guaranteed investment contracts.

(b) This chapter shall be liberally construed.

Added by Acts 2015, 84th Leg., R.S., Ch. 1187 (S.B. [1196](#)), Sec. 2, eff. September 1, 2015.

Sec. 1154.003. DEFINITIONS. In this chapter:

(1) "Annuity contract" means a contract, including a funding agreement, guaranteed investment contract, and synthetic guaranteed investment contract, issued by a life insurer, with or without a mortality or morbidity contingency, under which:

(A) the owner deposits cash or assets in one or more installments with the life insurer; and

(B) the owner or a beneficiary designated by the owner has a right to receive periodic payments for a specified future term.

(2) "Funding agreement" means a type of annuity contract under which a life insurer:

(A) accepts and accumulates funds, including noncash assets; and

(B) makes one or more payments at a future date in amounts that are not based on mortality or morbidity contingencies.

(3) "Governmental body" means a federal, state, municipal, local, or foreign court, tribunal, governmental department, commission, board, bureau, agency, authority, instrumentality, regulatory body, or quasi-regulatory body.

(4) "Group" means a group to which a group life insurance policy may be issued under Subchapter B, Chapter 1131.

(5) "Group annuity contract" means an annuity contract issued to a group and not an individual.

(6) "Guaranteed investment contract" means a type of annuity contract issued by a life insurer:

(A) that is a funding vehicle typically issued to a retirement plan; and

(B) under which the life insurer accepts a deposit or series of deposits from the purchaser and guarantees to pay a specified interest rate of return on the funds deposited during a specified period.

(7) "Life insurer" means an insurance company authorized to engage in the business of life insurance, including issuing annuity contracts, in this state.

(8) "Synthetic guaranteed investment contract" means a group annuity contract or other agreement issued by a life insurer that, wholly or partly, establishes the life insurer's obligations by reference to a segregated portfolio of assets that the life insurer

does not own.

Added by Acts 2015, 84th Leg., R.S., Ch. 1187 (S.B. 1196), Sec. 2, eff. September 1, 2015.

Sec. 1154.004. APPLICABILITY OF CERTAIN OTHER LAW. Chapters 521, 1107, 1115, and 1131 do not apply to funding agreements, guaranteed investment contracts, or synthetic guaranteed investment contracts without mortality or morbidity contingencies.

Added by Acts 2015, 84th Leg., R.S., Ch. 1187 (S.B. 1196), Sec. 2, eff. September 1, 2015.

Sec. 1154.005. RULES. The commissioner may adopt rules to implement or clarify this chapter.

Added by Acts 2015, 84th Leg., R.S., Ch. 1187 (S.B. 1196), Sec. 2, eff. September 1, 2015.

SUBCHAPTER B. FUNDING AGREEMENTS

Sec. 1154.051. ESTABLISHMENT OF FUNDING AGREEMENTS. (a) A life insurer may issue a funding agreement to generate an income stream for the purchaser of the agreement or fund a future liability or program of the purchaser or the purchaser's designee. A life insurer may issue a funding agreement to:

(1) an accredited investor, as defined by 17 C.F.R. Section 230.501;

(2) a governmental body; or

(3) an institution with assets in excess of \$25 million.

(b) A life insurer that issues a funding agreement in this state engages in the business of insurance for the purpose of regulation.

Added by Acts 2015, 84th Leg., R.S., Ch. 1187 (S.B. 1196), Sec. 2, eff. September 1, 2015.

SUBCHAPTER C. GUARANTEED INVESTMENT CONTRACTS

Sec. 1154.101. ESTABLISHMENT OF GUARANTEED INVESTMENT CONTRACTS. A life insurer may issue a guaranteed investment contract to provide a benefit in a fixed amount or a variable amount or a fixed amount and a variable amount.

Added by Acts 2015, 84th Leg., R.S., Ch. 1187 (S.B. 1196), Sec. 2, eff. September 1, 2015.

TITLE 8. HEALTH INSURANCE AND OTHER HEALTH COVERAGES

SUBTITLE A. HEALTH COVERAGE IN GENERAL

CHAPTER 1201. ACCIDENT AND HEALTH INSURANCE

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1201.001. DEFINITIONS. In this chapter:

(1) "Accident and health insurance policy" includes any policy or contract that provides insurance against loss resulting from:

- (A) accidental bodily injury;
- (B) accidental death; or
- (C) sickness.

(2) "Policy" means the entire contract between an insurer and an insured and includes riders, endorsements, and the application, if attached.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1201.002. PURPOSE. The purpose of this chapter is to:

(1) provide for reasonable standardization, readability, and simplification of terms and coverages in individual accident and health insurance policies;

(2) promote public understanding of coverages;

(3) eliminate provisions in individual accident and health insurance policies that may be unjust, unfair, misleading, or unreasonably confusing in connection with:

- (A) the purchase of coverage; or
- (B) the settlement of claims; and

(4) provide for full and fair disclosure in sales of accident and health coverage.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1201.003. APPLICABILITY OF CHAPTER. (a) This chapter applies only to an accident and health insurance policy delivered or issued for delivery in this state.

(b) Except as otherwise provided by this chapter, this chapter applies only to an individual accident and health insurance policy delivered or issued for delivery by:

- (1) a life, health, and accident insurance company;
- (2) a mutual insurance company, including:
 - (A) a mutual life insurance company; and
 - (B) a mutual assessment life insurance company;
- (3) a local mutual aid association;
- (4) a mutual or natural premium life or casualty insurance company;
- (5) a general casualty company;
- (6) a Lloyd's plan;
- (7) a reciprocal or interinsurance exchange;
- (8) a nonprofit hospital, medical, or dental service corporation, including a corporation operating under Chapter 842; or
- (9) another insurer required by law to be authorized by the department.

(c) This chapter applies to an accident and health insurance policy issued by a stipulated premium company subject to Chapter 884.

(d) This chapter does not apply to:

- (1) any society, company, or other insurer whose activities are exempt by statute from the control of the department and that is entitled by statute to a certificate from the department that shows the entity's exempt status;
- (2) a credit accident and health insurance policy issued under Chapter 1153;
- (3) a workers' compensation insurance policy;
- (4) a liability insurance policy, with or without supplementary expense coverage;
- (5) a reinsurance policy or contract;
- (6) a blanket or group insurance policy, except as otherwise provided by this chapter; or
- (7) a life insurance endowment or annuity contract or a contract supplemental to a life insurance endowment or annuity contract if the contract or supplemental contract contains only

provisions relating to accident and health insurance that:

(A) provide additional benefits in case of accidental death, accidental dismemberment, or accidental loss of sight; or

(B) operate to:

(i) safeguard the contract or supplemental contract against lapse; or

(ii) give a special surrender value, a special benefit, or an annuity if the insured or annuitant becomes totally and permanently disabled, as defined by the contract or supplemental contract.

(e) Subchapters C and D do not apply to a conversion policy issued under a contractual conversion privilege under a group accident and health insurance policy.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1201.004. CONSTRUCTION OF CHAPTER. This chapter does not enlarge the powers of an entity listed in Section 1201.003.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1201.005. REFERENCES TO CHAPTER. In this chapter, a reference to this chapter includes a reference to:

(1) Section 1202.052;

(2) Section 1271.005(a), to the extent that the subsection relates to the applicability of Section 1201.105, and Sections 1271.005(d) and (e);

(3) Chapter 1351;

(4) Subchapters C and E, Chapter 1355;

(5) Chapter 1356;

(6) Chapter 1365;

(7) Subchapter A, Chapter 1367; and

(8) Subchapters A, B, and G, Chapter 1451.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1201.006. RULEMAKING AUTHORITY. The commissioner may adopt reasonable rules as necessary to implement the purposes and

provisions of this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1201.007. NOTICE AND HEARING. The commissioner may adopt a general rule or order relating to a matter covered by this chapter only after a hearing held after the 10th day following the date the department by mail notifies each insurer to which this chapter applies.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1201.008. JUDICIAL REVIEW. An insurer that is dissatisfied with an order, act, rule, administrative ruling, or decision of the commissioner under this chapter may, after failing to get relief from the commissioner, file a petition seeking judicial review of the order, act, rule, ruling, or decision in accordance with Subchapter D, Chapter 36. The action has precedence over all other causes on the docket of a different nature.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1201.009. NONCONFORMING POLICY. (a) This chapter governs the rights, duties, and obligations of the insurer, the insured, and the beneficiary of an accident and health insurance policy regardless of a provision in the policy that conflicts with this chapter.

(b) An accident and health insurance policy that violates this chapter is a valid policy, but the policy shall be construed in a manner to make the policy consistent with this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1201.010. THIRD-PARTY OWNERSHIP OF POLICY. The use of "insured" in this chapter does not prevent a person with an insurable interest, other than the insured, from:

(1) applying for and owning an individual accident and health insurance policy covering the insured; or

(2) being entitled to an indemnity, right, or benefit provided for in an individual accident and health insurance policy covering the insured.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1201.011. COVERAGE FOR PREMIUM PERIOD WITH LIMITATIONS BY AGE OR DATE; MISSTATEMENT OF AGE OF INSURED. (a) Regardless of a provision in an individual accident and health insurance policy that specifies a date, by age limitation or otherwise, after which coverage under the policy is not effective, coverage continues in force, subject to any right of cancellation, until the end of the period for which the insurer accepts a premium if:

- (1) the insurer accepts the premium after the specified date; or
- (2) the specified date falls before the end of the period for which the insurer accepts the premium.

(b) Notwithstanding Subsection (a), if the age of the insured is misstated and, because of the insured's correct age, coverage of the insured would not have become effective or would have terminated before the insurer's acceptance of a premium, the liability of the insurer is limited to the refund, on request, of the premiums paid for the period not covered by the policy.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1201.012. DEFENSE OF CLAIM. The following actions by an insurer do not operate as a waiver of the insurer's rights in defense of a claim that arises under an individual accident and health insurance policy:

- (1) acknowledgment of the receipt of notice given under the policy;
- (2) provision of a form for filing a proof of loss;
- (3) acceptance of a proof of loss; or
- (4) investigation of a claim under the policy.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1201.013. PROGRAMS PROMOTING DISEASE PREVENTION, WELLNESS, AND HEALTH. (a) An insurer issuing an accident and health insurance policy may establish premium discounts, rebates, or a reduction in otherwise applicable copayments, coinsurance, or deductibles, or any combination of these incentives, for an insured who participates in programs promoting disease prevention, wellness, and health.

(b) A discount, rebate, or reduction established under this section does not violate Section 541.056(a).

Added by Acts 2007, 80th Leg., R.S., Ch. 112 (H.B. [2252](#)), Sec. 2, eff. May 17, 2007.

SUBCHAPTER B. POLICY TERMS

Sec. 1201.051. ENTIRE CONSIDERATION. An individual accident and health insurance policy must state the entire monetary and other consideration for the policy in the policy or in the application, if the application is made a part of the policy.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1201.052. TIME OF EFFECTIVENESS AND TERMINATION. An individual accident and health insurance policy must state the time the insurance takes effect and the time the insurance terminates.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1201.053. PERSONS INSURED. (a) Except as provided by this section, an individual accident and health insurance policy may not insure more than one individual.

(b) On the application of an adult member of a family, an individual accident and health insurance policy may, at the time of original issuance or by subsequent amendment, insure two or more eligible members of the adult's family, including a spouse, unmarried children younger than 25 years of age, including a grandchild of the adult as described by Section 1201.062(a)(1), a child the adult is required to insure under a medical support order or dental support order, if the policy provides dental coverage, issued under Chapter 154, Family Code, or enforceable by a court in this state, and any

other individual dependent on the adult.

(c) The adult who applies for the individual accident and health insurance policy is considered the policyholder.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1150 (S.B. 550), Sec. 56, eff. September 1, 2018.

Sec. 1201.054. APPEARANCE OF TEXT. (a) In this section, "text" includes all printed matter of an individual accident and health insurance policy except:

- (1) the name and address of the insurer;
- (2) the name or title of the policy;
- (3) the brief description, if any; and
- (4) captions and subcaptions.

(b) An individual accident and health insurance policy must have:

- (1) a style, arrangement, or overall appearance that does not give undue prominence to any portion of the text; and
- (2) every printed portion of its text and of any endorsements or attached papers printed plainly in a lightfaced type:
 - (A) of a style in general use; and
 - (B) in a uniform size not less than 10-point with a lowercase unspaced alphabet length not less than 120-point.

(c) Subsection (b)(2) does not apply to a copy of an application or identification card.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1201.055. EXCEPTIONS AND REDUCTIONS OF INDEMNITY. (a) An individual accident and health insurance policy must state each exception to or reduction of indemnity for the policy.

(b) Except as provided by Subchapter E, each exception to or reduction of indemnity for the policy must be printed, at the insurer's option:

- (1) with the benefit provision to which the exception or reduction applies; or
- (2) under an appropriate caption such as:

- (A) "Exceptions"; or
- (B) "Exceptions and Reductions."

(c) Notwithstanding Subsection (b), if an exception or reduction specifically applies only to a particular benefit of an individual accident and health insurance policy, the statement of the exception or reduction must be included with the benefit provision to which the exception or reduction applies.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1201.056. FORM NUMBER. Each form that constitutes a part of an individual accident and health insurance policy, including each rider or endorsement, must be identified by a form number placed in the lower left corner of the first page of the form.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1201.057. INCORPORATION OF OR REFERENCE TO OTHER DOCUMENTS. (a) An individual accident and health insurance policy that provides that a portion of the charter, rules, constitution, or bylaws of the insurer are a part of the policy must state that portion fully in the policy.

(b) An individual accident and health insurance policy may incorporate or refer to:

- (1) a statement of rates or classification of risks; or
- (2) a short-rate table filed with the department.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1201.058. NOTIFICATION THAT POLICY IS RETURNABLE; EFFECT OF RETURN. (a) An individual accident and health insurance policy must include a notice that states in substance that the individual to whom the policy is issued is entitled to have the premium paid refunded if, after the individual examines the policy, the individual is not satisfied with the policy for any reason and returns the policy not later than the 10th day after the date the policy is delivered to the individual.

(b) An individual accident and health insurance policy returned

to the insurer at the insurer's home or branch office or to the agent through whom the policy was purchased within the time provided by the notice is void from the date the policy was issued, and the parties are in the same position as if the policy had not been issued.

(c) The notice required by this section may be printed on the policy or attached to the policy.

(d) This section does not apply to a single premium nonrenewable policy.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1201.059. TERMINATION OF COVERAGE BASED ON AGE OF CHILD IN INDIVIDUAL, BLANKET, OR GROUP POLICY. (a) An accident and health insurance policy, including an individual, blanket, or group policy, and including a policy issued by a corporation operating under Chapter 842, that provides that coverage of a child terminates when the child attains a limiting age specified in the policy must provide in substance that the child's attainment of that age does not terminate coverage while the child is:

(1) incapable of self-sustaining employment because of an intellectual or physical disability; and

(2) chiefly dependent on the insured or group member for support and maintenance.

(b) To obtain coverage for a child as described by Subsection (a), the insured or group member must provide to the insurer proof of the child's incapacity and dependency:

(1) not later than the 31st day after the date the child attains the limiting age; and

(2) subsequently as the insurer requires, except that the insurer may not require proof more frequently than annually after the second anniversary of the date the child attains the limiting age.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 30 (H.B. 446), Sec. 8.02, eff. September 1, 2023.

Sec. 1201.060. REQUIRED DEFINITION OF "EMERGENCY CARE" IN INDIVIDUAL OR GROUP POLICY. An individual or group accident and

health insurance policy that provides an emergency care benefit, including a policy issued by a corporation operating under Chapter 842, must define "emergency care" as follows:

"Emergency care" means bona fide emergency services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:

- (1) placing the patient's health in serious jeopardy;
- (2) serious impairment to bodily functions; or
- (3) serious dysfunction of any bodily organ or part.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1201.0601. REQUIRED DEFINITIONS: SPECIFIED DISEASE POLICY. An individual or group specified disease insurance policy that uses the term "actual charge" or "actual fee" must define the terms as follows:

"Actual charge" or "actual fee" means the amount actually paid by or on behalf of the insured and accepted by a provider for services provided.

Added by Acts 2005, 79th Leg., Ch. 974 (H.B. 1775), Sec. 1, eff. September 1, 2005.

Sec. 1201.061. COVERAGE FOR ADOPTED CHILD. (a) An individual accident and health insurance policy that provides coverage for an insured's immediate family or children may not, solely because the insured's child is adopted:

- (1) exclude the child from coverage; or
- (2) limit coverage for the child.

(b) For the purposes of this section, a child is an insured's child if the insured is a party to a suit in which the insured seeks to adopt the child.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1201.062. COVERAGE FOR CERTAIN CHILDREN IN INDIVIDUAL OR

GROUP POLICY OR IN PLAN OR PROGRAM. (a) An individual or group accident and health insurance policy that is delivered, issued for delivery, or renewed in this state, including a policy issued by a corporation operating under Chapter 842, or a self-funded or self-insured welfare or benefit plan or program, to the extent that regulation of the plan or program is not preempted by federal law, that provides coverage for a child of an insured or group member, on payment of a premium, must provide coverage for:

(1) each grandchild of the insured or group member if the grandchild is:

(A) unmarried;

(B) younger than 25 years of age; and

(C) a dependent of the insured or group member for federal income tax purposes at the time application for coverage of the grandchild is made; and

(2) each child for whom the insured or group member must provide medical support or dental support, if the policy provides dental coverage, under an order issued under Chapter 154, Family Code, or enforceable by a court in this state.

(b) Coverage for a grandchild of the insured or group member may not be terminated solely because the grandchild is no longer a dependent of the insured or group member for federal income tax purposes.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1150 (S.B. 550), Sec. 57, eff. September 1, 2018.

Sec. 1201.063. PROHIBITION OF CERTAIN CRITERIA RELATING TO CHILD'S COVERAGE IN INDIVIDUAL OR GROUP POLICY. Regarding a natural or adopted child of an insured or group member or a child for whom the insured or group member must provide medical support or dental support, if the policy provides dental coverage, under an order issued under Chapter 154, Family Code, or enforceable by a court in this state, an individual or group accident and health insurance policy that provides coverage for a child of an insured or group member may not set a different premium for the child, exclude the child from coverage, or discontinue coverage of the child because:

(1) the child does not reside with the insured or group member; or

(2) the insured or group member does not claim the child as an exemption for federal income tax purposes under Section 151(c), Internal Revenue Code of 1986.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1150 (S.B. 550), Sec. 58, eff. September 1, 2018.

Sec. 1201.064. COVERAGE FOR CHILD OF SPOUSE IN INDIVIDUAL OR GROUP POLICY. An individual or group accident and health insurance policy that provides coverage for a child of an insured or group member may not:

(1) set a premium for a child that is different from the premium for other children because the child is the natural or adopted child of the spouse of the insured or group member;

(2) exclude a child described by Subdivision (1) from coverage; or

(3) discontinue coverage of a child described by Subdivision (1).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1201.065. AGE AND SCHOOL ENROLLMENT ELIGIBILITY CRITERIA FOR DEPENDENT CHILDREN IN INDIVIDUAL OR GROUP POLICY; LATE ENROLLMENT. (a) An individual or group accident and health insurance policy may contain criteria relating to a maximum age or enrollment in school to establish continued eligibility for coverage of a child 25 years of age or older.

(b) In the case of a late enrollment, an insurer may require evidence of insurability that is satisfactory to the insurer before a child is included for coverage under the policy.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.023(a), eff. September 1, 2005.

SUBCHAPTER C. GENERAL POLICY STANDARDS AND PROVISIONS

Sec. 1201.101. STANDARDS FOR POLICY PROVISIONS. (a) The commissioner shall adopt reasonable rules establishing specific standards for:

(1) the content of an individual accident and health insurance policy; and

(2) the manner of sale of an individual accident and health insurance policy, including disclosures required to be made in connection with the sale.

(b) Rules adopted under this section must establish standards for:

(1) policy readability; and

(2) full and fair policy disclosures.

(c) Standards established under this section may include standards that address:

(1) terms of policy renewability;

(2) initial and subsequent conditions of eligibility;

(3) nonduplication of coverage;

(4) coverage of dependents;

(5) preexisting conditions;

(6) termination of insurance;

(7) probationary periods;

(8) limitations;

(9) exceptions;

(10) reductions;

(11) elimination periods;

(12) requirements for replacement;

(13) recurrent conditions; and

(14) definitions of terms, including definitions of:

(A) "accident";

(B) "accidental means";

(C) "guaranteed renewable and noncancellable";

(D) "hospital";

(E) "injury";

(F) "nervous disorder";

(G) "partial disability";

(H) "physician";

(I) "sickness"; and

(J) "total disability."

(d) A definition of "hospital" adopted under Subsection (c) may not apply to a corporation operating under Chapter 842.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1201.102. PROHIBITION OF POLICY PROVISIONS. The commissioner may adopt rules prohibiting specific individual accident and health insurance policy provisions not specifically authorized by statute that the commissioner determines are unjust, unfair, or unfairly discriminatory to:

- (1) the policyholder;
- (2) an insured under the policy; or
- (3) a beneficiary.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1201.103. COMPLIANCE WITH MINIMUM STANDARDS FOR BENEFITS.

(a) An individual accident and health insurance policy must meet the minimum standards for benefits established under Section 1201.104 for each category of coverage provided under the policy.

(b) Subsection (a) does not apply if the commissioner determines that the policy is a supplemental policy or experimental policy or determines that the policy will fulfill a reasonable public need and the policy meets the requirements of Chapter 1701.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1201.104. MINIMUM STANDARDS FOR BENEFITS. (a) For individual accident and health insurance policies, the commissioner shall adopt rules establishing minimum standards for benefits under each of the following categories of coverage:

- (1) basic hospital expense;
- (2) basic medical-surgical expense;
- (3) hospital indemnity or other fixed indemnity;
- (4) major medical expense;
- (5) disability income protection;
- (6) accident only;

- (7) specified disease;
- (8) specified accident; and
- (9) limited benefit.

(b) This section does not prohibit the issuance of an individual accident and health insurance policy that combines categories of coverage listed by this section.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2015, 84th Leg., R.S., Ch. 25 (S.B. 979), Sec. 1, eff. May 15, 2015.

Sec. 1201.105. MINIMUM STANDARDS FOR BENEFITS FOR LONG-TERM CARE IN INDIVIDUAL, GROUP, OR BLANKET POLICY. (a) The commissioner shall adopt rules establishing minimum standards for benefits for long-term care coverage under individual, group, and blanket accident and health insurance policies and certificates delivered or issued for delivery in this state.

(b) Rules adopted under this section apply to group coverages delivered or issued for delivery by a corporation operating under Chapter 842.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1201.106. IDENTIFICATION OF POLICIES ACCORDING TO COVERAGE PROVIDED. The commissioner shall prescribe the method to identify an individual accident and health insurance policy according to the coverages the policy provides.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1201.107. OUTLINE OF COVERAGE REQUIRED. (a) An outline of coverage for an individual accident and health insurance policy must be delivered to the applicant at the time application is made, and an acknowledgment of receipt or certificate of delivery of an outline of coverage must be provided to the insurer with the application.

(b) If the policy issued differs from the policy for which the

applicant applied, an outline of coverage that properly describes the policy must:

- (1) accompany the policy when delivered; and
- (2) clearly state that the policy is not the policy for which the applicant applied.

(c) Subsection (a) does not apply to a direct response insurance product.

(d) An outline of coverage under a direct response insurance product must accompany the policy.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1201.108. FORMAT AND CONTENT OF OUTLINE OF COVERAGE. (a) In this section, "format" means style, arrangement, and overall appearance, including:

- (1) the size, color, and prominence of type; and
- (2) the arrangement of text and captions.

(b) The commissioner shall prescribe the format and content of an outline of coverage required by Section 1201.107.

(c) An outline of coverage must include:

- (1) a statement that identifies the applicable categories of coverage listed by Section 1201.104 and provided by the policy;
- (2) a description of the principal benefits and coverage provided by the policy;
- (3) a statement of the exceptions, reductions, and limitations in the policy;
- (4) a statement of the renewal provision, including any reservation of the insurer's right to change premiums;
- (5) a statement that:
 - (A) the outline is a summary of the policy issued or applied for; and
 - (B) the policy should be consulted to determine governing contractual provisions;
- (6) as the commissioner determines necessary to carry out the purposes of this chapter, a summary of the provisions required by Subchapter E to be in the policy; and
- (7) any other statement, description, or outline that the commissioner determines is reasonably necessary to carry out the purposes of this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1201.109. NOTICE OF RATE INCREASE FOR MAJOR MEDICAL EXPENSE INSURANCE POLICY. (a) Not less than 60 days before the date on which a premium rate increase takes effect on an individual accident and health insurance policy that provides major medical expense coverage and that is delivered or issued for delivery in this state by an insurer, the insurer shall:

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

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

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

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

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

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

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

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

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

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

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

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

(f) For purposes of this section, "major medical expense

coverage" means an individual major medical expense insurance policy to which this chapter applies under Section 1201.003 that constitutes creditable coverage under Section 1205.004.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1147 (H.B. 1951), Sec. 3.002, eff. September 1, 2011.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 454 (S.B. 853), Sec. 1, eff. June 14, 2013.

Acts 2013, 83rd Leg., R.S., Ch. 454 (S.B. 853), Sec. 2, eff. June 14, 2013.

SUBCHAPTER D. PREEXISTING CONDITIONS

Sec. 1201.151. COMPLIANCE WITH SUBCHAPTER; PROHIBITION OF DEFENSE. Except as provided by this subchapter, an individual accident and health insurance policy may not include a provision that permits a defense based on a preexisting condition.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1201.152. COVERAGE UNDER SIMPLIFIED APPLICATION FORM. (a) Notwithstanding Clause (b) of the provision required by Section 1201.208(a), an individual accident and health insurance policy must cover any loss that occurs after 12 months from a preexisting condition if the insurer uses a simplified application form that does not include a question concerning the applicant's health history or medical treatment history.

(b) This section applies regardless of whether the simplified application form includes a question regarding the applicant's health at the time of application.

(c) This section does not require an insurer to cover a loss from a condition that the policy specifically excludes from coverage.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1201.153. COVERAGE FOR INDIVIDUALS AGE 65 OR OLDER. (a) Notwithstanding Section 1201.152 or Clause (b) of the provision required by Section 1201.208(a), an individual accident and health

insurance policy delivered or issued for delivery to an individual who is 65 years of age or older may not include a provision that excludes from coverage a loss that occurs from a preexisting condition more than six months after the effective date of coverage under the policy.

(b) Notwithstanding Subsection (a), the commissioner may authorize a policy provision that excludes coverage for a preexisting condition for a period of not more than one year if the commissioner determines that the provision would serve the public interest.

(c) This section does not require an insurer to provide coverage for a loss from a preexisting condition specifically excluded from coverage by name or specific description in an exclusion endorsement or rider that is effective on the date of the loss.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1201.154. COVERAGE FOR CERTAIN PREVIOUSLY COVERED PERSONS.

(a) In this section, "creditable coverage" has the meaning assigned by Section 1205.004(a).

(b) A preexisting condition provision in an individual accident and health insurance policy may not apply to an individual who was continuously covered for an aggregate period of 18 months by creditable coverage that was in effect up to a date not more than 63 days before the effective date of the individual coverage, excluding any waiting period.

(c) In determining whether a preexisting condition provision of an individual accident and health insurance policy applies to an individual, an insurer shall credit the time the individual previously was covered under creditable coverage if the previous coverage was in effect at any time during the 18 months preceding the effective date of the individual coverage.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.024, eff. September 1, 2005.

Acts 2007, 80th Leg., R.S., Ch. 1070 (H.B. 2548), Sec. 1, eff. June 15, 2007.

SUBCHAPTER E. REQUIRED POLICY PROVISIONS

Sec. 1201.201. POLICY PROVISIONS REQUIRED. (a) Except as provided by Subsections (b) and (c), an individual accident and health insurance policy must contain the provisions required by this subchapter in the words provided by this subchapter.

(b) An insurer may substitute for a policy provision required by this subchapter a provision with different wording approved by the commissioner in accordance with reasonable rules adopted by the commissioner. A substituted provision may not be less favorable to an insured or a beneficiary of the policy than the provision required by this subchapter.

(c) If a policy provision required by this subchapter is wholly or partly inapplicable to or inconsistent with the coverage provided by a particular form of policy, the insurer, with the commissioner's approval, shall:

(1) omit from the policy each inapplicable provision or part of a provision; and

(2) modify each inconsistent provision or part of a provision so that the provision as contained in the policy is consistent with the coverage provided by the policy.

(d) A policy provision required by this subchapter must be preceded by the caption for the provision provided by this subchapter or, at the option of the insurer, by an appropriate individual or group caption or subcaption approved by the commissioner.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1201.202. ORDER OF REQUIRED POLICY PROVISIONS. (a) Except as provided by Subsection (b), policy provisions required by this subchapter or corresponding substitute provisions must be printed in the same consecutive order as provided by this subchapter.

(b) An insurer may print a policy provision required by this subchapter or a corresponding substitute provision as a unit in any part of the policy with other provisions to which the provision is logically related.

(c) A policy printed under Subsection (b) may not be wholly or partly unintelligible, uncertain, ambiguous, abstruse, or likely to mislead a person to whom the policy is offered, delivered, or issued.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1201.203. OTHER POLICY PROVISIONS. A policy provision that is not otherwise subject to this subchapter may not make an individual accident and health insurance policy or any portion of the policy less favorable in any way to the insured or the beneficiary than the policy provisions that are subject to this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1201.204. POLICY PROVISIONS REQUIRED BY OTHER JURISDICTION. An individual accident and health insurance policy of a foreign or alien insurer may contain any provision that is:

(1) not less favorable to the insured or the beneficiary than the provisions of this chapter; and

(2) prescribed or required by the law of the state under which the insurer is organized.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1201.205. POLICY PROVISIONS FOR POLICY DELIVERED OUTSIDE THIS STATE. An individual accident and health insurance policy issued by a domestic insurer for delivery in another state or country may contain any provision permitted or required by the laws of that state or country.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1201.206. FILING PROCEDURE. (a) The commissioner may adopt reasonable rules regarding the procedure for submitting policies subject to this chapter that are necessary, proper, or advisable for the administration of this chapter.

(b) This section does not limit any authority otherwise granted by law to the commissioner or department.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1201.207. POLICY PROVISION: ENTIRETY OF CONTRACT; POLICY CHANGES. An individual accident and health insurance policy must contain the following provision:

"Entire Contract; Changes: This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. A change in this policy is not valid until the change is approved by an executive officer of the insurer and unless the approval is endorsed on or attached to the policy. An agent does not have authority to change this policy or to waive any of its provisions."

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1201.208. POLICY PROVISION: INCONTESTABILITY. (a) Except as provided by Subsection (c), an individual accident and health insurance policy must contain the following provision:

"Time Limit on Certain Defenses: (a) After the second anniversary of the date this policy is issued, a misstatement, other than a fraudulent misstatement, made by the applicant in the application for the policy may not be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) beginning after that anniversary.

"(b) A claim for loss incurred or disability (as defined in the policy) beginning after the second anniversary of the date this policy is issued may not be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss existed before the effective date of coverage of this policy."

(b) Clause (a) of the provision required by Subsection (a) does not:

(1) affect any legal requirement for avoidance of a policy or denial of a claim during the initial two-year period; or

(2) limit the application of Section 1201.219, 1201.220, or 1201.221 in a case of a misstatement regarding age, occupation, or other insurance.

(c) For a policy that provides that the insured is entitled to continue the policy in force by the timely payment of premiums until the insured reaches at least 50 years of age or, if the policy was issued after the insured reached 44 years of age, until at least the

fifth anniversary of the policy's date of issuance, an insurer may use the following clause instead of Clause (a) of the provision required by Subsection (a):

"After this policy has been in force for a period of two years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestible as to the statements contained in the application."

(d) The provision provided by Subsection (c) must be under the caption "Incontestable." An insurer that uses the provision may omit the parenthetical clause.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1201.209. POLICY PROVISION: GRACE PERIOD. (a) An individual accident and health insurance policy must contain the following provision:

"Grace Period: A grace period of _____ (insert appropriate number) days will be granted for the payment of each premium due after the first premium. During the grace period, the policy continues in force."

(b) The number of days of the grace period may not be less than:

- (1) 7 for a weekly premium policy;
- (2) 10 for a monthly premium policy; or
- (3) 31 for any other policy.

(c) A policy that contains a cancellation provision may add, at the end of the provision required by Subsection (a): "subject to the right of the insurer to cancel the policy in accordance with the policy's cancellation provision."

(d) A policy in which the insurer reserves the right to refuse any renewal must include the following provision at the beginning of the provision required by Subsection (a):

"Unless, not less than five days before the premium due date, the insurer has delivered to the insured, or has mailed to the insured's last address as shown by the insurer's records, a written notice of the insurer's intention not to renew this policy beyond the period for which the premium has been accepted,"

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1201.210. POLICY PROVISION: REINSTATEMENT. (a) Except as provided by Subsection (b), an individual accident and health insurance policy must contain the following provision:

"Reinstatement: If a renewal premium is not paid before the expiration of the period granted for the insured to make the payment, a subsequent acceptance of the premium by the insurer or any agent authorized by the insurer to accept the premium, without requiring in connection with the acceptance an application for reinstatement, reinstates the policy. However, if the insurer or authorized agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated on approval of the application by the insurer or, if the application is not approved, on the 45th day after the date of the conditional receipt unless the insurer before that date has notified the insured in writing of the insurer's disapproval of the application. The reinstated policy covers only loss resulting from an accidental injury sustained after the date of reinstatement and loss due to sickness that begins more than 10 days after the date of reinstatement. In all other respects the insured and insurer have the same rights under the reinstated policy as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed in the policy or attached to the policy in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days before the date of reinstatement."

(b) The insurer may omit the last sentence of the provision required by Subsection (a) in a policy that provides that the insured is entitled to continue the policy in force by the timely payment of premiums until the insured reaches at least 50 years of age or, if the policy was issued after the insured reached 44 years of age, until at least the fifth anniversary of the policy's date of issuance.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1201.211. POLICY PROVISION: NOTICE OF CLAIM. (a) Except as provided by Subsection (b), an individual accident and health insurance policy must contain the following provision:

"Notice of Claim: A written notice of claim must be given to the insurer before the 21st day after the date of the occurrence or beginning of any loss covered by the policy, or as soon after that date as is reasonably possible. A notice given by or on behalf of the insured or the beneficiary to the insurer at _____ (insert the location of any office the insurer designates for the purpose), or to any authorized agent of the insurer, with information sufficient to identify the insured, constitutes notice to the insurer."

(b) In a policy that provides a loss of time benefit that may be payable for at least two years, an insurer may insert, between the first and second sentences of the provision required by Subsection (a), the following provision:

"Subject to the qualifications below, and except in the event of a legal incapacity, if the insured suffers loss of time on account of disability for which indemnity may be payable for at least two years, the insured shall, at least once in every _____ (insert appropriate number) months after having given notice of claim, give to the insurer notice of continuance of the disability. In applying this provision, the period of _____ (insert appropriate number) months following a filing of proof by the insured or any payment by the insurer on account of the claim or any denial of liability in whole or in part by the insurer shall be excluded. Delay in giving the notice does not impair the insured's right to any indemnity that would otherwise have accrued during the period of _____ (insert appropriate number) months preceding the date on which the notice is actually given."

(c) The number of months inserted in the clause permitted by Subsection (b) may not be less than one or greater than six.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1201.212. POLICY PROVISION: CLAIM FORMS. (a) Except as provided by Subsection (b), an individual accident and health insurance policy must contain the following provision:

"Claim Forms: The insurer, on receipt of a notice of claim, will provide to the claimant the forms usually provided by the insurer for filing proof of loss. If the forms are not provided before the 16th day after the date of the notice, the claimant shall

be considered to have complied with the requirements of this policy as to proof of loss on submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character, and the extent of the loss for which the claim is made."

(b) The provision required by this section is not required to be contained in a policy issued by a corporation operating under Chapter 842.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1201.213. POLICY PROVISION: PROOF OF LOSS. An individual accident and health insurance policy must contain the following provision:

"Proof of Loss: For a claim for loss for which this policy provides any periodic payment contingent on continuing loss, a written proof of loss must be provided to the insurer at the insurer's designated office before the 91st day after the termination of the period for which the insurer is liable. For a claim for any other loss, a written proof of loss must be provided to the insurer at the insurer's designated office before the 91st day after the date of the loss. Failure to provide the proof within the required time does not invalidate or reduce any claim if it was not reasonably possible to give proof within the required time. In that case, the proof must be provided as soon as reasonably possible but not later than one year after the time proof is otherwise required, except in the event of a legal incapacity."

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1201.214. POLICY PROVISION: TIME OF PAYMENT OF CLAIMS.

(a) Except as provided by Subsection (c), an individual accident and health insurance policy must contain the following provision:

"Time of Payment of Claims: Indemnities payable under this policy for any loss, other than a loss for which this policy provides any periodic payment, will be paid immediately on receipt of due written proof of the loss. Subject to due written proof of loss, all accrued indemnities for a loss for which this policy provides periodic payment will be paid _____ (insert period for payment)

and any balance remaining unpaid on termination of liability will be paid immediately on receipt of due written proof of loss."

(b) The period for payment to be inserted in the clause required by Subsection (a) may not be less frequent than monthly.

(c) The provision required by this section is not required to be contained in a policy issued by a corporation operating under Chapter 842.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1201.215. POLICY PROVISION: PAYMENT OF CLAIMS. (a) Except as provided by Subsection (d), an individual accident and health insurance policy must contain the following provision:

"Payment of Claims: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting indemnity payments that may be prescribed in this policy and effective at the time of payment. If such a designation or provision is not then effective, the indemnity will be payable to the insured's estate. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either in accordance with the beneficiary designation or to the insured's estate. All other indemnities will be payable to the insured."

(b) An insurer may include with the provision required by Subsection (a) one or both of the following provisions:

"If any indemnity of this policy is payable to the insured's estate, or to an insured or beneficiary who is a minor or is otherwise not competent to give a valid release, the insurer may pay the indemnity, up to an amount not exceeding \$_____ (insert amount), to any relative by blood or connection by marriage of the insured or beneficiary who is considered by the insurer to be equitably entitled to the indemnity. Any payment made by the insurer in good faith in accordance with this provision fully discharges the insurer to the extent of the payment."

"Subject to any written direction of the insured, in the application or otherwise, all or a portion of any indemnity provided by this policy on account of hospital, nursing, medical, or surgical services may, at the insurer's option and unless the insured requests otherwise in writing not later than the time of filing proof of the loss, be paid directly to the hospital or person providing the

services. It is not required that the service be provided by a particular hospital or person."

(c) The amount to be inserted in the clause permitted by Subsection (b) may not exceed \$1,000.

(d) The provision required by Subsection (a) is not required to be contained in a policy issued by a corporation operating under Chapter 842.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1201.216. POLICY PROVISION: PHYSICAL EXAMINATIONS AND AUTOPSY. An individual accident and health insurance policy must contain the following provision:

"Physical Examinations and Autopsy: The insurer at its own expense has the right and opportunity to conduct a physical examination of the insured when and as often as the insurer reasonably requires while a claim under the policy is pending and, in case of death, to require that an autopsy be conducted if not forbidden by law."

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1201.217. POLICY PROVISION: LEGAL ACTIONS. An individual accident and health insurance policy must contain the following provision:

"Legal Actions: An action at law or in equity may not be brought to recover on this policy before the 61st day after the date written proof of loss has been provided in accordance with the requirements of this policy. An action at law or in equity may not be brought after the expiration of three years after the time written proof of loss is required to be provided."

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1201.218. POLICY PROVISION: CHANGE OF BENEFICIARY. (a) Except as provided by Subsection (b), an individual accident and health insurance policy must contain the following provision:

"Change of Beneficiary: Unless the insured makes an irrevocable

designation of beneficiary, the right to change a beneficiary is reserved for the insured, and the consent of the beneficiary or beneficiaries is not required for the surrender or assignment of this policy, for any change of beneficiary or beneficiaries, or for any other changes in this policy."

(b) An insurer may omit the first clause of the provision required by Subsection (a) relating to an irrevocable designation of beneficiary.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1201.219. POLICY PROVISION: CHANGE OF OCCUPATION. An individual accident and health insurance policy must contain the following provision if the policy addresses the subject matter of the provision:

"Change of Occupation: If the insured is injured or contracts a sickness after the insured changes the insured's occupation to one classified by the insurer as more hazardous than the occupation stated in this policy or while doing for compensation anything pertaining to an occupation so classified, the insurer will pay only the portion of the indemnity provided in this policy as the premium paid would have purchased at the rates and within the limits fixed by the insurer for the more hazardous occupation. If the insured changes the insured's occupation to one classified by the insurer as less hazardous than the occupation stated in this policy, the insurer, on receipt of proof of the change of occupation, will reduce the premium rate accordingly, and will return the excess pro rata unearned premium from the date of change of occupation or from the policy anniversary date immediately preceding the receipt of the proof, whichever date is more recent. In applying this provision, the classification of occupational risk and the premium rates are the classification and rates that, before the occurrence of the loss for which the insurer is liable or before the date of proof of change in occupation, were:

(1) last filed by the insurer with the state official having supervision of insurance in the state where the insured resided at the time this policy was issued; or

(2) if filing was not required, last made effective by the insurer in the state where the insured resided at the time this

policy was issued."

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1201.220. POLICY PROVISION: MISSTATEMENT OF AGE. An individual accident and health insurance policy must contain the following provision if the policy addresses the subject matter of the provision:

"Misstatement of Age: If the age of the insured has been misstated, the amounts payable under this policy are the amounts the premium paid would have purchased at the correct age."

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1201.221. POLICY PROVISION: EXCESS INSURANCE. An individual accident and health insurance policy must contain one of the following provisions if the policy addresses the subject matter of the provision:

"Other Insurance With This Insurer: If an accident or health or accident and health policy or policies previously issued by the insurer to the insured is in force concurrently with this policy, making the aggregate indemnity for _____ (insert types of coverages) in excess of \$_____ (insert maximum limit of indemnity or indemnities), the excess insurance is void and all premiums paid for the excess shall be returned to the insured or to the insured's estate."

"Other Insurance With This Insurer: Insurance effective at any one time on the insured under the same type of policy or policies with this insurer is limited to the one policy elected by the insured, the insured's beneficiary, or the insured's estate, as the case may be, and the insurer will return all premiums paid for all other policies of the same type."

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1201.222. POLICY PROVISION: RELATION OF EARNINGS TO INSURANCE. (a) Subject to Subsection (b), an individual accident and health insurance policy must contain the following provision if

the policy addresses the subject matter of the provision:

"Relation of Earnings to Insurance: If the total monthly amount of loss of time benefits promised for the same loss under all valid loss of time coverage on the insured, regardless of whether the benefits are payable on a weekly or monthly basis, exceeds the amount of monthly earnings of the insured at the time the insured's disability began or the insured's average amount of monthly earnings for the period of two years immediately preceding a disability for which claim is made, whichever amount is greater, the insurer will be liable only for the proportionate amount of loss of time benefits under this policy as the amount of the insured's monthly earnings or average monthly earnings bears to the total amount of monthly benefits for the same loss under all loss of time coverage on the insured at the time the disability begins and for the return of the part of the premiums paid during the immediately preceding two years that exceeds the pro rata amount of the premiums for the benefits actually paid under this policy. This provision does not reduce the total monthly amount of benefits payable under all loss of time coverage on the insured to less than \$200 or the sum of the monthly benefits specified in the loss of time coverages, whichever amount is less, and does not reduce benefits other than loss of time benefits."

(b) The provision described by Subsection (a) may be included only in a policy that provides that the insured is entitled to continue the policy in force subject to its terms by the timely payment of premiums until the insured reaches at least 50 years of age or, if the policy was issued after the insured reached 44 years of age, until at least the fifth anniversary of the policy's date of issuance.

(c) An insurer may include in the provision described by Subsection (a) a definition of "valid loss of time coverage." The form of the definition must be approved by the commissioner. The subject matter of the definition must be limited to:

- (1) coverage provided by:
 - (A) governmental agencies; or
 - (B) organizations subject to regulation by insurance laws or by insurance authorities of this or any other state or any province of Canada;
- (2) any other coverage the inclusion of which is approved by the commissioner; or
- (3) any combination of coverages described by Subdivisions

(1) and (2).

(d) In the absence of a definition authorized under Subsection (c), "valid loss of time coverage" does not include:

(1) coverage provided for the insured under a compulsory benefit statute, including a workers' compensation or employer's liability statute; or

(2) benefits provided by:

(A) a union welfare plan;

(B) an employer benefit organization; or

(C) an employee benefit organization.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1201.223. POLICY PROVISION: UNPAID PREMIUM. An individual accident and health insurance policy must contain the following provision if the policy addresses the subject matter of the provision:

"Unpaid Premium: At the time of payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted from the payment."

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1201.224. POLICY PROVISION: CANCELLATION. An individual accident and health insurance policy must contain the following provision if the policy addresses the subject matter of the provision:

"Cancellation: The insurer may cancel this policy at any time by written notice delivered to the insured, or mailed to the insured's last address as shown by the records of the insurer, stating when the cancellation is effective, which may not be earlier than five days after the date the notice is delivered or mailed. After this policy has been continued beyond its original term, the insured may cancel the policy at any time by written notice delivered or mailed to the insurer, effective on receipt or on a later date specified in the notice. In the event of cancellation, the insurer will promptly return the unearned portion of any premium paid. If the insured cancels, the earned premium shall be computed by the use of the short-rate table last filed with the state official having

supervision of insurance in the state where the insured resided when the policy was issued. If the insurer cancels, the earned premium shall be computed pro rata. Cancellation is without prejudice to any claim originating before the effective date of cancellation."

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1201.225. POLICY PROVISION: CONFORMITY WITH STATE STATUTES. An individual accident and health insurance policy must contain the following provision if the policy addresses the subject matter of the provision:

"Conformity With State Statutes: Any provision of this policy that, on its effective date, conflicts with the statutes of the state in which the insured resides on the effective date is by this clause effectively amended to conform to the minimum requirements of that state's statutes."

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1201.226. POLICY PROVISION: ILLEGAL OCCUPATION. An individual accident and health insurance policy must contain the following provision if the policy addresses the subject matter of the provision:

"Illegal Occupation: The insurer is not liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation."

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

SUBCHAPTER F. APPLICATION FOR POLICY

Sec. 1201.271. ALTERATION OF POLICY APPLICATION. (a) A person may not alter a written application for an individual accident and health insurance policy unless the person has the written consent of the applicant.

(b) Notwithstanding Subsection (a), an insurer may make an insertion to an application solely for administrative purposes in a manner that indicates clearly that the insertion is not attributed to

the applicant.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1201.272. FALSE STATEMENTS. The falsity of a statement in an application for an individual accident and health insurance policy does not bar a right to recovery under the policy unless the statement materially affected the acceptance of the risk or the hazard assumed by the insurer.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1201.273. BINDING STATEMENTS. An insured may not be bound by a statement made in an application for an individual accident and health insurance policy unless a copy of the application is attached to or endorsed on the policy as a part of the policy when issued.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1201.274. INSURER'S EVIDENTIARY USE OF APPLICATION FOR REINSTATEMENT OR RENEWAL. (a) If an individual accident and health insurance policy is reinstated or renewed, and the insured or the beneficiary or assignee of the policy makes a written request for a copy of the application for reinstatement or renewal, the insurer shall, not later than the 15th day after the date the insurer receives the request at its home or branch office, deliver or mail a copy of the application to the person who made the request.

(b) An insurer that fails to comply with this section may not introduce the application for reinstatement or renewal as evidence in any action or proceeding based on or involving the policy or its reinstatement or renewal.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

SUBCHAPTER O. ENFORCEMENT

Sec. 1201.701. CIVIL PENALTY. A person, partnership, or corporation that wilfully violates this chapter or an order of the

commissioner made under this chapter is liable to the state for a civil penalty in an amount not to exceed \$5,000 for each violation. The penalty may be recovered through a civil action.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1201.702. ACTION AGAINST CERTIFICATE OF AUTHORITY OR LICENSE. The commissioner may suspend or revoke the certificate of authority or license of an insurer or agent who wilfully violates this chapter or an order of the commissioner made under this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

CHAPTER 1202. CANCELLATION AND CONTINUATION OF POLICIES IN GENERAL
SUBCHAPTER A. CONTINUOUS POLICIES

Sec. 1202.001. CONTINUOUS POLICIES. (a) A guaranteed renewable insurance policy or a noncancellable insurance policy is considered to be a continuous policy, subject only to the policy terms and conditions, including payment of the policy premium.

(b) A guaranteed renewable insurance policy or a noncancellable insurance policy:

(1) is continued in effect by the payment of the policy premium in accordance with the policy terms and conditions; and

(2) may not be considered or treated as a renewed policy by the payment of the policy premium.

(c) This section does not apply to a small employer health benefit plan adopted in accordance with Chapter 1501.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

SUBCHAPTER B. INDIVIDUAL HEALTH INSURANCE POLICIES

Sec. 1202.051. RENEWABILITY AND CONTINUATION OF INDIVIDUAL HEALTH INSURANCE POLICIES. (a) This section applies only to an individual health insurance policy that provides benefits for medical care under a hospital, medical, or surgical policy.

(b) Except as provided by Subsection (c), an insurer shall renew or continue an individual health insurance policy at the option of the individual.

(c) An insurer may decline to renew or continue an individual health insurance policy:

- (1) for failure to pay a premium or contribution in accordance with the terms of the policy;
- (2) for fraud or intentional misrepresentation;
- (3) because the insurer is ceasing to offer coverage in the individual market in accordance with rules adopted by the commissioner;
- (4) because an individual no longer resides, lives, or works in an area in which the insurer is authorized to provide coverage, but only if all policies are not renewed or not continued under this subdivision uniformly without regard to any health-status related factor of covered individuals; or
- (5) in accordance with federal law, including regulations.

(d) The commissioner shall adopt rules necessary to:

- (1) implement this section; and
- (2) meet the minimum requirements of federal law, including regulations.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1202.052. CANCELLATION PROHIBITED FOR AIDS OR HIV. (a) In this section, "AIDS" and "HIV" have the meanings assigned by Section 81.101, Health and Safety Code.

(b) Except as provided by Subsection (c), an insurer that delivers or issues for delivery an individual accident and health insurance policy in this state may not cancel that policy during its term because the insured:

- (1) has been diagnosed as having AIDS or HIV;
- (2) has been treated for AIDS or HIV; or
- (3) is being treated for AIDS or HIV.

(c) The insurer may cancel the policy for:

- (1) failure to pay a premium when due; or
- (2) fraud or misrepresentation in obtaining coverage by not disclosing a diagnosis of an AIDS or HIV-related condition.

(d) The provisions of Chapter 1201, including provisions relating to the applicability, purpose, and enforcement of that chapter, construction of policies under that chapter, rulemaking under that chapter, and definitions of terms applicable in that

chapter, apply to this section.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

CHAPTER 1203. COORDINATION OF BENEFITS PROVISIONS

SUBCHAPTER A. SUPPLEMENTAL INSURANCE POLICIES

Sec. 1203.001. APPLICABILITY OF SUBCHAPTER. (a) This subchapter applies only to:

- (1) a policy of group accident and health insurance as described by Chapter 1251;
- (2) a policy of blanket accident and health insurance as described by Chapter 1251;
- (3) a policy of individual accident and health insurance as defined by Section 1201.001; or
- (4) an evidence of coverage as defined by Section 843.002.

(b) This subchapter does not apply to an individual accident and health insurance policy that is designed to fully integrate with other policies through a variable deductible.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 572 (H.B. [3024](#)), Sec. 3, eff. September 1, 2015.

Sec. 1203.002. CERTAIN COORDINATION OF BENEFITS PROVISIONS PROHIBITED. (a) An accident and health insurance policy or evidence of coverage may not be delivered, issued for delivery, or renewed in this state if:

- (1) a provision of the policy or evidence of coverage excludes or reduces the payment of benefits to or on behalf of an insured or enrollee;
- (2) the reason for the exclusion or reduction is that benefits are also payable or have been paid to or on behalf of the insured or enrollee under a supplemental policy of accident and health insurance; and
- (3) the supplemental policy is individually underwritten and individually issued as a plan of coverage for:
 - (A) hospital confinement indemnity;
 - (B) a specified disease; or

(C) a limited benefit.

(b) Application of Subsection (a) to a provision of an accident and health insurance policy or evidence of coverage is not affected by:

- (1) the mode or channel by which the premium for a supplemental policy of accident and health insurance is paid to the insurer; or
- (2) a reduction in the premium for a supplemental policy of accident and health insurance because of the insured's membership in an organization or status as an employee.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1203.003. CERTAIN COORDINATION OF BENEFITS PROVISIONS VOID. A provision of an accident and health insurance policy or evidence of coverage that violates Section 1203.002 is void.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

SUBCHAPTER B. DENTAL INSURANCE

Sec. 1203.051. APPLICABILITY OF SUBCHAPTER; EXCEPTION. (a) This subchapter applies only to an insurance policy that provides benefits for dental expenses, including, except as provided by Subsection (b), an individual, group, blanket, or franchise insurance policy or insurance agreement, or a group hospital service contract, that is offered by:

- (1) an insurance company;
- (2) a group hospital service corporation operating under Chapter 842;
- (3) a fraternal benefit society operating under Chapter 885;
- (4) a stipulated premium company operating under Chapter 884;
- (5) a reciprocal exchange operating under Chapter 942; or
- (6) a Lloyd's plan operating under Chapter 941.

(b) This subchapter does not apply to a separate dental policy that exclusively provides a non-coordinated, fixed indemnity benefit, regardless of expenses incurred paid directly to the policyholder or to the provider under an assignment of benefits provision.

Added by Acts 2015, 84th Leg., R.S., Ch. 572 (H.B. 3024), Sec. 1, eff. September 1, 2015.

Sec. 1203.052. COORDINATION OF BENEFITS BETWEEN PRIMARY AND SECONDARY INSURERS. (a) This section applies if:

(1) an insured is covered by at least two different insurance policies; and

(2) each policy provides the insured dental benefits.

(b) The primary insurer, as determined under a coordination of benefits provision applicable to the policies, is responsible for dental expenses covered under the insurance policy issued by the primary insurer up to the full amount of any policy limit applicable to the covered dental expenses.

(c) Before the policy limit described by Subsection (b) is reached, the secondary insurer, as determined under a coordination of benefits provision applicable to the policies, is responsible only for dental expenses covered under the insurance policy issued by the secondary insurer that are not covered under the policy issued by the primary insurer.

(d) After the policy limit described by Subsection (b) has been reached, the secondary insurer, in addition to the responsibility described by Subsection (c), is responsible for any dental expenses covered by both policies that exceed the policy limit described by Subsection (b), not to exceed the policy limit of the secondary policy.

Added by Acts 2015, 84th Leg., R.S., Ch. 572 (H.B. 3024), Sec. 1, eff. September 1, 2015.

Sec. 1203.053. CERTAIN COORDINATION OF BENEFITS PROVISIONS PROHIBITED. An insurance policy subject to this subchapter may not be delivered, issued for delivery, or renewed in this state if:

(1) a provision of the policy excludes or reduces the payment of benefits for dental expenses to or on behalf of an insured;

(2) the reason for the exclusion or reduction is that dental benefits are payable or have been paid to or on behalf of the insured under another insurance policy; and

(3) the exclusion or reduction would apply before the full amount of the dental expenses incurred by the insured and covered by both policies have been paid or reimbursed or the full amount of the applicable policy limit of the policy containing the exclusion or reduction is reached.

Added by Acts 2015, 84th Leg., R.S., Ch. 572 (H.B. 3024), Sec. 1, eff. September 1, 2015.

Sec. 1203.054. CERTAIN COORDINATION OF BENEFITS PROVISIONS VOID. A provision of an insurance policy that violates Section 1203.053 is void.

Added by Acts 2015, 84th Leg., R.S., Ch. 572 (H.B. 3024), Sec. 1, eff. September 1, 2015.

SUBCHAPTER C. VISION AND EYE CARE BENEFITS

Sec. 1203.101. DEFINITIONS. In this subchapter:

(1) "Eye care expenses" means expenses related to vision or medical eye care services, procedures, or products.

(2) "Health benefit plan" means a policy, agreement, contract, or evidence of coverage that provides comprehensive medical coverage.

(3) "Vision benefit plan" means a limited-scope policy, agreement, contract, or evidence of coverage that provides coverage for eye care expenses but does not provide comprehensive medical coverage.

Added by Acts 2023, 88th Leg., R.S., Ch. 15 (S.B. 861), Sec. 1, eff. September 1, 2023.

Sec. 1203.102. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a health benefit plan or vision benefit plan that provides or arranges for benefits for vision or medical eye care services, procedures, or products, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, an evidence of coverage, or a vision benefit plan offered by:

- (1) an insurance company;
- (2) a group hospital service corporation operating under Chapter 842;
- (3) a health maintenance organization operating under Chapter 843;
- (4) a stipulated premium company operating under Chapter 884;
- (5) a fraternal benefit society operating under Chapter 885;
- (6) a Lloyd's plan operating under Chapter 941;
- (7) an exchange operating under Chapter 942; or
- (8) a person or entity that provides a vision benefit plan.

Added by Acts 2023, 88th Leg., R.S., Ch. 15 (S.B. [861](#)), Sec. 1, eff. September 1, 2023.

Sec. 1203.103. EXCEPTION. This subchapter does not apply to a supplemental insurance policy that only pays benefits directly to the policyholder.

Added by Acts 2023, 88th Leg., R.S., Ch. 15 (S.B. [861](#)), Sec. 1, eff. September 1, 2023.

Sec. 1203.104. COORDINATION OF BENEFITS BETWEEN PRIMARY AND SECONDARY PLAN ISSUERS. (a) This section applies if:

- (1) an enrollee is covered by at least two different health benefit plans or vision benefit plans; and
- (2) each plan provides the enrollee coverage for the same vision or medical eye care services, procedures, or products.

(b) The issuer of the primary health benefit plan or vision benefit plan, as determined under a coordination of benefits provision applicable to the plan, is responsible for eye care expenses covered under the plan up to the full amount of any plan coverage limit applicable to the covered eye care expenses.

(c) Before the plan coverage limit described by Subsection (b) is reached, the issuer of a secondary health benefit plan or vision benefit plan, as determined under a coordination of benefits provision applicable to the plan, is responsible only for eye care expenses covered under the plan that are not covered under the health

benefit plan or vision benefit plan issued by the primary plan issuer.

(d) After the plan coverage limit described by Subsection (b) has been reached, the secondary plan issuer, in addition to the responsibilities described by Subsection (c), is responsible for any eye care expenses covered by both plans that exceed the plan coverage limit described by Subsection (b) up to the coverage limit of the secondary plan.

(e) When an enrollee is covered by more than one health benefit plan or vision benefit plan that provides benefits for eye care expenses, the enrollee may use each plan on the same date of service up to the coverage limit of each plan.

(f) A vision benefit plan issuer shall coordinate benefits with a health benefit plan issuer if both provide benefits for eye care expenses.

(g) A vision benefit plan issuer may not require a claim denial before adjudicating a claim up to the coverage limit of the plan.

(h) Nothing in this section prevents a secondary plan issuer from requiring proof that a related claim has been submitted to a primary plan issuer for purposes of determining the remaining balance up to the secondary plan's coverage limits.

(i) If a secondary plan issuer requires proof that a related claim has been submitted to a primary plan issuer as described by Subsection (h), the mechanism of providing proof must be through an online submission.

Added by Acts 2023, 88th Leg., R.S., Ch. 15 (S.B. [861](#)), Sec. 1, eff. September 1, 2023.

Sec. 1203.105. CERTAIN COORDINATION OF BENEFITS PROVISIONS PROHIBITED. (a) A health benefit plan or vision benefit plan subject to this subchapter may not be delivered, issued for delivery, or renewed in this state if:

- (1) a provision of the plan excludes or reduces the payment of benefits for eye care expenses to or on behalf of an enrollee;
- (2) the reason for the exclusion or reduction is that eye care benefits are payable or have been paid to or on behalf of the enrollee under another plan; and
- (3) the exclusion or reduction would apply before the full

amount of the eye care expenses incurred by the enrollee and covered by both plans have been paid or reimbursed or the full amount of the applicable coverage limit of the plan containing the exclusion or reduction is reached.

(b) Nothing in this section requires a secondary plan issuer to pay an amount that, when added to a payment amount made by a primary plan issuer, would exceed the usual and customary billed charges of the health care provider.

Added by Acts 2023, 88th Leg., R.S., Ch. 15 (S.B. 861), Sec. 1, eff. September 1, 2023.

Sec. 1203.106. CERTAIN COORDINATION OF BENEFITS PROVISIONS VOID. A provision of a health benefit plan or vision benefit plan that violates this subchapter is void.

Added by Acts 2023, 88th Leg., R.S., Ch. 15 (S.B. 861), Sec. 1, eff. September 1, 2023.

Sec. 1203.107. RULES. The commissioner may adopt rules necessary to implement this subchapter.

Added by Acts 2023, 88th Leg., R.S., Ch. 15 (S.B. 861), Sec. 1, eff. September 1, 2023.

**CHAPTER 1204. PROCEDURES FOR PAYMENT OF CERTAIN HEALTH AND ACCIDENT
INSURANCE POLICY OR PLAN BENEFITS**

SUBCHAPTER A. PAYMENTS TO CERTAIN PUBLIC HOSPITALS

Sec. 1204.001. NONAPPLICABILITY TO CERTAIN FACILITIES. This subchapter does not apply to indigent care or chronic disease care provided in or by an eleemosynary institution, sanitarium, sanatorium, mental health treatment facility, tuberculosis treatment facility, or cancer treatment facility that is owned or controlled by the state or by a unit of local government.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1204.002. BENEFITS PAYABLE FOR TREATMENT PROVIDED BY HOSPITAL OWNED BY STATE OR UNIT OF LOCAL GOVERNMENT. An insurance policy providing hospital, nursing, medical, or surgical coverage that is issued or delivered in this state after August 27, 1973, may not include a provision that prevents the payment of benefits for expenses of a nonindigent patient incurred in a hospital facility that:

(1) is owned or controlled by the state or by a unit of local government; and

(2) regularly and customarily demands and collects from nonindigent persons payment for those expenses.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

SUBCHAPTER B. ASSIGNMENT OF BENEFIT PAYMENTS

Sec. 1204.051. DEFINITIONS. In this subchapter:

(1) "Covered person" means a person who is insured or covered by a health insurance policy or is a participant in an employee benefit plan. The term includes:

(A) a person covered by a health insurance policy because the person is an eligible dependent; and

(B) an eligible dependent of a participant in an employee benefit plan.

(2) "Employee benefit plan" or "plan" means a plan, fund, or program established or maintained by an employer, an employee organization, or both, to the extent that it provides, through the purchase of insurance or otherwise, health care services to employees, participants, or the dependents of employees or participants.

(3) "Health care provider" means a person who provides health care services under a license, certificate, registration, or other similar evidence of regulation issued by this or another state of the United States.

(4) "Health care service" means a service to diagnose, prevent, alleviate, cure, or heal a human illness or injury that is provided to a covered person by a physician or other health care provider.

(5) "Health insurance policy" means an individual, group, blanket, or franchise insurance policy, or an insurance agreement,

that provides reimbursement or indemnity for health care expenses incurred as a result of an accident or sickness.

(6) "Insurer" means an insurance company, association, or organization authorized to engage in business in this state under Chapter 841, 861, 881, 882, 883, 884, 885, 886, 887, 888, 941, 942, or 982.

(7) "Person" means an individual, association, partnership, corporation, or other legal entity.

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

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1204.052. APPLICABILITY TO CERTAIN PLANS OR PROGRAMS.

This subchapter applies to:

(1) an employee benefit plan, to the extent not preempted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.);

(2) benefit programs under Chapters 1551 and 1601, to the extent that the benefit programs are self-insuring; and

(3) insurance coverage provided under Chapter 1575.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1204.053. ASSIGNMENT OF BENEFITS. (a) An insurer may not deliver, renew, or issue for delivery in this state a health insurance policy that prohibits or restricts a covered person from making a written assignment of benefits to a physician or other health care provider who provides health care services to the person.

(b) This section does not:

(1) provide a coverage or benefit that is not otherwise available under the health insurance policy;

(2) allow assignment of a benefit to:

(A) a person who is not legally entitled to receive such a direct payment; or

(B) another person if, under the health insurance policy or plan, the benefit must be provided to the covered person by a physician or other health care provider who is a contractor or preferred provider under the policy; or

(3) prohibit an insurer from verifying, through the insurer's normal process, the health care services the physician or other health care provider provides to the covered person.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1204.054. PAYMENT OF BENEFITS ACCORDING TO ASSIGNMENT. An insurer shall pay benefits directly to a physician or other health care provider, and the insurer is relieved of the obligation to pay, and of any liability for paying, those benefits to the covered person if:

- (1) the covered person makes a written assignment of those benefits payable to the physician or other health care provider; and
- (2) the assignment is obtained by or delivered to the insurer with the claim for benefits.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1204.055. CONTRACTUAL RESPONSIBILITY FOR DEDUCTIBLES AND COPAYMENTS. (a) The payment of benefits under an assignment does not relieve a covered person of a contractual obligation to pay a deductible or copayment.

(b) A physician or other health care provider may not waive a deductible or copayment by the acceptance of an assignment.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

SUBCHAPTER C. UNIFORM CLAIM BILLING FORMS

Sec. 1204.101. DEFINITIONS. In this subchapter:

(1) "Health benefit plan" means a group, blanket, or franchise insurance policy, a group hospital service contract, or a group subscriber contract or evidence of coverage issued by a health maintenance organization, that provides benefits for health care services.

(2) "Health benefit plan issuer" means an entity authorized under this code or another insurance law of this state that provides health insurance or health benefits in this state, including:

- (A) an insurance company;

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

(C) a health maintenance organization operating under Chapter 843; and

(D) a stipulated premium company operating under Chapter 884.

(3) "Provider" means a person who provides health care under a license issued by this state. The term includes a health care practitioner listed in Section 1451.001 and a nurse first assistant, as defined by Section 1451.101.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1204.102. REQUIRED CLAIM BILLING FORMS. A provider who seeks payment or reimbursement under a health benefit plan and the health benefit plan issuer that issued the plan shall use uniform claim billing form UB-82/HCFR or HCFR 1500, or a successor to one of those forms, as developed by the National Uniform Billing Committee or its successor.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

SUBCHAPTER D. PAYMENTS FOR CERTAIN PUBLICLY PROVIDED SERVICES

Sec. 1204.151. DEFINITION. In this subchapter, "policy" means an individual or group policy of accident and health insurance, including a policy issued by a group hospital service corporation operating under Chapter 842.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1204.152. PAYMENT FOR CERTAIN EXPENSES INCURRED BY TEXAS DEPARTMENT OF HUMAN SERVICES. Each policy delivered or issued for delivery in this state must provide for the repayment of the actual costs of medical expenses the Texas Department of Human Services pays through medical assistance for an insured person if, under the policy, the insured person is entitled to payment for the medical expenses.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1204.153. PAYMENTS TO TEXAS DEPARTMENT OF HUMAN SERVICES FOR CERTAIN CHILDREN. (a) This section applies only to a policy that is delivered, issued for delivery, or renewed in this state and that provides coverage for a child whose parent:

- (1) purchased the policy; or
- (2) is a member of the group covered under the policy.

(b) Each policy must include a requirement that, after written notice to the insurer or group hospital service corporation at the insurer's or group hospital service corporation's home office, benefits payable on behalf of a child must be paid to the Texas Department of Human Services if:

(1) the parent who purchased the policy or who is a group member is required to pay child support by a court order or court-approved agreement and:

- (A) is a possessory conservator of the child under a court order issued in this state; or
- (B) is not entitled to possession of or access to the child;

(2) the Texas Department of Human Services is paying benefits on behalf of the child under Chapter 31 or 32, Human Resources Code; and

(3) the insurer or group hospital service corporation is notified, through an attachment to the claim for benefits at the time the claim is first submitted to the insurer or group hospital service corporation, that the benefits must be paid directly to the Texas Department of Human Services.

(c) The commissioner and the Texas Department of Human Services may consult regarding implementation of this section.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1204.154. UNIFORM PROVISIONS. (a) The commissioner shall adopt uniform policy provisions, riders, and endorsements for the policy requirement of Section 1204.153.

(b) Before the commissioner adopts or makes a change to a provision, rider, or endorsement under Subsection (a), the

commissioner shall present each provision, rider, or endorsement, and any amendment to a provision, rider, or endorsement, to the Texas Department of Human Services for comment.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

SUBCHAPTER E. EXCLUSIONARY CLAUSES

Sec. 1204.201. PROHIBITION OF EXCLUSION OF CERTAIN MEDICAL ASSISTANCE BENEFITS. An individual or group accident and health insurance policy delivered or issued for delivery in this state, including a policy issued by a group hospital service corporation operating under Chapter 842, may not include a provision that excludes or limits the insurer's or group hospital service corporation's coverage from paying benefits covered by Chapter 32, Human Resources Code.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

SUBCHAPTER F. PAYMENT OF BENEFITS TO CONSERVATOR OF MINOR

Sec. 1204.251. PAYMENT TO CONSERVATOR OTHER THAN GROUP MEMBER.

(a) An insurer or group hospital service corporation operating under Chapter 842 that delivers, issues for delivery, or renews in this state a group accident and health insurance policy that provides coverage for a minor child who qualifies as a dependent of a group member may pay benefits on the child's behalf to a person who is not a group member if an order providing for the appointment of a possessory or managing conservator of the child has been issued by a court in this or another state.

(b) A person who is not a group member is entitled to be paid benefits under this section only if the person presents to the insurer or group hospital service corporation, with the claim application:

(1) written notice that the person is a possessory or managing conservator of the child on whose behalf the claim is made; and

(2) a certified copy of a court order designating the person as possessory or managing conservator of the child or other evidence designated by rule of the commissioner that the person is eligible for the benefits as this section provides.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1204.252. PRECONDITIONS FOR PAYMENT; EXCEPTIONS. (a) In accordance with the terms of the policy and this subchapter, an insurer or group hospital service corporation may be required to pay benefits under a group accident and health insurance policy to a person who is not a group member and who complies with:

- (1) Section 1204.251;
- (2) the insurer's or group hospital service corporation's claim application procedures; and
- (3) department rules.

(b) Any requirement imposed on a possessory or managing conservator of a child under this subchapter does not apply with regard to:

- (1) an unpaid medical bill for which an assignment of benefits has been exercised, whether in accordance with policy provisions or otherwise; or
- (2) a claim presented by a group member for which the group member paid any portion of a medical bill that is covered under the policy's terms.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1204.253. RULES. The commissioner may adopt rules to ensure the effective implementation of this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

CHAPTER 1205. CERTIFICATION OF CREDITABLE COVERAGE

Sec. 1205.001. APPLICABILITY OF CHAPTER. This chapter applies only to a health benefit plan that:

- (1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

- (A) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

- (i) an insurance company;
 - (ii) a group hospital service corporation operating under Chapter 842;
 - (iii) a fraternal benefit society operating under Chapter 885;
 - (iv) a stipulated premium company operating under Chapter 884; or
 - (v) a health maintenance organization operating under Chapter 843; and
- (B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:
- (i) a multiple employer welfare arrangement as defined by Section 3 of that Act and operating under Chapter 846; or
 - (ii) an analogous benefit arrangement;
- (2) is offered by an approved nonprofit health corporation that holds a certificate of authority under Chapter 844; or
- (3) is offered by any other entity that:
- (A) is not authorized under this code or another insurance law of this state; and
 - (B) contracts directly for health care services on a risk-sharing basis, including a capitation basis.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1205.002. CERTIFICATION OF COVERAGE. (a) A health benefit plan issuer shall provide a certification of coverage as necessary to determine the period of applicable creditable coverage under that health benefit plan.

(b) The certification required under this section must be provided in accordance with the standards adopted by rule by the commissioner.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1205.003. RULES. The commissioner shall adopt rules as necessary to:

- (1) implement this chapter and related provisions of this code; and

(2) meet the minimum requirements of federal law, including regulations.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1205.004. CREDITABLE COVERAGE. (a) An individual's coverage is creditable coverage for purposes of this chapter if the coverage is provided under:

(1) a self-funded or self-insured employee welfare benefit plan that:

(A) provides health benefits; and

(B) is established in accordance with the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.);

(2) a group health benefit plan provided by a health insurer or health maintenance organization;

(3) an individual health insurance policy or evidence of coverage;

(4) Part A or Part B of Title XVIII of the Social Security Act (42 U.S.C. Section 1395c et seq.);

(5) Title XIX of the Social Security Act (42 U.S.C. Section 1396 et seq.), other than coverage consisting solely of benefits under Section 1928 of that act (42 U.S.C. Section 1396s);

(6) 10 U.S.C. Section 1071 et seq.;

(7) a medical care program of the Indian Health Service or of a tribal organization;

(8) a state health benefits risk pool;

(9) a health plan offered under 5 U.S.C. Section 8901 et seq.;

(10) a public health plan as defined by federal regulations; or

(11) a health benefit plan under Section 5(e), Peace Corps Act (22 U.S.C. Section 2504(e)).

(b) For purposes of this chapter, creditable coverage does not include:

(1) accident-only or disability income insurance or a combination of accident-only and disability income insurance;

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

(3) liability insurance, including general liability

insurance and automobile liability insurance;

(4) workers' compensation insurance or other similar insurance;

(5) automobile medical payment insurance;

(6) credit-only insurance;

(7) coverage for on-site medical clinics;

(8) other coverage that is:

(A) similar to the coverage described by this subsection under which benefits for medical care are secondary or incidental to other insurance benefits; and

(B) specified by federal regulations;

(9) coverage that provides limited-scope dental or vision benefits;

(10) long-term care, nursing home care, home health care, or community-based care coverage or benefits or any combination of those coverages or benefits;

(11) coverage that provides other limited benefits specified by federal regulations;

(12) coverage for a specified disease or illness;

(13) hospital indemnity or other fixed indemnity insurance;

or

(14) Medicare supplemental health insurance, as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss), coverage supplemental to the coverage provided under 10 U.S.C. Section 1071 et seq., or other similar supplemental coverage provided under a group plan.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

CHAPTER 1206. DENIAL OF HEALTH BENEFIT PLAN ENROLLMENT BASED ON EXISTING COVERAGE PROHIBITED

Sec. 1206.001. APPLICABILITY OF CHAPTER. This chapter applies only to a health benefit plan, including a small employer health benefit plan written under Chapter 1501, that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is offered by:

- (1) an insurance company;
- (2) a group hospital service corporation operating under Chapter 842;
- (3) a fraternal benefit society operating under Chapter 885;
- (4) a stipulated premium company operating under Chapter 884;
- (5) a reciprocal exchange operating under Chapter 942;
- (6) a health maintenance organization operating under Chapter 843;
- (7) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; or
- (8) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1206.002. EXCEPTION. This chapter does not apply to:

- (1) a plan that provides coverage:
 - (A) only for a specified disease or for another limited benefit;
 - (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;
 - (H) only for indemnity for hospital confinement; or
 - (I) in accordance with Title XXI of the Social Security Act (42 U.S.C. Section 1397aa et seq.);
- (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; or
- (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 as described by Section 1206.001.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1206.003. DENIAL OF ENROLLMENT PROHIBITED. A health benefit plan issuer may not refuse to enroll an individual in the plan solely because the individual is enrolled in another health benefit plan at the time the individual applies for coverage under the plan.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1206.004. VIOLATION OF CHAPTER: UNFAIR DISCRIMINATION. A health benefit plan issuer who violates this chapter engages in unfair discrimination under Subchapter B, Chapter 544.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

CHAPTER 1207. ENROLLMENT OF MEDICAL ASSISTANCE RECIPIENTS AND CHILDREN ELIGIBLE FOR STATE CHILD HEALTH PLAN

Sec. 1207.001. APPLICABILITY OF CHAPTER. This chapter applies only to a group health benefit plan, including a small employer health benefit plan written under Chapter 1501, a plan provided under Chapter 1551, 1575, or 1601, or a successor to a plan provided under one of those chapters, or a medical savings account plan or other health reimbursement arrangement authorized by law, that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including a group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or a group evidence of coverage or similar group coverage document that is offered by:

- (1) an insurance company;
- (2) a group hospital service corporation operating under Chapter 842;
- (3) a fraternal benefit society operating under Chapter 885;

- (4) a stipulated premium company operating under Chapter 884;
- (5) a reciprocal exchange operating under Chapter 942;
- (6) a health maintenance organization operating under Chapter 843;
- (7) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; or
- (8) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.025(a), eff. September 1, 2005.

Sec. 1207.002. ENROLLMENT REQUIRED. (a) A group health benefit plan issuer shall permit an individual who is otherwise eligible for enrollment in the plan to enroll in the plan, without regard to any enrollment period restriction, on receipt of written notice from the Health and Human Services Commission that the individual is:

- (1) a recipient of medical assistance under the state Medicaid program and is a participant in the health insurance premium payment reimbursement program under Section 32.0422, Human Resources Code; or
- (2) a child eligible for the state child health plan under Chapter 62, Health and Safety Code, and eligible to participate in the health insurance premium assistance program under Section 62.059, Health and Safety Code.

(b) A group health benefit plan issuer shall permit an individual who is otherwise eligible for enrollment in the plan to enroll in the plan, without regard to any enrollment period restriction, if the individual:

- (1) becomes ineligible for medical assistance under the state Medicaid program or enrollment in the state child health plan under Chapter 62, Health and Safety Code, after initially establishing eligibility; and
- (2) provides a written request for enrollment in the group health benefit plan not later than the 30th day after the date the

individual's eligibility for the state Medicaid program or the state child health plan terminated.

(c) If an individual described by Subsection (a)(1) or (2) or Subsection (b) is not eligible to enroll in the group health benefit plan unless a family member of the individual is also enrolled in the plan, the plan issuer, on receipt of written notice under Subsection (a) or a written request under Subsection (b), shall enroll both the individual and the family member in the plan.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.026(a), eff. September 1, 2005.

Acts 2007, 80th Leg., R.S., Ch. 268 (S.B. 10), Sec. 24(a), eff. September 1, 2007.

Sec. 1207.003. EFFECTIVE DATE OF ENROLLMENT. (a) Unless enrollment occurs during an established enrollment period, enrollment in a group health benefit plan under Section 1207.002 takes effect on:

(1) the eligibility enrollment date specified in the written notice from the Health and Human Services Commission under Section 1207.002(a); or

(2) the first day of the first calendar month that begins at least 30 days after the date written notice or a written request is received by the plan issuer under Section 1207.002(a) or (b), as applicable.

(b) Notwithstanding Subsection (a), the individual must comply with a waiting period required under the state child health plan under Chapter 62, Health and Safety Code, or under the health insurance premium assistance program under Section 62.059, Health and Safety Code, as applicable.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.026(a), eff. September 1, 2005.

Acts 2007, 80th Leg., R.S., Ch. 268 (S.B. 10), Sec. 24(b), eff. September 1, 2007.

Sec. 1207.004. TERMINATION OF ENROLLMENT. (a) Notwithstanding any other requirement of a group health benefit plan, the plan issuer shall permit an individual who is enrolled in the plan under Section 1207.002(a)(1), and any family member of the individual enrolled under Section 1207.002(c), to terminate enrollment in the plan not later than the 60th day after the date on which the individual provides satisfactory proof to the issuer that the individual is no longer:

(1) a recipient of medical assistance under the state Medicaid program; or

(2) a participant in the health insurance premium payment reimbursement program under Section 32.0422, Human Resources Code.

(b) Notwithstanding any other requirement of a group health benefit plan, the plan issuer shall permit an individual who is enrolled in the plan under Section 1207.002(a)(2), and any family member of the individual enrolled under Section 1207.002(c), to terminate enrollment in the plan not later than the 60th day after the date on which the individual provides a written request to disenroll from the plan because the individual no longer wishes to participate in the health insurance premium assistance program under Section 62.059, Health and Safety Code.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.026(a), eff. September 1, 2005.

Acts 2007, 80th Leg., R.S., Ch. 268 (S.B. 10), Sec. 24(c), eff. September 1, 2007.

CHAPTER 1208. IDENTITY OF AVAILABLE EMPLOYEE OF HEALTH BENEFIT PLAN ISSUER

Sec. 1208.001. APPLICABILITY OF CHAPTER. This chapter applies only to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is offered by:

(1) an insurance company;

- (2) a group hospital service corporation operating under Chapter 842;
- (3) a fraternal benefit society operating under Chapter 885;
- (4) a stipulated premium company operating under Chapter 884;
- (5) a reciprocal exchange operating under Chapter 942;
- (6) a health maintenance organization operating under Chapter 843;
- (7) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; or
- (8) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1208.002. DISCLOSURE REQUIRED. After an oral or written request by an insured or enrollee of a health benefit plan, the plan issuer shall provide to the insured or enrollee the name or employee identifier of the issuer's employee who is available to respond to questions or other communication from the insured or enrollee relating to coverage and benefits provided under the plan to the insured or enrollee. The issuer shall also provide:

- (1) the employee's mailing address;
- (2) the municipality and state of the employee's business location; and
- (3) the employee's job title.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

CHAPTER 1210. NOTICE OF CERTAIN POLICY PROVISIONS

Sec. 1210.001. NOTICE REQUIRED. A policy, contract, or certificate of insurance that insures against loss resulting from sickness or accidental bodily injury and that is subject to an increase in the premium at time of renewal or to nonrenewal on the insured attaining a certain age may not be delivered, issued, or used in this state unless the document contains on the first page above the policy provisions a printed notice in 10-point type that states that the policy, contract, or certificate is subject to either or

both conditions.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

CHAPTER 1211. WAIVERS REGARDING CERTAIN FEDERAL HEALTH PLANS

Sec. 1211.001. WAIVER OF CERTAIN PROVISIONS FOR CERTAIN FEDERAL PLANS. If the commissioner of insurance, in consultation with the commissioner of health and human services, determines that a provision of Section 843.209 or 843.321, Subchapter J, Chapter 843, Chapter 1213, Subchapter C or C-1, Chapter 1301, or Section 1301.008, 1301.069, or 1301.162 will cause a negative fiscal impact on the state with respect to providing benefits or services under Subchapter XIX, Social Security Act (42 U.S.C. Section 1396 et seq.), as amended, or Subchapter XXI, Social Security Act (42 U.S.C. Section 1397aa et seq.), as amended, the commissioner of insurance by rule shall waive the application of that provision to the providing of those benefits or services.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.027(a), eff. September 1, 2005.

CHAPTER 1213. ELECTRONIC HEALTH CARE TRANSACTIONS

Sec. 1213.001. DEFINITION OF HEALTH BENEFIT PLAN. (a) In this chapter, "health benefit plan" means a plan that provides benefits for medical, surgical, or other treatment expenses incurred as a result of a health condition, a mental health condition, an accident, sickness, or substance abuse, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is offered by:

- (1) an insurance company;
- (2) a group hospital service corporation operating under Chapter 842;
- (3) a fraternal benefit society operating under Chapter 885;
- (4) a stipulated premium insurance company operating under Chapter 884;
- (5) a Lloyd's plan operating under Chapter 941;
- (6) an exchange operating under Chapter 942;

(7) a health maintenance organization operating under Chapter 843;

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

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

(b) The term includes:

(1) a small employer health benefit plan written under Chapter 1501; and

(2) a health benefit plan offered under Chapter 1551, 1575, 1579, or 1601.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.029(a), eff. September 1, 2005.

Sec. 1213.002. ELECTRONIC SUBMISSION OF CLAIMS. (a) The issuer of a health benefit plan by contract may require that a health care professional licensed or registered under the Occupations Code or a health care facility licensed under the Health and Safety Code electronically submit a health care claim or equivalent encounter information, a referral certification, or an authorization or eligibility transaction. The health benefit plan issuer shall comply with the standards for electronic transactions required by this section and established by the commissioner by rule.

(b) The issuer of a health benefit plan by contract shall establish a default method to submit claims in a nonelectronic format if there is a system failure or failures or a catastrophic event substantially interferes with the normal business operations of the physician, provider, or health benefit plan or its agents. The health benefit plan issuer shall comply with the standards for nonelectronic transactions established by the commissioner by rule.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.029(a), eff. September 1, 2005.

Sec. 1213.003. ELECTRONIC SUBMISSION OF CLAIMS: WAIVER. (a) A contract between the issuer of a health benefit plan and a health care professional or health care facility must provide for a waiver of any requirement for electronic submission established under this

chapter.

(b) The commissioner shall establish circumstances under which a waiver is required, including:

(1) circumstances in which no method is available for the submission of claims in electronic form;

(2) the operation of small physician practices;

(3) the operation of other small health care provider practices;

(4) undue hardship, including fiscal or operational hardship; or

(5) any other special circumstance that would justify a waiver.

(c) Any health care professional or health care facility that is denied a waiver by the issuer of a health benefit plan may appeal the denial to the commissioner. The commissioner shall determine whether a waiver must be granted.

(d) The issuer of a health benefit plan may not refuse to contract or renew a contract with a health care professional or health care facility based in whole or in part on the professional or facility requesting or receiving a waiver or appealing a waiver determination.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.029(a), eff. September 1, 2005.

Sec. 1213.004. MODE OF TRANSMISSION. The issuer of a health benefit plan may not by contract limit the mode of electronic transmission that a health care professional or health care facility may use to submit information under this chapter.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.029(a), eff. September 1, 2005.

Sec. 1213.005. CERTAIN CHARGES PROHIBITED. A health benefit plan may not directly or indirectly charge or hold a health care professional, health care facility, or person enrolled in a health benefit plan responsible for a fee for the adjudication of a claim.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.029(a),

eff. September 1, 2005.

Sec. 1213.006. RULES. The commissioner may adopt rules as necessary to implement this chapter. The commissioner may not require any data element for electronically filed claims that is not required to comply with federal law.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.029(a), eff. September 1, 2005.

CHAPTER 1214. ADVERTISING FOR CERTAIN HEALTH BENEFITS

Sec. 1214.001. APPLICABILITY OF CHAPTER. This chapter applies only to a health benefit plan 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 agreement, a group hospital service contract, or an individual or group evidence of coverage issued by:

- (1) an insurance company;
- (2) a group hospital service corporation operating under Chapter 842;
- (3) a health maintenance organization operating under Section 1367.053, Subchapter A, Chapter 1452, Subchapter B, Chapter 1507, Chapter 222, 251, or 258, as applicable to a health maintenance organization, Chapter 843, Chapter 1271, and Chapter 1272; or
- (4) an approved nonprofit health corporation holding a certificate of authority under Chapter 844.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1G.001, eff. April 1, 2009.

Sec. 1214.002. EXCEPTION. This chapter does not apply to:

- (1) a health benefit plan that provides coverage:
 - (A) only for a specified disease;
 - (B) only for accidental death or dismemberment; or
 - (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; or
- (2) a long-term care insurance policy, including a nursing

home fixed indemnity policy, unless the commissioner determines that the policy provides benefits so comprehensive that the policy is a health benefit plan as described by Section 1214.001.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1G.001, eff. April 1, 2009.

Sec. 1214.003. RATE INFORMATION DISCLAIMERS. (a) Subject to Chapter 541 and Section 543.001, an advertisement for a health benefit plan may include rate information without including information about each benefit exclusion or limitation if the advertisement includes prominent disclaimers clearly indicating that:

- (1) the rates are illustrative;
- (2) a person should not send money to the health benefit plan issuer in response to the advertisement;
- (3) a person cannot obtain coverage under the plan until the person completes an application for coverage; and
- (4) benefit exclusions or limitations may apply to the plan.

(b) An advertisement that states a rate must also indicate the age, gender, and geographic location on which the rate is based.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1G.001, eff. April 1, 2009.

CHAPTER 1215. REPORTING OF CLAIMS INFORMATION

Sec. 1215.001. DEFINITIONS. (a) Except as provided by Subsection (b), in this chapter:

- (1) "Employer" has the meaning assigned by 29 U.S.C. Section 1002(5).
- (2) "Governmental entity" means a state agency or political subdivision of this state.
- (3) "Group health plan" has the meaning assigned by 45 C.F.R. Section 160.103, except that the term does not include disability income or long-term care insurance.
- (4) "Health insurance issuer" has the meaning assigned by 45 C.F.R. Section 160.103.
- (5) "Plan" means an employee welfare benefit plan as defined by 29 U.S.C. Section 1002(1).

(6) "Plan administrator" means an administrator as defined by 29 U.S.C. Section 1002(16)(A).

(7) "Plan sponsor" has the meaning assigned by 29 U.S.C. Section 1002(16)(B).

(8) "Political subdivision" means a county, municipality, school district, special-purpose district, or other subdivision of state government that has jurisdiction limited to a geographic portion of the state.

(9) "Protected health information" has the meaning assigned by 45 C.F.R. Section 160.103.

(b) A reference to a federal statute or regulation under Subsection (a) means that statute or regulation as it existed on September 1, 2007, except that the commissioner, by rule, may adopt a definition based on a later amended, enacted, or adopted federal statute or regulation if the commissioner determines that use of the later amended, enacted, or adopted statute or regulation is consistent with the purposes of this chapter and promotes regulatory consistency.

Added by Acts 2007, 80th Leg., R.S., Ch. 700 (H.B. 2015), Sec. 1, eff. September 1, 2007.

Sec. 1215.002. APPLICABILITY OF CHAPTER TO GOVERNMENTAL ENTITY; APPLICABILITY OF OTHER LAW WITH REFERENCE TO GOVERNMENTAL ENTITY.

(a) This chapter applies to a governmental entity that enters into a contract with a health insurance issuer that results in the health insurance issuer delivering, issuing for delivery, or renewing a group health plan.

(b) For purposes of this chapter, a health insurance issuer shall treat a governmental entity described by Subsection (a) as a plan sponsor or plan administrator.

(c) A report of claim information provided under this section to a governmental entity is confidential and exempt from public disclosure under Chapter 552, Government Code.

Added by Acts 2007, 80th Leg., R.S., Ch. 700 (H.B. 2015), Sec. 1, eff. September 1, 2007.

Sec. 1215.003. RECEIPT OF AND RESPONSE TO REQUEST FOR CLAIM

INFORMATION. (a) Not later than the 30th day after the date a health insurance issuer receives a written request for a written report of claim information from a plan, plan sponsor, or plan administrator, the health insurance issuer shall provide the requesting party the report, subject to Subsections (d), (e), and (f). The health insurance issuer is not obligated to provide a report under this subsection regarding a particular employer or group health plan more than twice in any 12-month period.

(b) A health insurance issuer shall provide the report of claim information under Subsection (a):

- (1) in a written report;
- (2) through an electronic file transmitted by secure electronic mail or a file transfer protocol site; or
- (3) by making the required information available through a secure website or web portal accessible by the requesting plan, plan sponsor, or plan administrator.

(c) A report of claim information provided under Subsection (a) must contain all information available to the health insurance issuer that is responsive to the request made under Subsection (a), including, subject to Subsections (d), (e), and (f), protected health information, for the 36-month period preceding the date of the report or the period specified by Subdivisions (4), (5), and (6), if applicable, or for the entire period of coverage, whichever period is shorter. Subject to Subsections (d), (e), and (f), a report provided under Subsection (a) must include:

- (1) aggregate paid claims experience by month, including claims experience for medical, dental, and pharmacy benefits, as applicable;
- (2) total premium paid by month;
- (3) total number of covered employees on a monthly basis by coverage tier, including whether coverage was for:
 - (A) an employee only;
 - (B) an employee with dependents only;
 - (C) an employee with a spouse only; or
 - (D) an employee with a spouse and dependents;
- (4) the total dollar amount of claims pending as of the date of the report;
- (5) a separate description and individual claims report for any individual whose total paid claims exceed \$15,000 during the 12-month period preceding the date of the report, including the

following information related to the claims for that individual:

- (A) a unique identifying number, characteristic, or code for the individual;
 - (B) the amounts paid;
 - (C) dates of service; and
 - (D) applicable procedure codes and diagnosis codes; and
- (6) for claims that are not part of the report described by Subdivisions (1)-(5), a statement describing precertification requests for hospital stays of five days or longer that were made during the 30-day period preceding the date of the report.

(d) A health insurance issuer may not disclose protected health information in a report of claim information provided under this section if the health insurance issuer is prohibited from disclosing that information under another state or federal law that imposes more stringent privacy restrictions than those imposed under federal law under the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191). To withhold information in accordance with this subsection, the health insurance issuer must:

- (1) notify the plan, plan sponsor, or plan administrator requesting the report that information is being withheld; and
- (2) provide to the plan, plan sponsor, or plan administrator a list of categories of claim information that the health insurance issuer has determined are subject to the more stringent privacy restrictions under another state or federal law.

(e) A plan sponsor is entitled to receive protected health information under Subsections (c)(5) and (6) and Section 1215.004 only after an appropriately authorized representative of the plan sponsor makes to the health insurance issuer a certification substantially similar to the following certification:

"I hereby certify that the plan documents comply with the requirements of 45 C.F.R. Section 164.504(f)(2) and that the plan sponsor will safeguard and limit the use and disclosure of protected health information that the plan sponsor may receive from the group health plan to perform the plan administration functions."

(f) A plan sponsor that does not provide the certification required by Subsection (e) is not entitled to receive the protected health information described by Subsections (c)(5) and (6) and Section 1215.004, but is entitled to receive a report of claim information that includes the information described by Subsections (c)(1)-(4).

(g) In the case of a request made under Subsection (a) after the date of termination of coverage, the report must contain all information available to the health insurance issuer as of the date of the report that is responsive to the request, including protected health information, and including the information described by Subsections (c)(1)-(6), for the period described by Subsection (c) preceding the date of termination of coverage or for the entire policy period, whichever period is shorter. Notwithstanding this subsection, the report may not include the protected health information described by Subsections (c)(5) and (6) unless a certification has been provided in accordance with Subsection (e).

(h) A plan, plan sponsor, or plan administrator must request a report under Subsection (a) before or on the second anniversary of the date of termination of coverage under a group health plan issued by the health benefit plan issuer.

Added by Acts 2007, 80th Leg., R.S., Ch. 700 (H.B. 2015), Sec. 1, eff. September 1, 2007.

Sec. 1215.004. REQUEST FOR ADDITIONAL INFORMATION. (a) On receipt of the report required by Section 1215.003(a), the plan, plan sponsor, or plan administrator may review the report and, not later than the 10th day after the date the report is received, may make a written request to the health insurance issuer for additional information in accordance with this section for specified individuals.

(b) With respect to a request for additional information concerning specified individuals for whom claims information has been provided under Section 1215.003(c)(5), the health insurance issuer shall provide additional information on the prognosis or recovery if available and, for individuals in active case management, the most recent case management information, including any future expected costs and treatment plan, that relate to the claims for that individual.

(c) The health insurance issuer must respond to the request for additional information under this section not later than the 15th day after the date of the request under this section unless the requesting plan, plan sponsor, or plan administrator agrees to a request for additional time.

(d) The health insurance issuer is not required to produce the report described by this section unless a certification has been provided in accordance with Section 1215.003(e).

Added by Acts 2007, 80th Leg., R.S., Ch. 700 (H.B. 2015), Sec. 1, eff. September 1, 2007.

Sec. 1215.005. COMPLIANCE WITH CHAPTER DOES NOT CREATE LIABILITY. A health insurance issuer that releases information, including protected health information, in accordance with this chapter has not violated a standard of care and is not liable for civil damages resulting from, and is not subject to criminal prosecution for, releasing that information.

Added by Acts 2007, 80th Leg., R.S., Ch. 700 (H.B. 2015), Sec. 1, eff. September 1, 2007.

Sec. 1215.006. ADMINISTRATIVE PENALTIES. A health insurance issuer that does not comply with this chapter is subject to administrative penalties under Chapter 84.

Added by Acts 2007, 80th Leg., R.S., Ch. 700 (H.B. 2015), Sec. 1, eff. September 1, 2007.

CHAPTER 1216. OUT-OF-COUNTRY COVERAGE PROHIBITED

Sec. 1216.001. DEFINITIONS. In this chapter:

- (1) "Enrollee" means an individual entitled to coverage under a health benefit plan.
- (2) "Foreign country" means a governmental unit other than:
 - (A) the United States;
 - (B) a state, district, commonwealth, territory, or insular possession of the United States;
 - (C) the Panama Canal Zone; or
 - (D) the Trust Territory of the Pacific Islands.
- (3) "Health care service" means a service to diagnose, prevent, alleviate, cure, or heal a health condition, sickness, or injury that is provided to an enrollee by a physician or other health care provider.

Added by Acts 2007, 80th Leg., R.S., Ch. 1322 (S.B. 1391), Sec. 1, eff. September 1, 2007.

Renumbered from Insurance Code, Section 1215.001 by Acts 2009, 81st Leg., R.S., Ch. 87 (S.B. 1969), Sec. 27.001(62), eff. September 1, 2009.

Sec. 1216.002. APPLICABILITY OF CHAPTER. (a) This chapter applies only to a health benefit plan that provides benefits for health care services, including medical or surgical expenses, incurred as a result of a health condition, accident, or sickness, including:

- (1) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:
 - (A) an insurance company;
 - (B) a group hospital service corporation operating under Chapter 842;
 - (C) a fraternal benefit society operating under Chapter 885;
 - (D) a stipulated premium company operating under Chapter 884; or
 - (E) a health maintenance organization operating under Chapter 843; and
- (2) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:
 - (A) a multiple employer welfare arrangement as defined by Section 3 of that Act; or
 - (B) another analogous benefit arrangement.

(b) For purposes of Subsection (a), a health benefit plan includes a consumer choice of benefits plan issued under Chapter 1507.

Added by Acts 2007, 80th Leg., R.S., Ch. 1322 (S.B. 1391), Sec. 1, eff. September 1, 2007.

Renumbered from Insurance Code, Section 1215.002 by Acts 2009, 81st Leg., R.S., Ch. 87 (S.B. 1969), Sec. 27.001(62), eff. September 1, 2009.

Sec. 1216.003. EXCEPTION. This chapter does not apply to:

- (1) a plan that provides coverage:
 - (A) only for a specified disease;
 - (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) only for dental or vision care;
 - (F) only for indemnity for hospital confinement; or
 - (G) only for health care services provided to an enrollee while the enrollee is traveling to, visiting, or residing in a foreign country;
- (2) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);
- (3) a workers' compensation insurance policy;
- (4) medical payment insurance coverage provided under a motor vehicle insurance policy; or
- (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 as described by Section 1216.002.

Added by Acts 2007, 80th Leg., R.S., Ch. 1322 (S.B. 1391), Sec. 1, eff. September 1, 2007.

Renumbered from Insurance Code, Section 1215.003 by Acts 2009, 81st Leg., R.S., Ch. 87 (S.B. 1969), Sec. 27.001(62), eff. September 1, 2009.

Renumbered from Insurance Code, Section 1215.003 and amended by Acts 2009, 81st Leg., R.S., Ch. 87 (S.B. 1969), Sec. 27.002(12), eff. September 1, 2009.

Sec. 1216.004. OUT-OF-COUNTRY CARE PROHIBITED. A health benefit plan issuer may not issue or offer for sale in this state a health benefit plan that requires an enrollee to travel to a foreign country to receive a particular health care service under the health benefit plan.

Added by Acts 2007, 80th Leg., R.S., Ch. 1322 (S.B. 1391), Sec. 1, eff. September 1, 2007.

Renumbered from Insurance Code, Section 1215.004 by Acts 2009, 81st Leg., R.S., Ch. 87 (S.B. 1969), Sec. 27.001(62), eff. September 1, 2009.

CHAPTER 1217. STANDARD REQUEST FORM FOR PRIOR AUTHORIZATION OF HEALTH CARE SERVICES

Sec. 1217.001. DEFINITIONS. In this chapter:

(1) "Health benefit plan issuer" means an entity authorized under this code or another insurance law of this state that delivers or issues for delivery a health benefit plan or other coverage that is covered under this chapter as described by Section 1217.002. The term includes:

- (A) an insurance company;
- (B) a group hospital service corporation operating under Chapter 842;
- (C) a fraternal benefit society operating under Chapter 885;
- (D) a stipulated premium company operating under Chapter 884;
- (E) a reciprocal exchange operating under Chapter 942;
- (F) a health maintenance organization operating under Chapter 843;
- (G) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; or
- (H) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844.

(2) "Health care services" includes medical or health care treatments, consultations, procedures, drugs, supplies, imaging and diagnostic services, inpatient and outpatient care, medical devices, and durable medical equipment. The term does not include prescription drugs as defined by Section 551.003, Occupations Code.

Added by Acts 2013, 83rd Leg., R.S., Ch. 1198 (S.B. 1216), Sec. 1, eff. September 1, 2013.

Sec. 1217.002. APPLICABILITY OF CHAPTER. (a) This chapter applies only to a health benefit plan 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 a small or large employer group contract or similar coverage document that is offered by:

- (1) an insurance company;
- (2) a group hospital service corporation operating under Chapter 842;
- (3) a fraternal benefit society operating under Chapter 885;
- (4) a stipulated premium company operating under Chapter 884;
- (5) a reciprocal exchange operating under Chapter 942;
- (6) a health maintenance organization operating under Chapter 843;
- (7) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; or
- (8) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844.

(b) This chapter applies to group health coverage made available by a school district in accordance with Section 22.004, Education Code.

(c) Notwithstanding any provision in Chapter 1551, 1575, 1579, or 1601 or any other law, this chapter applies to:

- (1) a basic coverage plan under Chapter 1551;
- (2) a basic plan under Chapter 1575;
- (3) a primary care coverage plan under Chapter 1579; and
- (4) basic coverage under Chapter 1601.

Text of subsection effective until April 1, 2025

(d) Notwithstanding any other law, this chapter applies to coverage under:

- (1) the child health plan program under Chapter 62, Health and Safety Code, or the health benefits plan for children under Chapter 63, Health and Safety Code; and
- (2) a Medicaid managed care program operated under Chapter 533, Government Code, or a Medicaid program operated under Chapter 32, Human Resources Code.

Text of subsection effective on April 1, 2025

(d) Notwithstanding any other law, this chapter applies to coverage under:

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

(2) a Medicaid managed care program operated under Chapter 540 or 540A, Government Code, as applicable, or a Medicaid program operated under Chapter 32, Human Resources Code.

Added by Acts 2013, 83rd Leg., R.S., Ch. 1198 (S.B. [1216](#)), Sec. 1, eff. September 1, 2013.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. [4611](#)), Sec. 2.120, eff. April 1, 2025.

Sec. 1217.003. EXCEPTION. This chapter does not apply to:

(1) a health benefit plan that provides coverage:

(A) only for a specified disease or for another single benefit;

(B) only for accidental death or dismemberment;

(C) only 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, Social Security Act (42 U.S.C. Section 1395ss);

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

(4) 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 as described by Section 1217.002; or

(5) a workers' compensation insurance policy.

Added by Acts 2013, 83rd Leg., R.S., Ch. 1198 (S.B. [1216](#)), Sec. 1, eff. September 1, 2013.

Sec. 1217.004. STANDARD FORM. (a) The commissioner by rule shall:

(1) prescribe a single, standard form for requesting prior authorization of health care services;

(2) require a health benefit plan issuer or the agent of the health benefit plan issuer that manages or administers health care services benefits to use the form for any prior authorization required by the plan of health care services; and

(3) require that the department and a health benefit plan issuer or the agent of the health benefit plan issuer that manages or administers health care services benefits make the form available in paper form and electronically on the website of:

(A) the department;

(B) the health benefit plan issuer; and

(C) the agent of the health benefit plan issuer.

(b) Not later than the second anniversary of the date national standards for electronic prior authorization of benefits are adopted, a health benefit plan issuer or the agent of the health benefit plan issuer that manages or administers health care services benefits shall exchange prior authorization requests electronically with a physician or health care provider who has electronic capability and who initiates a request electronically. For requests initiated on paper, a health benefit plan issuer or the agent of the health benefit plan issuer that manages or administers health care services benefits shall accept prior authorization requests using the standard paper form developed pursuant to this chapter.

(c) In prescribing a form under this section, the commissioner shall:

(1) develop the form with input from the advisory committee on uniform prior authorization forms for health care services benefits established under Section 1217.005; and

(2) take into consideration:

(A) any form for requesting prior authorization of health care services benefits that is widely used in this state or any form currently used by the department;

(B) request forms for prior authorization of health care services benefits established by the federal Centers for Medicare and Medicaid Services; and

(C) national standards, or draft standards, pertaining to electronic prior authorization of benefits.

Added by Acts 2013, 83rd Leg., R.S., Ch. 1198 (S.B. 1216), Sec. 1, eff. September 1, 2013.

Sec. 1217.005. ADVISORY COMMITTEE ON UNIFORM PRIOR AUTHORIZATION FORMS. (a) The commissioner shall appoint a committee to advise the commissioner on the technical, operational, and practical aspects of developing the single, standard prior authorization form required under Section 1217.004 for requesting prior authorization of health care services, including:

(1) requirements for the health benefit plan issuer or agent of the health benefit plan issuer to acknowledge receipt of the standard form;

(2) timelines under which the health benefit plan issuer or agent of the health benefit plan issuer must acknowledge receipt of the standard form; and

(3) implications, including administrative penalties, for the failure of a health benefit plan issuer or agent of a health benefit plan issuer to:

- (A) timely acknowledge receipt of the standard form; or
- (B) use or accept the form.

(b) The commissioner shall consult the advisory committee with respect to any rule relating to a subject described by Section 1217.004 before adopting the rule and may consult the committee as needed with respect to a subsequent amendment of an adopted rule.

(c) The advisory committee shall be composed of an equal number of members from each of the following groups of stakeholders:

- (1) physicians;
- (2) health care providers other than physicians;
- (3) hospitals;
- (4) representatives of health benefit plans; and
- (5) Health and Human Services Commission representatives.

(d) A physician may not serve on the advisory committee as a physician member under Subsection (c)(1) if the physician is or has been employed by or consults or has consulted for an insurance company.

(e) A member of the advisory committee serves without compensation.

(f) Section 39.003(a) of this code and Chapter 2110, Government Code, do not apply to the advisory committee.

Added by Acts 2013, 83rd Leg., R.S., Ch. 1198 (S.B. 1216), Sec. 1, eff. September 1, 2013.

Sec. 1217.006. FAILURE TO PRESCRIBE STANDARD FORM. Nothing in this chapter may be construed as authorizing the commissioner to decline to prescribe the form required by Section 1217.004.

Added by Acts 2013, 83rd Leg., R.S., Ch. 1198 (S.B. 1216), Sec. 1, eff. September 1, 2013.

Sec. 1217.007. CONSTRUCTION WITH OTHER LAW. Nothing in this chapter may be construed as permitting a health benefit plan issuer or an agent of a health benefit plan issuer to require prior authorization of health care services benefits when otherwise prohibited by law.

Added by Acts 2013, 83rd Leg., R.S., Ch. 1198 (S.B. 1216), Sec. 1, eff. September 1, 2013.

CHAPTER 1218. COVERAGE FOR ELECTIVE ABORTION; PROHIBITIONS AND REQUIREMENTS

Sec. 1218.001. DEFINITION. In this chapter, "elective abortion" means an abortion, as defined by Section 245.002, Health and Safety Code, other than an abortion performed due to a medical emergency as defined by Section 171.002, Health and Safety Code.

Added by Acts 2017, 85th Leg., 1st C.S., Ch. 5 (H.B. 214), Sec. 2, eff. December 1, 2017.

Sec. 1218.002. APPLICABILITY OF CHAPTER. (a) This chapter applies only to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is offered by:

- (1) an insurance company;

- (2) a group hospital service corporation operating under Chapter 842;
- (3) a fraternal benefit society operating under Chapter 885;
- (4) a stipulated premium company operating under Chapter 884;
- (5) an exchange operating under Chapter 942;
- (6) a health maintenance organization operating under Chapter 843;
- (7) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; or
- (8) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844.

(b) This chapter applies to group health coverage made available by a school district in accordance with Section 22.004, Education Code.

(c) Notwithstanding any provision in Chapter 1551, 1575, 1579, or 1601 or any other law, this chapter applies to:

- (1) a basic coverage plan under Chapter 1551;
- (2) a basic plan under Chapter 1575;
- (3) a primary care coverage plan under Chapter 1579; and
- (4) basic coverage under Chapter 1601.

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

(e) Notwithstanding Section 1507.003 or 1507.053 or any other law, this chapter applies to a standard health benefit plan provided under Chapter 1507.

Added by Acts 2017, 85th Leg., 1st C.S., Ch. 5 (H.B. [214](#)), Sec. 2, eff. December 1, 2017.

Sec. 1218.003. CERTAIN COVERAGE NOT AFFECTED. This chapter does not apply to health benefit plan coverage provided to an enrollee for any abortion other than an elective abortion as defined by Section 1218.001.

Added by Acts 2017, 85th Leg., 1st C.S., Ch. 5 (H.B. [214](#)), Sec. 2, eff. December 1, 2017.

Sec. 1218.004. COVERAGE BY HEALTH BENEFIT PLAN. A health benefit plan may provide coverage for elective abortion only if:

(1) the coverage is provided to an enrollee separately from other health benefit plan coverage offered by the health benefit plan issuer;

(2) the enrollee pays the premium for coverage for elective abortion separately from, and in addition to, the premium for other health benefit plan coverage, if any; and

(3) the enrollee provides a signature for coverage for elective abortion, separately and distinct from the signature required for other health benefit plan coverage, if any, provided to the enrollee by the health benefit plan issuer.

Added by Acts 2017, 85th Leg., 1st C.S., Ch. 5 (H.B. 214), Sec. 2, eff. December 1, 2017.

Sec. 1218.005. CALCULATION OF PREMIUM. (a) A health benefit plan issuer that provides coverage for elective abortion shall calculate the premium for the coverage so that the premium fully covers the estimated cost of elective abortion per enrollee, determined on an actuarial basis.

(b) In calculating a premium under Subsection (a), the health benefit plan issuer may not take into account any cost savings in other health benefit plan coverage offered by the health benefit plan issuer that is estimated to result from coverage for elective abortion.

(c) A health benefit plan issuer may not provide a premium discount to or reduce the premium for an enrollee for other health benefit plan coverage on the basis that the enrollee has coverage for elective abortion.

Added by Acts 2017, 85th Leg., 1st C.S., Ch. 5 (H.B. 214), Sec. 2, eff. December 1, 2017.

Sec. 1218.006. NOTICE BY ISSUER. A health benefit plan issuer that provides coverage for elective abortion shall at the time of enrollment in other health benefit plan coverage provide each enrollee with a notice that:

(1) coverage for elective abortion is optional and separate

from other health benefit plan coverage offered by the health benefit plan issuer;

(2) the premium cost for coverage for elective abortion is a premium paid separately from, and in addition to, the premium for other health benefit plan coverage offered by the health benefit plan issuer; and

(3) the enrollee may enroll in a health benefit plan without obtaining coverage for elective abortion.

Added by Acts 2017, 85th Leg., 1st C.S., Ch. 5 (H.B. 214), Sec. 2, eff. December 1, 2017.

CHAPTER 1221. EMPLOYER CONTRIBUTIONS TO INDIVIDUAL HEALTH INSURANCE POLICIES

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

Added by Acts 2011, 82nd Leg., R.S., Ch. 1067 (S.B. 859), Sec. 7, eff. June 17, 2011.

CHAPTER 1222. PREAUTHORIZATION FOR MEDICAL OR HEALTH CARE SERVICE

Sec. 1222.0001. DEFINITIONS. In this chapter:

(1) "Health benefit plan" means a plan to which this chapter applies under Section 1222.0002.

(2) "Health benefit plan issuer" means an entity authorized under this code or another insurance law of this state that provides health insurance or health benefits in this state.

(3) "Preauthorization" has the meaning assigned by Section 1301.001.

Added by Acts 2019, 86th Leg., R.S., Ch. 488 (H.B. 3041), Sec. 1, eff. September 1, 2019.

Sec. 1222.0002. APPLICABILITY OF CHAPTER. (a) This chapter applies only to a health benefit plan 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 issued by:

- (1) an insurance company;
- (2) a group hospital service corporation operating under Chapter 842;
- (3) a health maintenance organization operating under Chapter 843;
- (4) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844;
- (5) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846;
- (6) a stipulated premium company operating under Chapter 884;
- (7) a fraternal benefit society operating under Chapter 885;
- (8) a Lloyd's plan operating under Chapter 941; or
- (9) an exchange operating under Chapter 942.

Text of subsection effective until April 1, 2025

- (b) Notwithstanding any other law, this chapter applies to:
- (1) a small employer health benefit plan subject to Chapter 1501, including coverage provided through a health group cooperative under Subchapter B of that chapter;
 - (2) a standard health benefit plan issued under Chapter 1507;
 - (3) a basic coverage plan under Chapter 1551;
 - (4) a basic plan under Chapter 1575;
 - (5) a primary care coverage plan under Chapter 1579;
 - (6) a plan providing basic coverage under Chapter 1601;
 - (7) health benefits provided by or through a church benefits board under Subchapter I, Chapter 22, Business Organizations Code;
 - (8) group health coverage made available by a school district in accordance with Section 22.004, Education Code;
 - (9) the state Medicaid program, including the Medicaid managed care program operated under Chapter 533, Government Code;

(10) the child health plan program under Chapter 62, Health and Safety Code;

(11) a regional or local health care program operated under Section 75.104, Health and Safety Code; and

(12) a self-funded health benefit plan sponsored by a professional employer organization under Chapter 91, Labor Code.

Text of subsection effective on April 1, 2025

(b) Notwithstanding any other law, this chapter applies to:

(1) a small employer health benefit plan subject to Chapter 1501, including coverage provided through a health group cooperative under Subchapter B of that chapter;

(2) a standard health benefit plan issued under Chapter 1507;

(3) a basic coverage plan under Chapter 1551;

(4) a basic plan under Chapter 1575;

(5) a primary care coverage plan under Chapter 1579;

(6) a plan providing basic coverage under Chapter 1601;

(7) health benefits provided by or through a church benefits board under Subchapter I, Chapter 22, Business Organizations Code;

(8) group health coverage made available by a school district in accordance with Section 22.004, Education Code;

(9) the state Medicaid program, including the Medicaid managed care program operated under Chapters 540 and 540A, Government Code;

(10) the child health plan program under Chapter 62, Health and Safety Code;

(11) a regional or local health care program operated under Section 75.104, Health and Safety Code; and

(12) a self-funded health benefit plan sponsored by a professional employer organization under Chapter 91, Labor Code.

Added by Acts 2019, 86th Leg., R.S., Ch. 488 (H.B. [3041](#)), Sec. 1, eff. September 1, 2019.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. [4611](#)), Sec. 2.121, eff. April 1, 2025.

Sec. 1222.0003. PREAUTHORIZATION RENEWAL REQUEST. A health

benefit plan issuer that requires preauthorization as a condition of payment for a medical or health care service shall provide a preauthorization renewal process that allows a renewal of an existing preauthorization to be requested by a physician or health care provider at least 60 days before the date the preauthorization expires.

Added by Acts 2019, 86th Leg., R.S., Ch. 488 (H.B. 3041), Sec. 1, eff. September 1, 2019.

Sec. 1222.0004. DETERMINATION REQUIRED. If a health benefit plan issuer receives a preauthorization renewal request before the existing preauthorization expires, the health benefit plan issuer shall, if practicable, review the request and issue a determination indicating whether the medical or health care service is preauthorized before the existing preauthorization expires.

Added by Acts 2019, 86th Leg., R.S., Ch. 488 (H.B. 3041), Sec. 1, eff. September 1, 2019.

CHAPTER 1223. VERIFICATION OF HEALTH BENEFITS

Sec. 1223.001. APPLICABILITY OF CHAPTER. (a) This chapter applies only to a health benefit plan 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 issued by:

- (1) an insurance company;
- (2) a group hospital service corporation operating under Chapter 842;
- (3) a health maintenance organization operating under Chapter 843;
- (4) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844;
- (5) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846;
- (6) a stipulated premium company operating under Chapter 884;

- (7) a Lloyd's plan operating under Chapter 941; or
- (8) an exchange operating under Chapter 942.

(b) Notwithstanding any other law, this chapter applies to:

- (1) a small employer health benefit plan subject to Chapter 1501, including coverage provided through a health group cooperative under Subchapter B of that chapter;
- (2) a standard health benefit plan issued under Chapter 1507;
- (3) a basic coverage plan under Chapter 1551;
- (4) a basic plan under Chapter 1575;
- (5) a primary care coverage plan under Chapter 1579;
- (6) a plan providing basic coverage under Chapter 1601;
- (7) alternative health benefit coverage offered by a subsidiary of the Texas Mutual Insurance Company under Subchapter M, Chapter 2054;
- (8) group health coverage made available by a school district in accordance with Section 22.004, Education Code;
- (9) a regional or local health care program operated under Section 75.104, Health and Safety Code; and
- (10) a self-funded health benefit plan sponsored by a professional employer organization under Chapter 91, Labor Code.

(c) This chapter does not apply to the state Medicaid program, including the Medicaid managed care program operated under Chapter 533, Government Code, or the child health plan program operated under Chapter 62, Health and Safety Code.

Added by Acts 2023, 88th Leg., R.S., Ch. 881 (H.B. 4500), Sec. 1, eff. January 1, 2024.

Sec. 1223.002. INTERNET WEBSITE FOR VERIFICATION REQUIRED FOR EMERGENCY PHYSICIANS AND HEALTH CARE PROVIDERS. (a) A health benefit plan issuer shall maintain and make available a secure system on the issuer's Internet website that allows a physician or health care provider for a hospital or freestanding emergency medical care facility to determine at any time:

- (1) whether the physician's or provider's patient is covered by the issuer's health benefit plan; and
- (2) the deductible, copayment, or coinsurance for which the patient is responsible.

(b) A health benefit plan issuer may provide the information described by Subsection (a) through:

- (1) an existing Internet portal that is available at all times; or
- (2) an Internet portal that is:
 - (A) provided by a third party contracting with the issuer; and
 - (B) available at all times.

Added by Acts 2023, 88th Leg., R.S., Ch. 881 (H.B. 4500), Sec. 1, eff. January 1, 2024.

SUBTITLE B. GROUP HEALTH COVERAGE
CHAPTER 1251. GROUP AND BLANKET HEALTH INSURANCE
SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1251.001. DEFINITIONS. In this chapter:

- (1) "Blanket accident and health insurance" means accident, health, or accident and health insurance covering a group described by Subchapter H.
- (2) "Group accident and health insurance" means accident, health, or accident and health insurance covering a group described by Subchapter B.
- (3) "Group hospital service corporation" means a corporation operating under Chapter 842.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1251.002. CERTAIN GROUP HEALTH INSURANCE AUTHORIZED. A group policy of accident, health, or accident and health insurance, including a group contract issued by a group hospital service corporation, may be delivered or issued for delivery in this state only if the policy:

- (1) covers a group described by Subchapter B; and
- (2) meets the requirements adopted under this chapter for a group policy.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1251.003. CERTAIN BLANKET HEALTH INSURANCE AUTHORIZED. A blanket policy of accident, health, or accident and health insurance may be delivered or issued for delivery in this state only if the policy:

- (1) covers a group described by Subchapter H; and
- (2) meets the requirements adopted under this chapter for a blanket policy.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1251.004. CERTAIN PAYMENTS BY INSURERS PROHIBITED. (a) Except as reimbursement for the cost of services that otherwise would have been provided by the insurer, an insurer may not pay to any individual, firm, corporation, or group entity a fee or allowance for services related to:

- (1) a group accident and health insurance policy; or
 - (2) a blanket accident and health insurance policy.
- (b) Subsection (a) does not limit an insurer's right to:
- (1) pay dividends;
 - (2) return a premium to a group or a combination of groups;
 - (3) provide for a rate stabilization fund with combinations of groups; or
 - (4) pay compensation, including a commission, to a licensed agent.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1251.005. PAYMENT OF BENEFITS. (a) Except as otherwise provided by this section or Section 1251.113, benefits under a group accident and health insurance policy or blanket accident and health insurance policy must be paid to:

- (1) the insured;
- (2) the insured's designated beneficiary;
- (3) the insured's estate; or
- (4) if the insured is a minor or is otherwise not competent to give a valid release, the insured's parent, guardian, or other person actually supporting the insured.

(b) A group accident and health insurance policy or blanket accident and health insurance policy may provide that all or a

portion of any indemnity provided by the policy because of hospital, nursing, medical, or surgical services may, at the option of the insurer and unless the insured requests otherwise in writing not later than the time of filing a proof of the loss, be paid directly to the hospital or person providing the services. A payment made as provided by this subsection discharges the obligation of the insurer with respect to the amount paid.

(c) A group accident and health insurance policy or blanket accident and health insurance policy must provide that all or a portion of any benefits provided by the policy for dental care services may, at the option of the insured, be assigned to the dentist providing the services. In the case of an assignment under this subsection, payment must be made directly to the dentist designated. A payment made pursuant to an assignment under this subsection discharges the obligation of the insurer with respect to the amount paid.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1251.006. POLICY MAY NOT SPECIFY SERVICE PROVIDER. A group accident and health insurance policy or blanket accident and health insurance policy may not require that a covered service be provided by a particular hospital or person.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1251.007. EXCEPTIONS. This subchapter and Subchapters B-I do not apply to:

(1) a credit accident and health insurance policy subject to Chapter 1153;

(2) any group specifically provided for or authorized by law in existence and covered under a policy filed with the State Board of Insurance before April 1, 1975;

(3) accident or health coverage that is incidental to any form of a group automobile, casualty, property, workers' compensation, or employers' liability policy approved by the commissioner; or

(4) any policy or contract of insurance with a state agency, department, or board providing health services:

(A) to eligible individuals under Chapter 32, Human Resources Code; or

(B) under a state plan adopted in accordance with 42 U.S.C. Sections 1396-1396g, as amended, or 42 U.S.C. Section 1397aa et seq., as amended.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1251.008. RULES. The commissioner may adopt rules necessary to administer this chapter. A rule adopted under this section is subject to notice and hearing as provided by Section 1201.007 for a rule adopted under Chapter 1201.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

**SUBCHAPTER B. GROUP ACCIDENT AND HEALTH INSURANCE: ELIGIBLE
POLICYHOLDERS**

Sec. 1251.051. EMPLOYERS. (a) For purposes of this section, "employee" includes:

- (1) an officer, manager, or employee of the employer;
- (2) an individual proprietor or partner, if the employer is an individual proprietorship or partnership;
- (3) an officer, manager, or employee of a subsidiary or affiliated corporation; and
- (4) an individual proprietor, partner, or employee of an individual or firm, if the business of the employer and the individual or firm is under common control through stock ownership, contract, or otherwise.

(b) A policy issued to insure employees of a public body may provide that the term "employee" includes an elected or appointed officer of the body.

(c) A policy issued to the trustees of a fund established by an employer may provide that the term "employee" includes a trustee, an employee of the trustees, or both, if the person's duties are principally connected with the trusteeship.

(d) A group accident and health insurance policy may be issued to an employer or trustees of a fund established by an employer to insure the employer's active and retired employees for the benefit of persons other than the employer.

(e) The employer or the trustees of a fund established by an employer are the policyholder under a policy to which this section applies.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1251.052. ASSOCIATIONS. (a) A group accident and health insurance policy may be issued to an association, including a labor union or an organization of labor unions, a membership corporation organized or holding a certificate of authority under the Texas Non-Profit Corporation Act (Article 1396-1.01 et seq., Vernon's Texas Civil Statutes), and a cooperative or corporation subject to the supervision and control of the Farm Credit Administration, to insure the association's active and retired members, employees, or employees of members for the benefit of persons other than the association or its officers or trustees.

(b) To be eligible to obtain a group accident and health insurance policy, an association must:

- (1) have a constitution and bylaws;
- (2) have been organized and have actively existed for at least two years; and
- (3) be maintained in good faith for purposes other than that of obtaining insurance.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1251.053. FUNDS ESTABLISHED BY EMPLOYERS, LABOR UNIONS, OR ASSOCIATIONS. (a) A group accident and health insurance policy may be issued to the trustees of a fund established by two or more employers in the same or related industry, by one or more labor unions, by one or more employers and one or more labor unions, or by an association described by Section 1251.052 to insure the active and retired employees of the employers, members of the union or association, or employees of the association for the benefit of persons other than the employers, union, or association.

(b) A policy issued to the trustees of a fund established by employers or a labor union or association may provide that the term "employee" includes:

- (1) an officer or manager of the employer;

(2) an individual proprietor or partner, if the employer is an individual proprietorship or partnership; or

(3) a trustee, an employee of the trustees, or both, if the person's duties are principally connected with the trusteeship.

(c) The trustees of a fund established by employers or a labor union or association are the policyholder under a policy to which this section applies.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1251.054. ELIGIBILITY FOR GROUP LIFE INSURANCE. A group accident and health insurance policy may be issued to any individual or organization to which a policy of group life insurance may be issued or delivered in this state to insure any class or classes of individuals that could be insured under the group life policy.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1251.055. FUND FOR FORMER EMPLOYEES AND MEMBERS. (a) An insurer may issue a group accident and health insurance policy to a trustee of a fund to insure former employees, former members, and the spouses, former spouses, and dependents of former employees and members who were previously insured by the insurer under a policy issued to any entity described by this subchapter.

(b) The trustee of a fund is the policyholder under a policy to which this section applies.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1251.056. OTHER GROUPS. (a) Under the requirements prescribed by this section, a group accident and health insurance policy may be issued to cover a group other than a group described by Sections 1251.051-1251.055 if the commissioner determines that:

(1) the issuance of the policy is not contrary to the best interest of the public;

(2) the issuance of the policy would result in economies of acquisition or administration; and

(3) the benefits are reasonable in relation to the premiums

charged.

(b) Group accident and health insurance coverage may not be offered to a group in this state by an insurer under a policy issued in another state unless this state or another state having requirements substantially similar to those prescribed by Subsections (a)(1)-(3) has determined that those requirements have been met.

(c) The premium for the policy must be paid from the policyholder's funds, funds contributed by the covered persons, or both.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

SUBCHAPTER C. GROUP ACCIDENT AND HEALTH INSURANCE: REQUIRED PROVISIONS

Sec. 1251.101. REQUIRED PROVISIONS. (a) A group accident and health insurance policy, including a group contract issued by a group hospital service corporation, may not be delivered in this state unless the policy contains in substance the provisions prescribed by this subchapter or provisions in relation to provisions prescribed by this subchapter that, in the opinion of the commissioner, are:

(1) more favorable to the insureds under the policy; or

(2) at least as favorable to the insureds under the policy and more favorable to the policyholder.

(b) The standard provisions required for individual health insurance policies do not apply to group health insurance policies.

(c) If any provision of this subchapter is wholly or partly inapplicable to or inconsistent with the coverage provided by a particular form of policy, the insurer, with the approval of the commissioner, shall:

(1) omit the inapplicable provision or part from the policy; or

(2) modify the inconsistent provision in a manner that makes the provision as contained in the policy consistent with the coverage provided by the policy.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1251.102. PAYMENT OF PREMIUMS. A group accident and health insurance policy must provide that premiums due under the

policy must be remitted by the premium payor as designated in the policy:

- (1) on or before the due date; or
- (2) within any grace period specified in the policy.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1251.103. INCONTESTABILITY OF POLICY. (a) A group accident and health insurance policy must provide that:

(1) the validity of the policy may not be contested after the policy has been in force for two years after its date of issue; and

(2) in the absence of fraud, a statement made by any individual covered by the policy relating to the individual's insurability may not be used in contesting the validity of the insurance with respect to which the statement was made:

(A) after the insurance has been in force before the contest for two years during the individual's lifetime; and

(B) unless the statement is contained in a written instrument signed by the individual making the statement.

(b) Subsection (a)(1) does not apply to a contest based on nonpayment of premiums.

(c) The provisions required by this section do not preclude the assertion at any time of a defense based on:

(1) a provision in the policy that relates to eligibility for coverage;

(2) a provision in a group accident and health insurance policy or disability insurance policy that relates to overinsurance;

(3) a provision in a disability policy that relates to the relation of earnings to insurance; or

(4) another similar provision in a group accident and health insurance policy or disability insurance policy that limits the amounts of recovery from all sources to not more than 100 percent of the total actual losses or expenses incurred.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1251.104. ENTIRE CONTRACT. A group accident and health insurance policy must provide that the policy and any application

attached to the policy constitute the entire contract between the parties.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1251.105. STATEMENT MADE BY POLICYHOLDER OR INSURED. A group accident and health insurance policy must provide that:

(1) in the absence of fraud, a statement made by the policyholder or an insured is considered a representation and not a warranty; and

(2) a statement made by the policyholder or an insured may not be used in any contest under the policy, unless a copy of the written instrument containing the statement is or has been provided to:

(A) the person making the statement; or

(B) if the statement was made by the insured and the insured has died or become incapacitated, the insured's beneficiary or personal representative.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1251.106. DISTINCTION BASED ON MARITAL STATUS PROHIBITED. A group accident and health insurance policy must include a provision that prohibits a distinction on the basis of the marital status or lack of marital status between an insured and the other parent in the determination of the dependents or the beneficiaries of the insured, or both.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1251.107. EVIDENCE OF INSURABILITY. A group accident and health insurance policy must state the conditions, if any, under which the insurer reserves the right to require an individual eligible for insurance to provide evidence of individual insurability satisfactory to the insurer as a condition of obtaining part or all of the coverage.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1251.108. EXCLUSION OR LIMITATION OF COVERAGE FOR PREEXISTING CONDITIONS. (a) A group accident and health insurance policy must specify the additional exclusions or limitations, if any, applicable under the policy with respect to a disease or physical condition of an insured, not otherwise excluded from the insured's coverage by name or specific description effective on the date of the insured's loss, that existed before the effective date of the insured's coverage under the policy.

(b) An exclusion or limitation described by Subsection (a) may apply only to a disease or physical condition for which the insured received medical advice or treatment during the 12 months before the effective date of the insured's coverage.

(c) An exclusion or limitation described by Subsection (a) may not apply to a loss incurred or disability beginning after the earlier of:

(1) the end of 12 consecutive months, beginning on or after the effective date of the insured's coverage, during which the insured has not received medical advice or treatment in connection with the disease or physical condition; or

(2) the second anniversary of the effective date of the insured's coverage.

(d) This section does not apply to:

(1) a credit accident and health insurance policy; or

(2) a group accident and health insurance policy subject to Chapter 1501.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1251.109. ADJUSTMENT OF PREMIUMS OR BENEFITS IF AGE OF INSURED IS MISSTATED. (a) A group accident and health insurance policy under which the premiums or benefits vary by age must specify an equitable adjustment of premiums or benefits, or both, to be made if the age of an insured has been misstated.

(b) The provision required by Subsection (a) must contain a clear statement of the method of adjustment to be used.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1251.110. DEADLINE FOR NOTICE OF CLAIM. (a) A group accident and health insurance policy must provide that written notice of a claim must be given to the insurer not later than the 20th day after the date of the occurrence or beginning of any loss covered by the policy.

(b) Failure to give notice within the time prescribed by Subsection (a) does not invalidate or reduce any claim if it is shown that:

(1) it was not reasonably possible to give the notice within that time; and

(2) notice was given as soon as was reasonably possible.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1251.111. CLAIM FORMS. (a) A group accident and health insurance policy must provide that the insurer will furnish to the person making a claim or to the policyholder for delivery to a person making a claim the forms usually provided by the insurer for filing a proof of loss.

(b) If the forms for a proof of loss are not provided before the 16th day after the date the insurer received notice of a claim under the policy, the person making the claim is considered to have complied with the requirements of the policy as to proof of loss on submitting, within the time set in the policy for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which the claim is made.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1251.112. DEADLINE FOR CLAIM. (a) A group accident and health insurance policy must provide that:

(1) in the case of a claim for a loss other than a claim for a loss of time for disability, written proof of the loss must be provided to the insurer not later than the 90th day after the date of the loss; and

(2) in the case of a claim for loss of time for disability:

(A) written proof of the loss must be provided to the insurer not later than the 90th day after the beginning of the period for which the insurer is liable; and

(B) subsequent written proofs of the continuance of the disability must be provided to the insurer at intervals as reasonably required by the insurer.

(b) Failure to provide written proof of a loss within the time prescribed by Subsection (a) does not invalidate or reduce a claim if:

(1) it was not reasonably possible to provide written proof of the loss within that time;

(2) written proof of the loss is provided as soon as reasonably possible; and

(3) unless the claimant does not have the legal capacity to provide proof of loss, proof of loss is provided not later than the first anniversary of the date the proof of loss is otherwise required.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1251.113. PROMPT PAYMENT OF BENEFITS REQUIRED. A group accident and health insurance policy must provide that:

(1) all benefits payable under the policy, other than benefits for loss of time, must be paid not later than the 60th day after the date the proof of loss is received; and

(2) subject to written proof of loss, all accrued benefits payable under the policy for loss of time must be paid at least monthly during the period for which the insurer is liable, and that any balance remaining unpaid at the end of that period must be paid as soon as possible after the proof of loss is received.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1251.114. PAYMENT OF BENEFITS. (a) A group accident and health insurance policy must provide that all benefits of the policy, other than benefits for loss of life, must be paid to the insured or the insured's assignee.

(b) A group accident and health insurance policy must provide that, subject to the provisions of the policy, benefits for loss of life of an insured must be paid to:

(1) the beneficiary designated by the insured or the beneficiary's assignee;

(2) the family member specified by the policy terms, if the policy contains conditions relating to family status; or

(3) the estate of the insured, if the designated or specified beneficiary is not living at the time the insured dies.

(c) A group accident and health insurance policy may provide that if any benefits are payable to the estate of an individual or to an individual who is a minor or is otherwise not competent to give a valid release, the insurer may pay the benefits, up to an amount established by the commissioner, to any individual related by consanguinity or affinity to the individual who is considered by the insurer to be equitably entitled to the benefits.

(d) This section does not apply to:

(1) a credit accident and health insurance policy; or

(2) a group contract issued by a group hospital service corporation.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1251.115. RIGHT TO CONDUCT PHYSICAL EXAMINATION OR AUTOPSY. A group accident and health insurance policy must provide that the insurer has the right and opportunity to:

(1) conduct a physical examination of an individual for whom a claim is made when and as often as the insurer reasonably requires during the pendency of the claim under the policy; and

(2) in the case of a death, require that an autopsy be conducted, unless the autopsy is prohibited by law.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1251.116. LEGAL OR EQUITABLE ACTIONS; LIMITATIONS. A group accident and health insurance policy must provide that an action at law or in equity may not be brought to recover on the policy:

(1) before the 61st day after the date written proof of loss is filed as required under the policy; or

(2) after the third anniversary of the date on which written proof of loss is required under the policy to be filed.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1251.117. CONTINUATION OR CONVERSION OF COVERAGE. (a) A group accident and health insurance policy must describe the continuation of group coverage and any conversion coverage provided in accordance with Subchapter F.

(b) Subsection (a) does not apply to a credit accident and health insurance policy.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

SUBCHAPTER D. GROUP ACCIDENT AND HEALTH INSURANCE: COVERAGE FOR DEPENDENTS

Sec. 1251.151. COVERAGE FOR CERTAIN GRANDCHILDREN. (a) A group policy or contract of insurance for hospital, surgical, or medical expenses incurred as a result of accident or sickness, including a group contract issued by a group hospital service corporation, that provides coverage under the policy or contract for a child of an insured must, on payment of a premium, provide coverage for any grandchild of the insured if the grandchild is:

- (1) unmarried;
- (2) younger than 25 years of age; and
- (3) a dependent of the insured for federal income tax purposes at the time the application for coverage of the grandchild is made.

(b) Coverage for a grandchild of the insured under this section may not be terminated solely because the covered grandchild is no longer a dependent of the insured for federal income tax purposes.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1251.152. OPTIONAL COVERAGE FOR SPOUSES AND DEPENDENTS.

(a) For purposes of this section, "dependent" includes:

- (1) a child of an employee or member who is:
 - (A) unmarried; and
 - (B) younger than 25 years of age; and
- (2) a grandchild of an employee or member who is:
 - (A) unmarried;
 - (B) younger than 25 years of age; and

(C) a dependent of the insured for federal income tax purposes at the time the application for coverage of the grandchild is made.

(b) A group accident and health insurance policy may provide coverage for the spouse or a dependent of an employee or member.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1251.153. OPTIONAL CONTINUATION OF DEPENDENTS' BENEFITS ON DEATH OF INSURED. (a) A group accident and health insurance policy that provides for the payment by the insurer of benefits for members of the family or dependents of an insured may provide for a continuation of all or part of those benefits after the death of the insured.

(b) Insurance provided by benefits described by Subsection (a) is not life insurance under Title 7.

(c) Coverage described by Subsection (a) may continue for any period subject to any other policy provisions relating to the termination of a dependent's coverage.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1251.154. COVERAGE FOR ADOPTED CHILDREN. A group policy or contract of insurance for hospital, surgical, or medical expenses incurred as a result of accident or sickness, including a group contract issued by a group hospital service corporation, that provides coverage for the immediate family or a child of an insured may not exclude from coverage or limit coverage of a child of the insured solely because the child is adopted. A child is considered to be the child of an insured if the insured is a party to a suit in which the insured seeks to adopt the child.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

SUBCHAPTER E. GROUP ACCIDENT AND HEALTH INSURANCE: GENERAL PROVISIONS

Sec. 1251.201. CERTIFICATE OF INSURANCE; NOTICE OF SEPARATE AVAILABLE COVERAGE. (a) An insurer issuing a group policy under

this chapter shall provide to the policyholder for delivery to each employee or member of the insured group:

(1) a certificate of insurance that:

(A) summarizes the essential features of the insurance coverage of the employee or member, including the annual deductibles, annual and lifetime policy limits, and maximum out-of-pocket expenses under the policy; and

(B) states the person to whom benefits are payable; and

(2) a notice that informs the employee or member of the availability of and premiums for a rider or separate insurance policy that would provide coverage in addition to the coverage provided under the policy.

(b) If dependents are included in the coverage, an insurer is not required to provide more than one certificate or notice for each family unit.

(c) By agreement between the insurer and the policyholder, a certificate may be delivered electronically.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.030(a), eff. September 1, 2005.

Acts 2005, 79th Leg., Ch. 939 (H.B. 765), Sec. 1, eff. September 1, 2005.

Sec. 1251.202. NOTICE REGARDING CERTAIN EMPLOYER HEALTH BENEFIT PLANS. (a) In this section, "standard health benefit plan" means a plan offered under Chapter 1507.

(b) If an employer offers to employees a standard health benefit plan, the employer shall:

(1) provide a copy of the disclosure statement provided to the employer by the plan issuer under Section 1507.006 or 1507.056 to:

(A) each employee:

(i) before the employee initially enrolls in the plan, unless the employee received notice under Paragraph (B) on or after the 90th day before the date the employee initially enrolls; and

(ii) not later than the 30th day before the date

the employee renews enrollment in the plan; and

(B) each prospective employee before the prospective employee is hired by the employer; and

(2) obtain a copy of the notice signed by the employee or prospective employee at the time the notice is provided.

Added by Acts 2005, 79th Leg., Ch. 939 (H.B. 765), Sec. 2, eff. September 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2G.001, eff. April 1, 2009.

**SUBCHAPTER F. CONTINUATION OR CONVERSION PRIVILEGE ON TERMINATION OF
COVERAGE UNDER GROUP POLICY**

Sec. 1251.251. CONTINUATION OF GROUP COVERAGE REQUIRED; EXCEPTION. (a) An insurer or group hospital service corporation that issues policies that provide hospital, surgical, or major medical expense insurance coverage or any combination of those coverages on an expense incurred basis shall, as required by this subchapter, provide continuation of group coverage for employees or members and their eligible dependents, subject to the eligibility provisions prescribed by Section 1251.252.

(b) This subchapter does not apply to an insurance policy that provides benefits only for expenses incurred because of a specified disease or an accident.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1251.252. ELIGIBILITY FOR CONTINUATION OF GROUP COVERAGE. (a) An employee, member, or dependent is entitled to continuation of group coverage if:

(1) the individual's coverage under the group policy is terminated for any reason other than involuntary termination for cause, including discontinuance of the group policy in its entirety or with respect to an insured class; and

(2) the individual has been continuously insured under the group policy, or under any group policy providing similar benefits that the policy replaces, for at least three consecutive months immediately before termination.

(b) For purposes of Subsection (a), involuntary termination for cause does not include termination for any health-related cause.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1251.253. REQUEST FOR CONTINUATION OF GROUP COVERAGE. An employee, member, or dependent must provide to the employer or group policyholder a written request for continuation of group coverage not later than the 60th day after the later of:

(1) the date the group coverage would otherwise terminate;
or

(2) the date the individual is given, in a format prescribed by the commissioner, notice by either the employer or the group policyholder of the right to continuation of group coverage.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 550 (S.B. 1771), Sec. 2, eff. June 19, 2009.

Sec. 1251.254. PAYMENT OF CONTRIBUTIONS. Except as provided by this section, an employee, member, or dependent who elects to continue group coverage under this subchapter must pay to the employer or group policyholder each month the amount of contribution required by the employer or policyholder, plus two percent of the group rate for the coverage being continued under the group policy. A payment under this section must be made not later than the 45th day after the date of the initial election for coverage and on the due date of each payment thereafter. Following the first payment made after the initial election for coverage, the payment of any other premium shall be considered timely if made on or before the 30th day after the date on which the payment is due.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 550 (S.B. 1771), Sec. 3, eff. June 19, 2009.

Sec. 1251.255. TERMINATION OF CONTINUED COVERAGE. (a) Group coverage continued under this subchapter may not terminate until the earliest of:

(1) the date the maximum continuation period provided by law would end, which is:

(A) for any employee, member, or dependent not eligible for continuation coverage under Title X, Consolidated Omnibus Budget Reconciliation Act of 1985 (29 U.S.C. Section 1161 et seq.) (COBRA), nine months after the date the employee, member, or dependent elects to continue the group coverage; or

(B) for any employee, member, or dependent eligible for continuation coverage under COBRA, six additional months following any period of continuation coverage provided under COBRA;

(2) the date failure to make timely payments would terminate the group coverage;

(3) the date the group coverage terminates in its entirety;

(4) the date the insured is or could be covered under Medicare;

(5) the date the insured is covered for similar benefits by another plan or program, including:

(A) a hospital, surgical, medical, or major medical expense insurance policy;

(B) a hospital or medical service subscriber contract;
or

(C) a medical practice or other prepayment plan;

(6) the date the insured is eligible for similar benefits, whether or not covered for those benefits, under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis; or

(7) the date similar benefits are provided or available to the insured under any state or federal law other than continuation coverage under Title X, Consolidated Omnibus Budget Reconciliation Act of 1985 (29 U.S.C. Section 1161 et seq.) (COBRA).

(b) Repealed by Acts 2013, 83rd Leg., R.S., Ch. 615, Sec. 8(a)(3), eff. January 1, 2014.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2009, 81st Leg., R.S., Ch. 550 (S.B. 1771), Sec. 4, eff. June 19, 2009.

Acts 2013, 83rd Leg., R.S., Ch. 615 (S.B. 1367), Sec. 8(a)(3), eff. January 1, 2014.

Sec. 1251.256. CONVERSION OF GROUP POLICY. (a) An insurer may offer a conversion policy to each employee, member, or dependent who is covered under a group accident and health insurance policy that is terminating.

(b) If offered, an issuer shall issue a conversion policy without evidence of insurability if a written application for the policy and payment of the first premium are made not later than the 31st day after the date of termination.

(c) Any conversion policy must meet the minimum standards for benefits for conversion policies.

(d) The insurer may provide the conversion coverage on an individual or group basis.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1251.257. PREMIUM FOR CONVERTED POLICY. (a) An insurer shall determine the premium for a converted policy issued under this subchapter in accordance with the insurer's table of premium rates for coverage that was provided under the group policy. The premium:

(1) must be based on the type of converted policy and the coverage provided by the policy; and

(2) may be based on the age and geographic location of each individual to be covered.

(b) The premium for the same coverage and benefits under a converted policy may not exceed 200 percent of the premium determined for the group policy in accordance with Subsection (a).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1251.258. BENEFITS UNDER CONVERTED POLICY. The commissioner by rule shall establish minimum standards for benefits under converted policies issued under this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1251.259. TERMINATION OF CONVERTED POLICY. Conversion coverage under this subchapter for an insured may not terminate until the earlier of:

(1) the date failure to make timely payments would terminate coverage; or

(2) the date of an event specified by Section 1251.255(a)(4), (5), (6), or (7) for termination of continued group coverage.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1251.260. NOTICE OF CONTINUATION AND CONVERSION PRIVILEGES. (a) An employer that provides to its employees group accident and health insurance coverage that includes a group continuation or conversion privilege on termination of coverage shall give written notice of the continuation or conversion privileges under the policy to each employee or dependent insured under the group and affected by the termination.

(b) The commissioner by rule shall establish minimum standards for the notice required by this section.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

SUBCHAPTER G. CONTINUATION OF GROUP COVERAGE FOR CERTAIN FAMILY MEMBERS AND DEPENDENTS

Sec. 1251.301. CONTINUATION OF GROUP COVERAGE. A group policy or contract delivered, issued for delivery, renewed, amended, or extended in this state, including a group contract issued by a group hospital service corporation, that provides insurance for hospital, surgical, or medical expenses incurred as a result of accident or sickness must include an option for each individual covered by the policy or contract because of a family or dependent relationship to an individual who is a member of the group for which the policy or contract is provided to continue coverage with the group if the individual's eligibility for coverage under the policy or contract ends because of:

(1) the severance of the family relationship; or

(2) the retirement or death of the group member.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1251.302. ELIGIBILITY FOR CONTINUED COVERAGE. A family member or dependent of an insured is eligible for continued coverage under this subchapter if the family member or dependent:

- (1) has been a member of the group for a period of at least one year; or
- (2) is an infant under one year of age.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1251.303. PHYSICAL EXAMINATION NOT REQUIRED. An individual who exercises the option to continue group coverage under this subchapter may not be required to take and pass a physical examination as a condition to continuing coverage.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1251.304. SCOPE OF COVERAGE. (a) An individual covered under group continuation coverage under this subchapter is entitled to coverage that is identical in scope to the coverage provided under the group health insurance policy or contract. An exclusion that was not included in the health insurance policy or contract may not be included in the group continuation coverage.

(b) If the group policyholder or contract holder replaces the health insurance policy or contract within the period prescribed by Section 1251.310(3), an individual covered under group continuation coverage may obtain coverage identical in scope to the coverage under the replacement group policy as provided by this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1251.305. AMOUNT OF PREMIUM. Except as provided by Section 1551.064, the premium for continuation of a spouse or dependent on the group health insurance policy or contract may not be more than the premium charged under the group policy or contract for the individual had the family relationship not been severed.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1251.306. PAYMENT OF PREMIUMS. (a) An individual covered under group continuation coverage under this subchapter shall pay premiums for the coverage directly to the group policyholder or contract holder.

(b) The coverage must provide the individual with the option of paying the premiums in monthly installments.

(c) The group policyholder or contract holder may require the individual to pay a monthly fee of not more than \$5 for administrative costs.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1251.307. NOTICE OF CONTINUATION OPTION. Except as provided by Section 1551.064, at the time a health insurance policy or contract is issued, the group policyholder or contract holder shall give written notice to each group member and each dependent of a group member covered by the policy or contract of the continuation option under this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1251.308. NOTICE OF SEVERANCE OF FAMILY RELATIONSHIP; NOTICE OF DESIRE TO EXERCISE OPTION. (a) Except as provided by Section 1551.064, each group health insurance policy or contract must require a group member to give written notice to the group policyholder or contract holder not later than the 15th day after the date of any severance of the family relationship that might activate the continuation option under this subchapter. Written notice under this subsection may be given by the group member's dependent.

(b) On receipt of notice under Subsection (a), the group policyholder or contract holder shall immediately give written notice of the continuation option under this subchapter to each affected dependent of the group member.

(c) On receipt of notice of the death or retirement of a group member, the group policyholder or contract holder shall immediately give written notice of the continuation option under this subchapter

to each dependent of the group member. The notice must state the amount of the premium to be charged and must be accompanied by any necessary enrollment forms.

(d) Not later than the 60th day after the date of the severance of the family relationship or the retirement or death of the group member, a dependent must give written notice to the group policyholder or contract holder of the individual's desire to exercise the continuation option under this subchapter. Coverage under the health insurance policy or contract remains in effect during the period prescribed by this subsection if the policy or contract premiums are paid.

(e) If a dependent does not give written notice of the individual's desire to exercise the continuation option under this subchapter within the time prescribed by Subsection (d), the option expires.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1251.309. CONTINUATION OF CERTAIN COVERAGES. (a) Any period of previous coverage under the health insurance policy or contract, including a policy or contract executed under Chapter 1551, must be used in full or partial satisfaction of any required probationary or waiting periods provided in the contract for dependent coverage.

(b) If a health insurance policy or contract provides to a group member continuation rights to cover the period between the time the member retires and the time the member is eligible for coverage by Medicare, those same continuation rights must be made available to the group member's dependents.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1251.310. TERMINATION OF CONTINUED COVERAGE. The coverage of an individual who exercises the continuation option under this subchapter continues without interruption and may not be canceled or otherwise terminated until:

(1) the insured fails to make a premium payment within the time required to make the payment;

(2) the insured becomes eligible for substantially similar

coverage under another plan or program, including a group health insurance policy or contract, hospital or medical service subscriber contract, or medical practice or other prepayment plan; or

(3) the third anniversary of:

(A) the severance of the family relationship; or

(B) the retirement or death of the group member.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

**SUBCHAPTER H. BLANKET ACCIDENT AND HEALTH INSURANCE: ELIGIBLE
POLICYHOLDERS**

Sec. 1251.351. COMMON CARRIER OR MOTOR VEHICLE RENTAL OR LEASING COMPANY. (a) A blanket accident and health insurance policy may be issued to:

(1) a common carrier or the operator, owner, or lessor of a means of transportation to cover a group of individuals who may become passengers defined by reference to their travel status on the common carrier or means of transportation; or

(2) an automobile or truck rental or leasing company to cover a group of individuals who may become renters, lessees, or passengers defined by their travel status on the rented or leased vehicles.

(b) The common carrier, the operator, owner, or lessor of a means of transportation, or the automobile or truck rental or leasing company is the policyholder under a policy to which this section applies.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1251.352. EMPLOYERS. (a) A blanket accident and health insurance policy may be issued to an employer to cover any group of employees, dependents, or guests defined by reference to specified hazards incident to an activity or operation of the employer.

(b) The employer is the policyholder under a policy to which this section applies.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1251.353. EDUCATIONAL INSTITUTIONS. (a) A blanket accident and health insurance policy may be issued to a college, school, or other institution of learning, to a school district or school jurisdictional unit, or to the head, principal, or governing board of such an educational unit to cover students, teachers, or employees.

(b) The institution, head, principal, or governing board is the policyholder under a policy to which this section applies.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1251.354. RELIGIOUS, CHARITABLE, RECREATIONAL, EDUCATIONAL, OR CIVIC ORGANIZATION. (a) A blanket accident and health insurance policy may be issued to a religious, charitable, recreational, educational, or civic organization, or a branch of the organization, to cover any group of members or participants defined by reference to specified hazards incident to an activity or operation sponsored or supervised by the organization or branch.

(b) The organization or branch is the policyholder under a policy to which this section applies.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1251.355. SPORTS TEAM OR CAMP. (a) A blanket accident and health insurance policy may be issued to a sports team or camp or the sponsor of a sports team or camp to cover members, campers, employees, officials, or supervisors.

(b) The sports team, camp, or sponsor is the policyholder under a policy to which this section applies.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1251.356. GOVERNMENTAL OR VOLUNTEER EMERGENCY SERVICES ORGANIZATION. (a) A blanket accident and health insurance policy may be issued to a governmental or volunteer fire department or fire company, first aid or civil defense organization, or similar governmental or volunteer organization to cover a group of members or participants defined by reference to specified hazards incident to an

activity or operation sponsored or supervised by the organization.

(b) The governmental or volunteer organization is the policyholder under a policy to which this section applies.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1251.357. NEWSPAPER OR OTHER PUBLISHER. (a) A blanket accident and health insurance policy may be issued to a newspaper or other publisher to cover the publisher's carriers.

(b) The publisher is the policyholder under a policy to which this section applies.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1251.358. ASSOCIATION. (a) A blanket accident and health insurance policy may be issued to an association, including a labor union, to cover any group of members or participants defined by reference to specified hazards incident to an activity or operation sponsored or supervised by the association.

(b) To be eligible to obtain a blanket accident and health insurance policy, an association must:

(1) have a constitution and bylaws; and

(2) have been organized and be maintained in good faith for purposes other than that of obtaining insurance.

(c) The association is the policyholder under a policy to which this section applies.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1251.359. COVERAGE FOR OTHER RISKS. (a) A blanket accident and health insurance policy may be issued to cover any risk or class of risks other than a risk described by this subchapter that, as determined by the commissioner, is eligible for blanket accident and health insurance.

(b) The commissioner may make a determination under Subsection (a) based on an individual risk, a class of risks, or both.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

SUBCHAPTER I. BLANKET ACCIDENT AND HEALTH INSURANCE: GENERAL PROVISIONS

Sec. 1251.401. INDIVIDUAL APPLICATION AND CERTIFICATE NOT REQUIRED. (a) An individual application from an insured under a blanket accident and health insurance policy is not required.

(b) An insurer is not required to provide a certificate to each insured under a blanket accident and health insurance policy.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1251.402. LIABILITY OF POLICYHOLDER NOT AFFECTED.

Subchapter H and this subchapter do not affect the legal liability of a policyholder for the death of or injury to a member of a group.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

SUBCHAPTER J. REGULATION OF OUT-OF-STATE GROUP ACCIDENT AND HEALTH INSURANCE COVERAGE

Sec. 1251.451. APPLICABILITY OF CERTAIN LAWS TO OUT-OF-STATE GROUP ACCIDENT AND HEALTH INSURANCE COVERAGE. (a) Chapters 1365 and 1368 and Subchapters A and C, Chapter 1451, apply to:

(1) a certificate of insurance issued to a resident of this state under a group accident and health insurance policy delivered, issued for delivery, or renewed outside this state; or

(2) a certificate issued to a resident of this state under a policy delivered, issued for delivery, or renewed outside this state by a group hospital service corporation.

(b) Subsection (a) does not apply to a specified disease or limited benefit policy.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

CHAPTER 1252. DISCONTINUATION AND REPLACEMENT OF GROUP AND GROUP-TYPE HEALTH BENEFIT PLAN COVERAGE

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1252.001. DEFINITIONS. In this chapter:

- (1) "Carrier" means:
- (A) an insurer; or
 - (B) a group hospital service corporation operating under Chapter 842.
- (2) "Health benefit plan" means:
- (A) any accident and health insurance policy;
 - (B) a subscriber contract of a group hospital service corporation; or
 - (C) an accident and health benefits package of a multiple employer trust that is not exempt from regulation by this state as an employee welfare benefit plan under the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), as amended.
- (3) "Previous carrier" means a carrier whose health benefit plan coverage has been replaced with health benefit plan coverage provided by a succeeding carrier.
- (4) "Succeeding carrier" means a carrier that replaces the health benefit plan coverage provided by another carrier with its own health benefit plan coverage.
- (5) "Total disability" or "totally disabled" means:
- (A) with respect to an employee or other primary insured covered under a health benefit plan, the complete inability of that individual to perform all of the substantial and material duties and functions of the individual's occupation and any other gainful occupation in which the individual earns substantially the same compensation earned before the disability; and
 - (B) with respect to any other individual covered under a health benefit plan, confinement as a bed patient in a hospital.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1252.002. APPLICABILITY OF CHAPTER. (a) This chapter applies only to a health benefit plan that:

- (1) provides coverage on a group or group-type basis to an individual eligible for that coverage because of the individual's status as:
- (A) an employee of an employer; or
 - (B) a member of a labor union or a member of an association; and

(2) is delivered or issued for delivery in this state.

(b) This chapter does not apply to an entity that is not engaged in the business of insurance in this state.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1252.003. COVERAGE ISSUED ON GROUP-TYPE BASIS. (a) For purposes of this chapter, health benefit plan coverage is provided on a group-type basis if:

(1) the plan provides coverage under an insurance policy or subscriber contract to a class of employees or a class of members of a labor union or members of an association and the class is determined by conditions relating to their employment or to their membership in the union or association;

(2) coverage under the plan is not available to the general public and can be obtained and maintained only because of the covered individual's employment status or membership in a labor union or an association;

(3) premiums or subscription charges for the plan are paid to the carrier on an aggregate or bulk-payment basis; and

(4) the plan is sponsored by:

(A) the employer of the class of employees covered by the plan; or

(B) the labor union or an association to which the class of members covered by the plan belongs.

(b) Health benefit plan coverage is not provided on a group-type basis if it is a salary-budget plan using individual insurance policies or subscriber contracts that do not meet the conditions for group-type coverage specified by Subsection (a).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

SUBCHAPTER B. DISCONTINUATION OF COVERAGE

Sec. 1252.101. NOTICE OF DISCONTINUATION OF COVERAGE. A notice of discontinuation of a health benefit plan must include a request to the group policyholder or other entity responsible for making payments or submitting subscription charges to the carrier to notify employees or members covered by the plan of the discontinuation and the date of the discontinuation.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1252.102. EXTENSION OF BENEFITS PROVISION; EXEMPTION.

(a) A health benefit plan must contain, subject to this section and Section 1252.103, a reasonable provision providing for an extension of benefits for a total disability that exists on the date of the plan's discontinuation.

(b) A health benefit plan must contain a reasonable extension of benefits provision for coverage for hospital or medical expenses other than dental expenses. A provision is considered reasonable if it provides to an individual who is covered under the plan and who is totally disabled on the date of the plan's discontinuation an extension of benefits for expenses incurred in treating the condition causing the total disability and the extension is provided for at least the lesser of:

- (1) 90 days; or
- (2) the duration of the total disability.

(c) An extension of benefits provision required under this section may provide for an exclusion from coverage for an individual whose coverage is being discontinued and replaced with coverage that:

- (1) is provided by a succeeding carrier; and
- (2) provides a level of benefits that is at least

substantially equal to the level of benefits provided under the replaced health benefit plan.

(d) An applicable extension of benefits provision must be described in the policy or contract and the group insurance certificate.

(e) Benefits payable during an extension period may be subject to the regular benefit limits of the health benefit plan.

(f) This section does not apply to a health benefit plan that was delivered or issued for delivery in this state before January 1, 1982, and whose level of benefits has not been modified after December 31, 1981.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1252.103. INDEMNITY OR BENEFITS PAYABLE FOR DISABILITY. A discontinuation of health benefit plan coverage occurring during a

period of disability does not affect:

(1) any benefits payable under the plan for loss of time from work because of the disability; or

(2) any specific indemnity required to be provided under the plan during a period of hospital confinement.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1252.104. **LIABILITY FOR LOSS UNDER AUTOMATICALLY DISCONTINUED COVERAGE.** (a) If a health benefit plan provides for automatic discontinuation of coverage when a premium or subscription charge due under the plan is not paid before the expiration of a grace period specified in the plan for that payment, the carrier or other entity responsible for making premium payments or for submitting premiums or subscription charges to the carrier is liable, on the submission of a valid claim, for a loss that is:

(1) covered by the plan; and

(2) incurred before the expiration of the grace period.

(b) The commissioner may adopt reasonable rules necessary to implement this section.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

SUBCHAPTER C. REPLACEMENT OF COVERAGE

Sec. 1252.201. **TOTAL DISABILITY STATUS.** In this subchapter, a reference to the total disability status of an individual means the individual's disability status immediately preceding the date on which the succeeding carrier's coverage takes effect.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1252.202. **EFFECTIVE DATE OF COVERAGE UNDER REPLACEMENT PLAN.** (a) An individual who was covered by a previous carrier's health benefit plan on the date on which that plan was discontinued shall be provided coverage under the succeeding carrier's health benefit plan as of the replacement plan's effective date if the individual:

(1) is eligible for coverage because the individual is a

member of a class eligible for coverage under the replacement plan and satisfies the replacement plan's actively at work and nonconfinement requirements; and

(2) elects to be covered under the replacement plan.

(b) An individual who would be covered by the succeeding carrier under Subsection (a) but who does not satisfy the replacement plan's actively at work and nonconfinement requirements shall be covered under the replacement plan when the individual satisfies those requirements.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1252.203. EXTENSION OF BENEFITS FOR TOTAL DISABILITY. (a) With respect to providing a type of coverage for which Section 1252.102 requires an extension of benefits for an individual with a total disability, a succeeding carrier replacing a previous carrier's plan that is not subject to that section must provide, subject to Subsection (b), the lesser of:

(1) extended benefit coverage that the previous carrier would have been required to provide under Section 1252.102 if the previous carrier had been subject to that section; or

(2) extended benefit coverage that the succeeding carrier is required to provide under Section 1252.102.

(b) The extended benefit coverage may be reduced by any benefits actually payable under the previous carrier's health benefit plan.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1252.204. COVERAGE FOR PREEXISTING CONDITIONS. (a) A succeeding carrier's health benefit plan that limits coverage in accordance with a preexisting conditions provision, other than a waiting period, must provide, during the period the limitation on coverage is in effect, the level of benefits prescribed by this section to an individual covered by the succeeding carrier who:

(1) has a preexisting condition; and

(2) was covered by the previous carrier's plan on the date on which that plan was discontinued.

(b) The health benefit plan must provide a level of benefits

equal to the lesser of:

(1) the level of benefits available under the succeeding carrier's plan as determined without applying the preexisting conditions provision; or

(2) the level of benefits that would have been available under the previous carrier's plan.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1252.205. WAITING PERIOD. If the benefits that were available under a previous carrier's health benefit plan are similar to the benefits available under a succeeding carrier's health benefit plan, the succeeding carrier shall give credit for the satisfaction or partial satisfaction of any waiting period or similar provision that has been satisfied under the previous carrier's plan.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1252.206. DETERMINATION OF BENEFITS AVAILABLE UNDER REPLACED PLAN. (a) If a succeeding carrier requires a determination of the benefits available under the previous carrier's health benefit plan, the previous carrier shall provide at the request of the succeeding carrier:

(1) a statement of the benefits available under the previous carrier's plan; or

(2) pertinent information sufficient either to allow verification of those benefits or to allow the succeeding carrier to make a determination of those benefits.

(b) A determination of benefits under this section must be made using the definitions of, and in accordance with all of the conditions and covered expense provisions of, the previous carrier's plan as if that plan had not been replaced.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1252.207. LIABILITY OF PREVIOUS CARRIER. A carrier of a health benefit plan that is being discontinued is liable only for any accrued liabilities regarding the plan and for any extension of

benefits provided under the plan, regardless of whether the group policyholder or any other entity responsible for making payments or for submitting subscription charges to the carrier:

- (1) replaces the coverage provided under the discontinued plan with health benefit plan coverage provided by another carrier;
- (2) self-insures a health benefit plan; or
- (3) does not provide health benefit plan coverage.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

CHAPTER 1253. CANCELLATION OF GROUP COVERAGE IN CERTAIN CIRCUMSTANCES
SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1253.001. LIMITATION OF SERVICES AND BENEFITS ON CONTRACT RENEGOTIATION. (a) In this section, "health benefit contract" means a contract providing group health care coverage for employees that is delivered, issued for delivery, or renewed in this state by:

- (1) an insurance company;
- (2) a group hospital service corporation operating under Chapter 842; or
- (3) a health maintenance organization operating under Chapter 843.

(b) Subject to Subsection (c), if an employer in this state agrees to renegotiate a health benefit contract, a change in the renegotiated contract may not operate solely to terminate eligibility with respect to any member of the group who, before the contract was renegotiated:

- (1) was covered under the contract; and
- (2) had a sickness or injury for which a service was being provided or a benefit was being paid under the contract.

(c) A renegotiated health benefit contract may include a different durational or dollar limit or a different deductible amount or amount of coinsurance applicable to a sickness or injury for which a service was being provided or benefit was being paid before the contract was renegotiated if that same or a similar limit or amount applies to a service provided or benefit paid for a similar sickness or a related condition or injury covered by the contract.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

**SUBCHAPTER B. CONTINUATION OF GROUP ACCIDENT AND HEALTH INSURANCE
POLICIES DURING LABOR DISPUTE**

Sec. 1253.051. APPLICABILITY OF SUBCHAPTER. This subchapter applies to a group accident and health insurance policy that is delivered or issued for delivery in this state and as to which any part of the premium is paid or is to be paid by an employer under the terms of a collective bargaining agreement.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1253.052. CONTINUATION OF GROUP ACCIDENT AND HEALTH INSURANCE DURING LABOR DISPUTE REQUIRED FOR CERTAIN POLICIES. An insurer may not deliver or issue for delivery a policy subject to this subchapter unless the policy provides that if the employees covered by the policy stop work because of a labor dispute, coverage continues under the policy, on timely payment of the premium, for each employee who:

- (1) is covered under the policy on the date the work stoppage begins;
- (2) continues to pay the employee's individual contribution, subject to the conditions provided by this subchapter; and
- (3) assumes and pays during the work stoppage the contribution due from the employer, subject to the conditions provided by this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1253.053. CONTRIBUTIONS IF POLICYHOLDER IS TRUSTEE. (a) An employee's contribution for purposes of a policy as to which the policyholder is a trustee or the trustees of a fund established or maintained wholly or partly by the employer is the amount the employee and employer would have been required to contribute to the fund for the employee if:

- (1) the work stoppage had not occurred; and
- (2) the agreement requiring the employer to make contributions to the fund were in effect.

(b) The policy may provide that continuation of coverage is contingent on the collection of individual contributions by the

policyholder or the policyholder's agent.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1253.054. CONTRIBUTIONS IF POLICYHOLDER IS NOT TRUSTEE.

(a) A policy as to which the policyholder is not a trustee or the trustees of a fund established or maintained in whole or in part by the employer must provide that the employee's individual contribution:

(1) is the policy rate applicable:

(A) on the date the work stoppage begins; and

(B) to an individual in the class to which the employee belongs as provided by the policy; or

(2) if the policy does not provide for a rate applicable to an individual, is an amount equal to the amount determined by dividing:

(A) the total monthly premium in effect under the policy on the date the work stoppage begins; by

(B) the total number of insureds under the policy on that date.

(b) The policy may provide that continuation of coverage under this subchapter is contingent on the collection of individual contributions by the union or unions representing the employees.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1253.055. PAYMENT OF CONTRIBUTION AND PREMIUM. A policy may provide that continuation of coverage for an employee under the policy is contingent on timely payment of:

(1) contributions by the employee; and

(2) the premium by the entity responsible for collecting the individual employee contributions.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1253.056. PAST DUE PREMIUM. (a) A policy may provide that the continuation of coverage is contingent on payment of any premium that:

- (1) is unpaid on the date the work stoppage begins; and
- (2) became due before the date the work stoppage begins.

(b) A premium described by Subsection (a) must be paid before the date the next premium becomes due under the policy.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1253.057. INDIVIDUAL PREMIUM RATE INCREASE. (a) A policy may provide that, during the period of a work stoppage, each individual premium rate shall be increased by an amount not to exceed 20 percent of the amount shown in the policy, or a greater percentage as approved by the commissioner, to provide sufficient compensation to the insurer to cover increased:

- (1) administrative costs; and
- (2) mortality and morbidity.

(b) If a policy provides for a premium rate increase in accordance with this section, the amount of an employee's contribution must be increased by the same percentage.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1253.058. PREMIUM RATE CHANGE NOT LIMITED. (a) This subchapter does not limit any right of the insurer under a policy to increase or decrease a premium rate before, during, or after a work stoppage if the insurer would be entitled to increase the premium rate had a work stoppage not occurred.

(b) A change in a premium rate made in accordance with this section takes effect on a date that is determined by the insurer in accordance with the terms of the policy.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1253.059. LIMITATIONS ON CONTINUATION OF COVERAGE. This subchapter does not require the continuation of coverage under a policy for any loss of time benefits included in the policy or the continuation of other coverage for a period:

- (1) longer than six months after a work stoppage occurs;
- (2) beyond the time that 75 percent of the covered

employees continue the coverage; or

(3) as to an individual covered employee, beyond the time that the employee takes a full-time job with another employer.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1253.060. OTHER PROVISIONS; COMMISSIONER APPROVAL REQUIRED. A policy may contain any other provision relating to continuation of policy coverage during a work stoppage that the commissioner approves.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

**CHAPTER 1254. NOTICE OF RATE INCREASE FOR GROUP HEALTH AND ACCIDENT
COVERAGE**

Sec. 1254.001. NOTICE OF RATE INCREASE. (a) In this section, "insurer" means:

- (1) a life insurance company;
- (2) a health insurance company;
- (3) an accident insurance company;
- (4) a general casualty company;
- (5) a mutual life insurance company or other mutual insurance company;
- (6) a mutual or natural premium life insurance company;
- (7) a Lloyd's plan;
- (8) a reciprocal or interinsurance exchange;
- (9) a fraternal benefit society;
- (10) a local mutual aid association; or
- (11) a group hospital service corporation.

(b) Not less than 60 days before the date on which a premium rate increase takes effect on a group policy of health insurance, accident and health insurance, or life, health, and accident insurance delivered or issued for delivery in this state by an insurer, the insurer shall give written notice to the policyholder of:

- (1) the amount of the increase; and
- (2) the date on which the increase is to take effect.

(c) A health maintenance organization shall give notice of an increase in subscriber charges and service fees under a group

contract or coverage in the same manner as is required of an insurer under Subsection (b).

(d) An insurer that issues a group policy described by Subsection (b) to a multiple employer trust shall give the notice required by that subsection to the trustee or group policyholder.

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

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

(g) An insurer may not require a policyholder or trustee 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 (b) is given.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.031(a), eff. September 1, 2005.

CHAPTER 1255. GROUP FAMILY LEAVE INSURANCE

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1255.001. DEFINITIONS. In this chapter:

(1) "Continuing supervision by a health care provider" includes a period of incapacity that is permanent or long-term due to a condition for which treatment may not be effective and for which the affected individual is not receiving active treatment by a health care provider.

(2) "Dependent" means an individual who is under 18 years of age, or 18 years of age or older and incapable of self-care due to a mental or physical disability, and is, in relation to an insured:

- (A) a biological, adopted, or foster child;
- (B) a legal ward;
- (C) a child of the insured's spouse;
- (D) a child with respect to whom the insured is a party to a suit in which the insured seeks to adopt the child; or
- (E) a child of a person to whom the insured stands in

loco parentis.

(3) "Family leave" means leave taken by an employee from work for reasons described by Section 1255.102.

(4) "Family leave insurance" means an insurance policy issued through an employer related to a benefit program provided to an employee to pay for a portion of the employee's income loss due to family leave taken by the employee.

(5) "Family member," in relation to an insured, includes a dependent, spouse, or parent or any other person defined as a family member in the family leave insurance policy.

(6) "Health care provider" means a person licensed, certified, or otherwise authorized by the laws of this state to provide health care services in the ordinary course of business or practice of a profession.

(7) "Parent" means, in relation to an insured:

(A) a biological, adoptive, or foster parent;

(B) a stepparent;

(C) a legal guardian; or

(D) a person who stood in loco parentis to the insured when the insured was a child.

(8) "Serious health condition" means an illness, injury, impairment, or physical or mental condition, including transplantation preparation and recovery from surgery related to organ or tissue donation, that involves:

(A) inpatient care in a hospital, hospice, or residential health care facility;

(B) continuing treatment; or

(C) continuing supervision by a health care provider.

Added by Acts 2023, 88th Leg., R.S., Ch. 703 (H.B. 1996), Sec. 2, eff. September 1, 2023.

Sec. 1255.002. APPLICABILITY OF CHAPTER. (a) This chapter applies only to a family leave insurance policy, amendment, or rider to a group disability policy delivered or issued for delivery in this state by a life, health, and accident insurance company.

(b) Notwithstanding Chapter 1701 and except as provided by Section 1255.108, this chapter does not apply to a certificate of family leave insurance delivered to a resident in this state if the

group policy was delivered or issued for delivery in another state.

(c) This chapter applies to an insurance company authorized to write life, health, and accident insurance in this state, including a stipulated premium company operating under Chapter 884.

(d) This chapter does not apply to:

(1) a society, company, or other insurer whose activities are exempt by statute from department regulation and that is entitled by statute to a certificate from the department that shows the entity's exempt status;

(2) a credit accident and health insurance policy issued under Chapter 1153;

(3) a workers' compensation insurance policy;

(4) a liability insurance policy, with or without supplementary expense coverage;

(5) a reinsurance policy or contract;

(6) a blanket or group insurance policy, except as otherwise provided by this chapter; or

(7) a life insurance endowment or annuity contract, or a contract supplemental to a life insurance endowment or annuity contract, if the contract or supplemental contract contains only provisions relating to accident and health insurance that:

(A) provide additional benefits in case of accidental death, accidental dismemberment, or accidental loss of sight; or

(B) operate to:

(i) safeguard the contract or supplemental contract against lapse; or

(ii) give a special surrender value, a special benefit, or an annuity if the insured or annuitant becomes totally and permanently disabled, as defined by the contract or supplemental contract.

Added by Acts 2023, 88th Leg., R.S., Ch. 703 (H.B. 1996), Sec. 2, eff. September 1, 2023.

Sec. 1255.003. CONSIDERATION AS DISABILITY INCOME INSURANCE. A family leave insurance policy is considered a type of disability income insurance for all purposes under this code.

Added by Acts 2023, 88th Leg., R.S., Ch. 703 (H.B. 1996), Sec. 2, eff. September 1, 2023.

Sec. 1255.004. APPLICATION OF OTHER LAW; CONFLICTS. (a) The provisions of Subchapter B, Chapter 1251, governing eligibility for group accident and health insurance apply to govern the eligibility of a group for purposes of this chapter to the extent those provisions do not conflict with this chapter. This chapter prevails over Subchapter B, Chapter 1251, if there is a conflict.

(b) Notwithstanding any other law, the law of the state in which the group or master policy providing family leave insurance is delivered or issued for delivery governs disputes between the insurer, group policyholder, and certificate holder.

Added by Acts 2023, 88th Leg., R.S., Ch. 703 (H.B. 1996), Sec. 2, eff. September 1, 2023.

Sec. 1255.005. RULEMAKING AUTHORITY. The commissioner may adopt reasonable rules as necessary to implement this chapter.

Added by Acts 2023, 88th Leg., R.S., Ch. 703 (H.B. 1996), Sec. 2, eff. September 1, 2023.

SUBCHAPTER B. MINIMUM POLICY STANDARDS

Sec. 1255.101. COMPLIANCE WITH MINIMUM STANDARDS FOR BENEFITS. A group family leave insurance policy must meet the minimum standards for benefits as provided by this subchapter.

Added by Acts 2023, 88th Leg., R.S., Ch. 703 (H.B. 1996), Sec. 2, eff. September 1, 2023.

Sec. 1255.102. FAMILY LEAVE BENEFITS. A group family leave insurance policy may provide benefits for any leave taken by an insured from work to:

(1) participate in providing care, including physical or psychological care, for a family member of the insured made necessary by a serious health condition of the family member;

(2) bond with the insured's child during the first 12 months after the child's birth, or the first 12 months after the

placement of the child for adoption or foster care with the insured;

(3) address a qualifying exigency, as interpreted under the Family and Medical Leave Act of 1993 (29 U.S.C. Section 2612(a)(1)(E)) and 29 C.F.R. Sections 825.126(b)(1)-(8), arising from the fact that the spouse, dependent, or parent of the insured is on active duty or has been notified of an impending call or order to active duty in the armed forces of the United States, including the National Guard and armed forces reserves;

(4) care for a family member described by Subdivision (3) who is injured in the line of duty; or

(5) take other leave to provide care for a family member or other family leave as specified in the policy.

Added by Acts 2023, 88th Leg., R.S., Ch. 703 (H.B. 1996), Sec. 2, eff. September 1, 2023.

Sec. 1255.103. EXPLANATION OF COVERED FAMILY LEAVE REASONS. A group family leave insurance policy must provide the details regarding and requirements for each covered family leave reason.

Added by Acts 2023, 88th Leg., R.S., Ch. 703 (H.B. 1996), Sec. 2, eff. September 1, 2023.

Sec. 1255.104. BENEFIT PERIOD. (a) A group family leave insurance policy must establish the length of family leave benefits that are available for each covered family leave reason.

(b) The length of family leave benefits available for a covered family leave reason may not be less than two weeks during a period of 52 consecutive calendar weeks.

(c) A group family leave insurance policy may calculate the 52 consecutive calendar weeks by any of the following methods:

(1) a calendar year;

(2) a fixed period starting on a particular date, including an effective or anniversary date;

(3) the period measured forward from the insured's first day of family leave;

(4) a rolling period measured from the insured's first day of family leave; or

(5) any other method that is specified in the policy.

Added by Acts 2023, 88th Leg., R.S., Ch. 703 (H.B. 1996), Sec. 2, eff. September 1, 2023.

Sec. 1255.105. WAITING PERIOD. (a) A group family leave insurance policy must specify whether there is an unpaid waiting period.

(b) If a group family leave insurance policy contains an unpaid waiting period, the terms of the unpaid waiting period may include:

- (1) whether the waiting period runs over a consecutive calendar day period;
- (2) whether the waiting period is counted toward the annual allotment of family leave benefits or is in addition to the annual allotment of family leave benefits;
- (3) whether the waiting period must be met only once per benefit year or must be met for each separate claim for benefits; and
- (4) whether the insured may work or receive paid time off or other compensation by the employer during the waiting period.

Added by Acts 2023, 88th Leg., R.S., Ch. 703 (H.B. 1996), Sec. 2, eff. September 1, 2023.

Sec. 1255.106. AMOUNT OF FAMILY LEAVE BENEFITS; OTHER INCOME.

(a) A group family leave insurance policy must specify:

- (1) the amount of benefits that will be paid for covered family leave reasons;
- (2) the definition of wages or other income on which the amount of family leave benefits is based; and
- (3) the method for calculating those wages or other income.

(b) If the family leave benefits are subject to offsets for wages or other income received by the insured or for which the insured may be eligible, the group family leave insurance policy must specify:

- (1) which wages or other income may be offset; and
- (2) the circumstances under which the wages or other income may be offset.

Added by Acts 2023, 88th Leg., R.S., Ch. 703 (H.B. 1996), Sec. 2, eff. September 1, 2023.

Sec. 1255.107. PERMISSIBLE LIMITATIONS, EXCLUSIONS, OR REDUCTIONS. (a) A group family leave insurance policy that limits, excludes, or reduces eligibility for family leave benefits under this chapter must state the limit, exclusion, or reduction in the policy.

(b) Permissible limitations, exclusions, or reductions in the policy include a limitation, exclusion, or reduction for:

(1) a period of family leave for which the required notice and medical certification have not been provided as prescribed by the policy;

(2) family leave related to a serious health condition or other harm to a family member brought about by the wilful intention of the insured;

(3) a period of family leave during which the insured performed work for compensation or profit;

(4) a period of family leave for which the insured is eligible to receive money from the insured's employer or from a fund to which the employer has contributed;

(5) a period of family leave in which the insured is eligible to receive benefits under another statutory program or employer-sponsored program, including unemployment insurance benefits, workers' compensation benefits, statutory disability benefits, statutory paid leave benefits, or paid time off from the employer's paid leave policy;

(6) a period of family leave beginning before the insured becomes eligible for family leave benefits under the policy; or

(7) periods of family leave during which more than one person covered under the policy seeks family leave for the same family member.

Added by Acts 2023, 88th Leg., R.S., Ch. 703 (H.B. 1996), Sec. 2, eff. September 1, 2023.

Sec. 1255.108. CERTIFICATE OF INSURANCE. (a) An insurer providing family leave insurance shall issue a certificate of insurance to each employee or member of the insured group.

(b) The certificate of insurance must include:

(1) a summary of the essential features of the paid family leave insurance coverage and benefits available to the insured;

(2) the limitations, exclusions, or reductions;

- (3) the annual and lifetime policy limits; and
- (4) the person to whom the benefits are payable.

(c) An insurer may file a certificate issued to an insured in this state for a group policy providing family leave insurance that was delivered or issued for delivery in another state with the department for informational purposes.

(d) An insurer is not required to file or receive approval under Chapter 1701 for a certificate for a foreign group.

Added by Acts 2023, 88th Leg., R.S., Ch. 703 (H.B. 1996), Sec. 2, eff. September 1, 2023.

SUBTITLE C. MANAGED CARE

CHAPTER 1271. BENEFITS PROVIDED BY HEALTH MAINTENANCE ORGANIZATIONS; EVIDENCE OF COVERAGE; CHARGES

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1271.001. APPLICABILITY OF DEFINITIONS. In this chapter, terms defined by Section 843.002 have the meanings assigned by that section.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1271.002. RIGHT TO EVIDENCE OF COVERAGE; ISSUANCE. (a) Each enrollee residing in this state is entitled to evidence of coverage under a health care plan.

(b) The health maintenance organization shall issue the evidence of coverage, except as provided by Subsection (c).

(c) If the enrollee obtains coverage under a health care plan through an insurance policy or a contract issued by a group hospital service corporation, whether by option or otherwise, the insurer or the group hospital service corporation shall issue the evidence of coverage.

(d) By agreement between the health maintenance organization, insurer, or group hospital service corporation and the subscriber or person entitled to receive the evidence of coverage, policy, or contract, the evidence of coverage required by this section may be delivered electronically.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.032(a), eff. September 1, 2005.

Sec. 1271.003. EVIDENCE OF COVERAGE NOT HEALTH INSURANCE POLICY. An evidence of coverage is not a health insurance policy as that term is defined by this code.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1271.004. INDIVIDUAL HEALTH CARE PLAN. (a) In this section, "individual health care plan" means a health care plan:

(1) that provides health care services for individuals and their dependents;

(2) under which an enrollee:

(A) pays the premium; and

(B) is not covered under the contract in accordance with a continuation of services or continuation of benefits requirement applicable under federal or state law; and

(3) in which the evidence of coverage meets the requirements of the definition of "basic health care services" provided by Section 843.002.

(b) A health maintenance organization may provide an individual health care plan in accordance with this section and Section 1271.307.

(c) A health maintenance organization may limit enrollment in an individual health care plan to individuals who reside or work within the service area for the plan's network.

(d) The commissioner may adopt rules necessary to implement this section and to meet the minimum requirements of federal law, including regulations.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1271.005. APPLICABILITY OF OTHER LAW. (a) Chapters 1368 and 1652 apply to a health maintenance organization other than a health maintenance organization that offers only a single health care service plan.

(b) Subchapter B, Chapter 1355, applies to a health maintenance organization providing benefits for mental health treatment in a residential treatment center for children and adolescents or crisis stabilization unit to the extent that:

(1) Subchapter B, Chapter 1355, does not conflict with this chapter, Chapter 843, Subchapter A, Chapter 1452, or Subchapter B, Chapter 1507; and

(2) the residential treatment center for children and adolescents or crisis stabilization unit is located within the service area of the health maintenance organization and is subject to inspection and review as required by this chapter, Chapter 843, Subchapter A, Chapter 1452, or Subchapter B, Chapter 1507, or rules adopted under this chapter, Chapter 843, Subchapter A, Chapter 1452, or Subchapter B, Chapter 1507.

(c) A health maintenance organization shall comply with Subchapter B, Chapter 542, with respect to prompt payment to an enrollee.

(d) Notwithstanding any other law, Subchapter C, Chapter 1355, applies to a group contract issued by a health maintenance organization.

(e) Notwithstanding any other law, Section 1201.062 applies to an evidence of coverage issued by a health maintenance organization.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.074(b), eff. September 1, 2005.

Sec. 1271.006. BENEFITS TO DEPENDENT CHILD AND GRANDCHILD. (a) If children are eligible for coverage under the terms of an evidence of coverage, any limiting age applicable to an unmarried child of an enrollee, including an unmarried grandchild of an enrollee, is 25 years of age. The limiting age applicable to a child must be stated in the evidence of coverage.

(b) A health maintenance organization may provide benefits under a health care plan to an enrollee's dependent grandchild who is living with and in the household of the enrollee.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1271.007. RELIGIOUS CONVICTIONS. (a) This chapter, Chapters 843, 1272, and 1367, Subchapter A, Chapter 1452, and Subchapter B, Chapter 1507, do not require a health maintenance organization, physician, or provider to recommend, offer advice concerning, pay for, provide, assist in, perform, arrange, or participate in providing or performing any health care service that violates the religious convictions of the health maintenance organization, physician, or provider.

(b) A health maintenance organization that limits or denies health care services under this section shall state the limitations in the evidence of coverage as required by Section 1271.052.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.074(c), eff. September 1, 2005.

Text of section effective until September 1, 2025

Sec. 1271.008. BALANCE BILLING PROHIBITION NOTICE. (a) A health maintenance organization shall provide written notice in accordance with this section in an explanation of benefits provided to the enrollee and the physician or provider in connection with a health care service or supply or transport provided by a non-network physician or provider. The notice must include:

(1) a statement of the billing prohibition under Section 1271.155, 1271.157, 1271.158, or 1271.159, as applicable;

(2) the total amount the physician or provider may bill the enrollee under the enrollee's health benefit plan and an itemization of copayments, coinsurance, deductibles, and other amounts included in that total; and

(3) for an explanation of benefits provided to the physician or provider, information required by commissioner rule advising the physician or provider of the availability of mediation or arbitration, as applicable, under Chapter 1467.

(b) A health maintenance organization shall provide the explanation of benefits with the notice required by this section to a physician or health care provider not later than the date the health maintenance organization makes a payment under Section 1271.155, 1271.157, 1271.158, or 1271.159, as applicable.

Added by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 1.02, eff. September 1, 2019.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 981 (S.B. 2476), Sec. 2(a), eff. September 1, 2023.

Acts 2023, 88th Leg., R.S., Ch. 981 (S.B. 2476), Sec. 2(b), eff. September 1, 2025.

Text of section effective on September 1, 2025

Sec. 1271.008. BALANCE BILLING PROHIBITION NOTICE. (a) A health maintenance organization shall provide written notice in accordance with this section in an explanation of benefits provided to the enrollee and the physician or provider in connection with a health care service or supply provided by a non-network physician or provider. The notice must include:

(1) a statement of the billing prohibition under Section 1271.155, 1271.157, or 1271.158, as applicable;

(2) the total amount the physician or provider may bill the enrollee under the enrollee's health benefit plan and an itemization of copayments, coinsurance, deductibles, and other amounts included in that total; and

(3) for an explanation of benefits provided to the physician or provider, information required by commissioner rule advising the physician or provider of the availability of mediation or arbitration, as applicable, under Chapter 1467.

(b) A health maintenance organization shall provide the explanation of benefits with the notice required by this section to a physician or health care provider not later than the date the health maintenance organization makes a payment under Section 1271.155, 1271.157, or 1271.158, as applicable.

Added by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 1.02, eff. September 1, 2019.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 981 (S.B. 2476), Sec. 2(a), eff. September 1, 2023.

Acts 2023, 88th Leg., R.S., Ch. 981 (S.B. 2476), Sec. 2(b), eff. September 1, 2025.

SUBCHAPTER B. CONTENTS OF EVIDENCE OF COVERAGE

Sec. 1271.051. EVIDENCE OF COVERAGE: CONTRACT AND CERTIFICATE REQUIREMENTS. (a) An evidence of coverage that is a contract must contain a clear and complete statement of the information required by Sections 1271.052, 1271.053, and 1271.054.

(b) An evidence of coverage that is a certificate must contain a reasonably complete facsimile of the information required by Sections 1271.052, 1271.053, and 1271.054.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1271.052. INFORMATION ABOUT BENEFITS AND LIMITATIONS. An evidence of coverage must state:

(1) the health care services, limited health care services, or single health care service to which the enrollee is entitled under the health care plan, limited health care service plan, or single health care service plan;

(2) the issuance of other benefits, if any, to which the enrollee is entitled under the health care plan, limited health care service plan, or single health care service plan; and

(3) any limitation on the services, kinds of services, benefits, or kinds of benefits to be provided, including any deductible or copayment feature.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1271.053. INFORMATION ABOUT OBTAINING SERVICES. An evidence of coverage must indicate where and in what manner information is available about how to obtain services.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1271.054. INFORMATION ABOUT COMPLAINTS AND APPEALS. (a) An evidence of coverage must contain a clear and understandable description of the health maintenance organization's methods for resolving enrollee complaints, including:

(1) the enrollee's right to appeal denial of an adverse determination to an independent review organization; and

(2) the procedures for appealing to an independent review organization.

(b) A health maintenance organization may indicate a subsequent change to the methods for resolving enrollee complaints in a separate document issued to the enrollee.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1271.055. OUT-OF-NETWORK SERVICES. (a) An evidence of coverage must contain a provision regarding non-network physicians and providers in accordance with the requirements of this section.

(b) If medically necessary covered services are not available through network physicians or providers, the health maintenance organization, on the request of a network physician or provider and within a reasonable period, shall:

(1) allow referral to a non-network physician or provider; and

(2) fully reimburse the non-network physician or provider at the usual and customary rate or at an agreed rate.

(c) Before denying a request for a referral to a non-network physician or provider, a health maintenance organization must provide for a review conducted by a specialist of the same or similar type of specialty as the physician or provider to whom the referral is requested.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1271.056. UNFAIR OR DECEPTIVE PROVISIONS AND STATEMENTS PROHIBITED. An evidence of coverage may not contain a provision or statement that:

(1) is unjust, unfair, inequitable, misleading, or deceptive;

(2) encourages misrepresentation; or

(3) is untrue, misleading, or deceptive within the meaning of Section 843.204.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1271.057. DISCRETIONARY CLAUSES PROHIBITED. (a) An evidence of coverage may not contain a discretionary clause provision.

(b) A discretionary clause provision includes a provision that:

(1) purports or acts to bind the enrollee to, or grant deference in subsequent proceedings to, adverse eligibility or benefit decisions or interpretations of the evidence of coverage by the health maintenance organization; or

(2) specifies:

(A) that an enrollee or other claimant may not contest or appeal a denial of a benefit;

(B) that the health maintenance organization's interpretation of the terms of an evidence of coverage or other form or its decision to deny coverage or the amount of benefits is binding on an enrollee or other claimant;

(C) that in an appeal, the health maintenance organization's decision-making power as to the interpretation of the terms of an evidence of coverage or other form, or as to coverage, is binding; or

(D) a standard of review in any appeal process that gives deference to the original benefit decision or provides standards of interpretation or review that are inconsistent with the laws of this state, including the common law.

Added by Acts 2011, 82nd Leg., R.S., Ch. 560 (H.B. 3017), Sec. 1, eff. June 17, 2011.

SUBCHAPTER C. COMMISSIONER APPROVAL

Sec. 1271.101. APPROVAL OF FORM OF EVIDENCE OF COVERAGE OR GROUP CONTRACT. (a) An evidence of coverage or an amendment of an evidence of coverage may not be issued or delivered to a person in this state until the form of the evidence of coverage or amendment has been filed with and approved by the commissioner.

(b) Except as provided by Subsection (c), the form of an evidence of coverage or group contract to be used in this state or an amendment to one of those forms is subject to the filing and approval requirements of Section 1271.102.

(c) If the form of an evidence of coverage or group contract or of an amendment to one of those forms is subject to the jurisdiction

of the commissioner under laws governing health insurance or group hospital service corporations, the filing and approval provisions of those laws apply to that form. However, Subchapters B and E apply to that form to the extent that laws governing health insurance or group hospital service corporations do not apply to the requirements of Subchapters B and E.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1271.102. PROCEDURES FOR APPROVAL OF FORM OF EVIDENCE OF COVERAGE OR GROUP CONTRACT; WITHDRAWAL OF APPROVAL. (a) The commissioner shall, within a reasonable period, approve the form of an evidence of coverage or group contract or an amendment to one of those forms if the form meets the requirements of this chapter.

(b) If the commissioner does not disapprove a form before the 31st day after the date the form is filed, the form is considered approved. The commissioner may, by written notice, extend the period for approval or disapproval as necessary for proper consideration of the filing for not more than an additional 30 days.

(c) If the commissioner disapproves a form, the commissioner shall notify the person who filed the form of the reason for the disapproval.

(d) A hearing on the disapproval of a form shall be granted not later than the 30th day after the date the person filing the form makes a written request for a hearing.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1271.103. WITHDRAWAL OF APPROVAL OF FORM. (a) After notice and opportunity for hearing, the commissioner may withdraw approval of the form of an evidence of coverage or group contract or an amendment to one of those forms if the commissioner determines that the form violates this chapter, Chapter 843, 1272, or 1367, Subchapter A, Chapter 1452, or Subchapter B, Chapter 1507, or a rule adopted by the commissioner.

(b) If the commissioner withdraws approval of a form under this section, the form may not be issued until it is approved.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.074(d), eff. September 1, 2005.

Sec. 1271.104. INFORMATION REQUIRED BY COMMISSIONER. The commissioner may require the submission of any relevant information the commissioner considers necessary in determining whether to approve or disapprove a filing under this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

SUBCHAPTER D. CERTAIN BENEFITS REQUIRED

Sec. 1271.151. PROVISION OF BASIC HEALTH CARE SERVICES. A health maintenance organization that offers a basic health care plan shall provide or arrange for basic health care services to its enrollees as needed and without limitation as to time and cost other than any limitation prescribed by rule of the commissioner.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1271.152. STANDARDS FOR BASIC HEALTH CARE SERVICES. The commissioner may adopt minimum standards relating to basic health care services.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1271.153. PERIODIC HEALTH EVALUATIONS. (a) The basic health care services provided under an evidence of coverage must include periodic health evaluations for each adult enrollee.

(b) The services provided under this section must include a health risk assessment at least once every three years and, for a female enrollee, an annual well-woman examination provided in accordance with Subchapter F, Chapter 1451.

(c) This section does not apply to an evidence of coverage for a limited health care service plan or a single health care service plan.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1271.154. WELL-CHILD CARE FROM BIRTH. (a) In this section, "well-child care from birth" has the meaning used under Section 1302, Public Health Service Act (42 U.S.C. Section 300e-1), and its subsequent amendments. The term includes administration of newborn screening required by the Department of State Health Services and the cost of the newborn screening test kit described by Section 33.019, Health and Safety Code.

(b) A health maintenance organization shall ensure that each health care plan provided by the health maintenance organization includes well-child care from birth that complies with:

(1) federal requirements adopted under Chapter XI, Public Health Service Act (42 U.S.C. Section 300e et seq.), and its subsequent amendments; and

(2) the rules adopted by the executive commissioner of the Health and Human Services Commission to implement those requirements, including rules on the cost of the newborn screening test kit described by Section 33.019, Health and Safety Code.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2019, 86th Leg., R.S., Ch. 599 (S.B. 747), Sec. 4, eff. September 1, 2019.

Sec. 1271.155. EMERGENCY CARE. (a) A health maintenance organization shall pay for emergency care performed by non-network physicians or providers at the usual and customary rate or at an agreed rate.

(b) A health care plan of a health maintenance organization must provide the following coverage of emergency care:

(1) a medical screening examination or other evaluation required by state or federal law necessary to determine whether an emergency medical condition exists shall be provided to covered enrollees in a hospital emergency facility or comparable facility;

(2) necessary emergency care shall be provided to covered enrollees, including the treatment and stabilization of an emergency medical condition;

(3) services originated in a hospital emergency facility, freestanding emergency medical care facility, or comparable emergency facility following treatment or stabilization of an emergency medical condition shall be provided to covered enrollees as approved by the health maintenance organization, subject to Subsections (c) and (d); and

(4) supplies related to a service described by this subsection shall be provided to covered enrollees.

(c) A health maintenance organization shall approve or deny coverage of poststabilization care as requested by a treating physician or provider within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but not to exceed one hour from the time of the request.

(d) A health maintenance organization shall respond to inquiries from a treating physician or provider in compliance with this provision in the health care plan of the health maintenance organization.

(e) A health care plan of a health maintenance organization shall comply with this section regardless of whether the physician or provider furnishing the emergency care has a contractual or other arrangement with the health maintenance organization to provide items or services to covered enrollees.

(f) For emergency care subject to this section or a supply related to that care, a health maintenance organization shall make a payment required by Subsection (a) directly to the non-network physician or provider not later than, as applicable:

(1) the 30th day after the date the health maintenance organization receives an electronic clean claim as defined by Section 843.336 for those services that includes all information necessary for the health maintenance organization to pay the claim; or

(2) the 45th day after the date the health maintenance organization receives a nonelectronic clean claim as defined by Section 843.336 for those services that includes all information necessary for the health maintenance organization to pay the claim.

(g) For emergency care subject to this section or a supply related to that care, a non-network physician or provider or a person asserting a claim as an agent or assignee of the physician or provider may not bill an enrollee in, and the enrollee does not have financial responsibility for, an amount greater than an applicable

copayment, coinsurance, and deductible under the enrollee's health care plan that:

(1) is based on:

(A) the amount initially determined payable by the health maintenance organization; or

(B) if applicable, a modified amount as determined under the health maintenance organization's internal appeal process; and

(2) is not based on any additional amount determined to be owed to the physician or provider under Chapter 1467.

(h) This section may not be construed to require the imposition of a penalty under Section 843.342.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1273 (H.B. 1357), Sec. 3, eff. March 1, 2010.

Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 1.03, eff. September 1, 2019.

Sec. 1271.156. BENEFITS FOR REHABILITATION SERVICES AND THERAPIES. (a) If benefits are provided for rehabilitation services and therapies under an evidence of coverage, the provision of a rehabilitation service or therapy that, in the opinion of a physician, is medically necessary may not be denied, limited, or terminated if the service or therapy meets or exceeds treatment goals for the enrollee.

(b) For an enrollee with a physical disability, treatment goals may include maintenance of functioning or prevention of or slowing of further deterioration.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1271.157. NON-NETWORK FACILITY-BASED PROVIDERS. (a) In this section, "facility-based provider" means a physician or provider who provides health care services to patients of a health care facility.

(b) Except as provided by Subsection (d), a health maintenance organization shall pay for a covered health care service performed

for or a covered supply related to that service provided to an enrollee by a non-network physician or provider who is a facility-based provider at the usual and customary rate or at an agreed rate if the provider performed the service at a health care facility that is a network provider. The health maintenance organization shall make a payment required by this subsection directly to the physician or provider not later than, as applicable:

(1) the 30th day after the date the health maintenance organization receives an electronic clean claim as defined by Section 843.336 for those services that includes all information necessary for the health maintenance organization to pay the claim; or

(2) the 45th day after the date the health maintenance organization receives a nonelectronic clean claim as defined by Section 843.336 for those services that includes all information necessary for the health maintenance organization to pay the claim.

(c) Except as provided by Subsection (d), a non-network facility-based provider or a person asserting a claim as an agent or assignee of the provider may not bill an enrollee receiving a health care service or supply described by Subsection (b) in, and the enrollee does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, and deductible under the enrollee's health care plan that:

(1) is based on:

(A) the amount initially determined payable by the health maintenance organization; or

(B) if applicable, a modified amount as determined under the health maintenance organization's internal appeal process; and

(2) is not based on any additional amount determined to be owed to the provider under Chapter 1467.

(d) This section does not apply to a nonemergency health care or medical service:

(1) that an enrollee elects to receive in writing in advance of the service with respect to each non-network physician or provider providing the service; and

(2) for which a non-network physician or provider, before providing the service, provides a complete written disclosure to the enrollee that:

(A) explains that the physician or provider does not have a contract with the enrollee's health benefit plan;

(B) discloses projected amounts for which the enrollee may be responsible; and

(C) discloses the circumstances under which the enrollee would be responsible for those amounts.

(e) This section may not be construed to require the imposition of a penalty under Section 843.342.

Added by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 1.04, eff. September 1, 2019.

Sec. 1271.158. NON-NETWORK DIAGNOSTIC IMAGING PROVIDER OR LABORATORY SERVICE PROVIDER. (a) In this section, "diagnostic imaging provider" and "laboratory service provider" have the meanings assigned by Section 1467.001.

(b) Except as provided by Subsection (d), a health maintenance organization shall pay for a covered health care service performed by or a covered supply related to that service provided to an enrollee by a non-network diagnostic imaging provider or laboratory service provider at the usual and customary rate or at an agreed rate if the provider performed the service in connection with a health care service performed by a network physician or provider. The health maintenance organization shall make a payment required by this subsection directly to the physician or provider not later than, as applicable:

(1) the 30th day after the date the health maintenance organization receives an electronic clean claim as defined by Section 843.336 for those services that includes all information necessary for the health maintenance organization to pay the claim; or

(2) the 45th day after the date the health maintenance organization receives a nonelectronic clean claim as defined by Section 843.336 for those services that includes all information necessary for the health maintenance organization to pay the claim.

(c) Except as provided by Subsection (d), a non-network diagnostic imaging provider or laboratory service provider or a person asserting a claim as an agent or assignee of the provider may not bill an enrollee receiving a health care service or supply described by Subsection (b) in, and the enrollee does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, and deductible under the enrollee's health

care plan that:

(1) is based on:

(A) the amount initially determined payable by the health maintenance organization; or

(B) if applicable, a modified amount as determined under the health maintenance organization's internal appeal process; and

(2) is not based on any additional amount determined to be owed to the provider under Chapter 1467.

(d) This section does not apply to a nonemergency health care or medical service:

(1) that an enrollee elects to receive in writing in advance of the service with respect to each non-network physician or provider providing the service; and

(2) for which a non-network physician or provider, before providing the service, provides a complete written disclosure to the enrollee that:

(A) explains that the physician or provider does not have a contract with the enrollee's health benefit plan;

(B) discloses projected amounts for which the enrollee may be responsible; and

(C) discloses the circumstances under which the enrollee would be responsible for those amounts.

(e) This section may not be construed to require the imposition of a penalty under Section 843.342.

Added by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. [1264](#)), Sec. 1.04, eff. September 1, 2019.

For expiration of this section, see Subsection (g).

Sec. 1271.159. NON-NETWORK EMERGENCY MEDICAL SERVICES PROVIDER.

(a) In this section, "emergency medical services provider" has the meaning assigned by Section 773.003, Health and Safety Code, except that the term does not include an air ambulance.

(b) Except as provided by Subsection (c), a health maintenance organization shall pay for a covered health care service performed for, or a covered supply or covered transport related to that service provided to, an enrollee by a non-network emergency medical services provider at:

(1) if the political subdivision has submitted the rate to the department under Section 38.006, the rate set, controlled, or regulated by the political subdivision in which:

- (A) the service originated; or
- (B) the transport originated if transport is provided;

or

(2) if the political subdivision has not submitted the rate to the department, the lesser of:

- (A) the provider's billed charge; or
- (B) 325 percent of the current Medicare rate, including any applicable extenders and modifiers.

(c) A health maintenance organization shall adjust a payment required by Subsection (b)(1) each plan year by increasing the payment by the lesser of the Medicare Inflation Index or 10 percent of the provider's previous calendar year rates.

(d) The health maintenance organization shall make a payment required by this section directly to the provider not later than, as applicable:

(1) the 30th day after the date the health maintenance organization receives an electronic clean claim as defined by Section 843.336 for those services that includes all information necessary for the health maintenance organization to pay the claim; or

(2) the 45th day after the date the health maintenance organization receives a nonelectronic clean claim as defined by Section 843.336 for those services that includes all information necessary for the health maintenance organization to pay the claim.

(e) A non-network emergency medical services provider or a person asserting a claim as an agent or assignee of the provider may not bill an enrollee receiving a health care service or supply or transport described by Subsection (b) in, and the enrollee does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, and deductible under the enrollee's health care plan that is based on:

(1) the amount initially determined payable by the health maintenance organization; or

(2) if applicable, a modified amount as determined under the health maintenance organization's internal appeal process.

(f) This section may not be construed to require the imposition of a penalty under Section 843.342.

(g) This section expires September 1, 2025.

Added by Acts 2023, 88th Leg., R.S., Ch. 981 (S.B. 2476), Sec. 3, eff. September 1, 2023.

SUBCHAPTER E. CHOICE OF PRIMARY CARE PHYSICIAN FOR CERTAIN ENROLLEES

Sec. 1271.201. DESIGNATION OF SPECIALIST AS PRIMARY CARE PHYSICIAN. (a) An evidence of coverage must provide that an enrollee with a chronic, disabling, or life-threatening illness may apply to the health maintenance organization's medical director to use a nonprimary care physician specialist as the enrollee's primary care physician.

(b) The application must:

- (1) include information specified by the health maintenance organization, including certification of the medical need; and
- (2) be signed by the enrollee and the nonprimary care physician specialist interested in serving as the enrollee's primary care physician.

(c) To be eligible to serve as the enrollee's primary care physician, a physician specialist must:

- (1) meet the health maintenance organization's requirements for primary care physician participation; and
- (2) agree to accept the responsibility to coordinate all of the enrollee's health care needs.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1271.202. APPEAL. If a health maintenance organization denies a request under Section 1271.201, the enrollee may appeal the decision through the health maintenance organization's established complaint and appeals process.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1271.203. EFFECTIVE DATE OF DESIGNATION. (a) The effective date of the designation of a nonprimary care physician specialist as an enrollee's primary care physician under Section 1271.201 may not be applied retroactively.

(b) A health maintenance organization may not reduce the amount of compensation owed to the original primary care physician for

services provided before the date of the new designation.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

SUBCHAPTER F. SCHEDULE OF CHARGES

Sec. 1271.251. APPROVAL OF FORMULA OR METHOD FOR COMPUTING SCHEDULE OF CHARGES. (a) The formula or method for computing the schedule of charges for enrollee coverage for health care services must be filed with the commissioner before the formula or method is used in conjunction with a health care plan.

(b) The formula or method must be established in accordance with actuarial principles for the various categories of enrollees. The filing of the method or formula must contain:

(1) a statement by a qualified actuary that certifies that the formula or method is appropriate; and

(2) supporting information that the commissioner considers adequate.

(c) The formula or method must produce charges that are not excessive, inadequate, or unfairly discriminatory. Benefits must be reasonable with respect to the rates produced by the formula or method.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1271.252. CONSIDERATION OF INDIVIDUAL HEALTH STATUS PROHIBITED. The charges resulting from the application of a formula or method described by Section 1271.251 may not be altered for an individual enrollee based on the status of that enrollee's health.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1271.253. INFORMATION REQUIRED BY COMMISSIONER. The commissioner may require the submission of any relevant information the commissioner considers necessary in determining whether to approve or disapprove a filing under this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

**SUBCHAPTER G. CONTINUATION OF COVERAGE, CONVERSION CONTRACTS, AND
RENEWAL**

Sec. 1271.301. ENTITLEMENT TO CONTINUATION OF GROUP COVERAGE.

(a) In this section, "involuntary termination for cause" does not include termination for any health-related reason.

(b) A health maintenance organization shall provide a group coverage continuation privilege as required by and subject to the eligibility provisions of this subchapter.

(c) An enrollee is entitled to continue group coverage as provided by this subchapter if:

(1) the enrollee's coverage under a group contract is terminated for any reason except involuntary termination for cause; and

(2) the enrollee for at least three consecutive months immediately before the termination of coverage has been continuously covered under the group contract and under any previous group contract providing similar services and benefits that the current group contract replaced.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1271.302. REQUEST FOR CONTINUED COVERAGE; DEADLINE. An enrollee must provide to the employer or group contract holder a written notice of election to continue group coverage under this subchapter not later than the 60th day after the later of:

(1) the date the group coverage would otherwise terminate; or

(2) the date the enrollee is given notice of the right of continuation by the employer or group contract holder.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 550 (S.B. 1771), Sec. 5, eff. June 19, 2009.

Sec. 1271.303. PAYMENT FOR CONTINUED COVERAGE. (a) An enrollee electing continuation of group coverage must pay to the employer or group contract holder the amount of contribution required by the employer or group contract holder, plus an amount equal to two

percent of the group rate for the coverage being continued under the group contract.

(b) The enrollee must make the payment not later than the 45th day after the initial election for coverage and on the due date of each payment thereafter. Following the first payment made after the initial election for coverage, the payment of any other premium shall be considered timely if made by the 30th day after the date on which payment is due.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 550 (S.B. 1771), Sec. 6, eff. June 19, 2009.

Sec. 1271.304. TERMINATION OF CONTINUED COVERAGE. Group continued coverage under this subchapter may not terminate until the earliest of:

(1) the date the maximum continuation period provided by law would end, which is:

(A) for any enrollee not eligible for continuation coverage under Title X, Consolidated Omnibus Budget Reconciliation Act of 1985 (29 U.S.C. Section 1161 et seq.) (COBRA), the end of the nine-month period after the date the election to continue coverage is made; or

(B) for any enrollee eligible for continuation coverage under COBRA, six additional months following any period of continuation provided under that statute;

(2) the date on which failure to make timely payments terminates coverage;

(3) the date on which the enrollee is covered for similar services and benefits by any other plan or program, including a hospital, surgical, medical, or major medical expense insurance policy, hospital or medical service subscriber contract, or medical practice or other prepayment plan; or

(4) the date on which the group coverage terminates in its entirety.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 550 (S.B. 1771), Sec. 7, eff.

June 19, 2009.

Sec. 1271.306. CONVERSION CONTRACTS. (a) A health maintenance organization may offer to each enrollee a conversion contract.

(b) A health maintenance organization shall issue the conversion contract without evidence of insurability if written application for the contract and payment of the first premium are made not later than the 31st day after the date of termination of coverage.

(c) A conversion contract must meet the minimum standards for services and benefits for conversion contracts. The commissioner shall adopt rules to prescribe the minimum standards for services and benefits applicable to conversion contracts.

(d) The premium for a conversion contract shall be determined in accordance with the health maintenance organization's premium rates for coverage provided under the group contract or plan. The premium may be based on the geographic location of each person to be covered and must be based on the type of conversion contract and the coverage provided by the contract. The premium may not exceed 200 percent of the premium rates for the same coverage provided under a group contract or plan.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1271.307. RENEWABILITY OF COVERAGE: INDIVIDUAL HEALTH CARE PLANS AND CONVERSION CONTRACTS. (a) In this section, "individual health care plan" has the meaning assigned by Section 1271.004.

(b) An individual health care plan or a conversion contract that provides health care services to an enrollee is renewable at the option of the enrollee. A health maintenance organization may decline to renew an individual health care plan or conversion contract only:

(1) for failure to pay premiums or contributions in accordance with the terms of the plan or because the issuer of the plan has not received timely premium payments;

(2) for fraud or intentional misrepresentation;

(3) because the health maintenance organization ceases to

offer coverage in the individual market in accordance with rules established by the commissioner;

(4) because the enrollee no longer resides or works in the area in which the health maintenance organization is authorized to provide coverage, if coverage under the plan is terminated uniformly for this reason without regard to any factor related to the health status of a covered enrollee; or

(5) in accordance with applicable federal law, including regulations.

(c) The commissioner may adopt rules necessary to implement this section and to meet the minimum requirements of federal law, including regulations.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

CHAPTER 1272. DELEGATION OF CERTAIN FUNCTIONS BY HEALTH MAINTENANCE ORGANIZATION

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1272.001. DEFINITIONS. (a) In this chapter:

(1) "Delegated entity" means an entity, other than a health maintenance organization authorized to engage in business under Chapter 843, that by itself, or through subcontracts with one or more entities, undertakes to arrange for or provide medical care or health care to an enrollee in exchange for a predetermined payment on a prospective basis and that accepts responsibility for performing on behalf of the health maintenance organization a function regulated by this chapter, Chapter 222, 251, or 258, as applicable to a health maintenance organization, Chapter 843 or 1271, Section 1367.053, Subchapter A, Chapter 1452, or Subchapter B, Chapter 1507. The term does not include:

(A) an individual physician; or

(B) a group of employed physicians, practicing medicine under one federal tax identification number, whose total claims paid to providers not employed by the group constitute less than 20 percent of the group's total collected revenue computed on a calendar year basis.

(2) "Delegated network" means a delegated entity that assumes total financial risk for more than one of the following categories of health care services: medical care, hospital or other

institutional services, or prescription drugs, as defined by Section 551.003, Occupations Code. The term does not include a delegated entity that shares risk for a category of services with a health maintenance organization.

(3) "Delegated third party" means a third party other than a delegated entity that contracts with a delegated entity, either directly or through another third party, to:

(A) accept responsibility for performing a function regulated by this chapter, Chapter 222, 251, or 258, as applicable to a health maintenance organization, Chapter 843 or 1271, Section 1367.053, Subchapter A, Chapter 1452, or Subchapter B, Chapter 1507; or

(B) receive, handle, or administer funds, if the receipt, handling, or administration is directly or indirectly related to a function regulated by this chapter, Chapter 222, 251, or 258, as applicable to a health maintenance organization, Chapter 843 or 1271, Section 1367.053, Subchapter A, Chapter 1452, or Subchapter B, Chapter 1507.

(4) "Delegation agreement" means an agreement by which a health maintenance organization assigns the responsibility for a function regulated by this chapter, Chapter 222, 251, or 258, as applicable to a health maintenance organization, Chapter 843 or 1271, Section 1367.053, Subchapter A, Chapter 1452, or Subchapter B, Chapter 1507.

(5) "Limited provider network" means a subnetwork within a health maintenance organization delivery network in which contractual relationships exist between physicians, certain providers, independent physician associations, or physician groups that limits an enrollee's access to physicians and providers to those physicians and providers in the subnetwork.

(b) In this chapter, terms defined by Section 843.002 have the meanings assigned by that section.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.074(e), eff. September 1, 2005.

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.02701, eff. September 1, 2007.

Sec. 1272.002. COMPLIANCE OF LIMITED PROVIDER NETWORK OR DELEGATED ENTITY WITH CERTAIN LEGAL REQUIREMENTS. A limited provider network or delegated entity shall comply with each statutory or regulatory requirement that relates to a function assumed by or carried out by the network or entity under this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

SUBCHAPTER B. DELEGATION AGREEMENTS

Sec. 1272.051. APPLICABILITY OF SUBCHAPTER. This subchapter does not apply to a group model health maintenance organization, as defined by Section 843.111.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1272.052. DELEGATION AGREEMENT REQUIRED. (a) A health maintenance organization that delegates a function required by this chapter, Chapter 843, 1271, or 1367, Subchapter A, Chapter 1452, or Subchapter B, Chapter 1507, shall execute a written delegation agreement with the entity to which the function is delegated.

(b) The health maintenance organization shall file the delegation agreement with the department not later than the 30th day after the date the agreement is executed.

(c) The parties to the delegation agreement shall determine which party bears the expense of complying with a requirement of this subchapter, including the cost of an examination required by the department under Subchapter B, Chapter 401, if applicable.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.074(f), eff. September 1, 2005.

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2G.002, eff. April 1, 2009.

Sec. 1272.053. MONITORING PLAN. A delegation agreement required by Section 1272.052 must establish a monitoring plan that:

(1) allows the health maintenance organization to monitor

compliance with the minimum solvency requirements established under Subchapter D, if applicable; and

(2) includes:

(A) a description of financial practices that will ensure that the delegated entity tracks and reports liabilities that have been incurred but not reported;

(B) a summary of the total amount paid by the entity to physicians and providers on a monthly basis; and

(C) a summary of complaints from physicians, providers, and enrollees regarding delays in payment or nonpayment of claims, including the status of each complaint, on a monthly basis.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1272.054. REQUIREMENTS FOR TERMINATION WITHOUT CAUSE. A delegation agreement required by Section 1272.052 must provide that the agreement cannot be terminated without cause by the delegated entity or the health maintenance organization unless the party terminating the agreement provides written notice before the 90th day before the termination date.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1272.055. COLLECTION OF PAYMENTS. A delegation agreement required by Section 1272.052 must prohibit the delegated entity and the physicians and providers with whom the entity has contracted from billing or attempting to collect from an enrollee under any circumstance, including the insolvency of the health maintenance organization or entity, payments for covered services other than authorized copayments and deductibles.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1272.056. COMPLIANCE WITH STATUTORY AND REGULATORY REQUIREMENTS. A delegation agreement required by Section 1272.052 must provide that:

(1) the agreement does not limit in any way the health maintenance organization's authority or responsibility, including

financial responsibility, to comply with each statutory or regulatory requirement; and

(2) the delegated entity shall comply with each statutory or regulatory requirement relating to a function assumed by or carried out by the entity.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1272.057. EXAMINATION BY COMMISSIONER. A delegation agreement required by Section 1272.052 must require the delegated entity to permit the commissioner to examine at any time any information the commissioner reasonably believes is relevant to:

(1) the financial solvency of the entity; or

(2) the ability of the entity to meet the entity's responsibilities in connection with any function delegated to the entity by the health maintenance organization.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1272.058. INFORMATION RELATING TO DELEGATED THIRD PARTY. A delegation agreement required by Section 1272.052 must require the delegated entity to provide the license number of a delegated third party performing a function that requires:

(1) a license as a third-party administrator under Chapter 4151 or utilization review agent under Chapter 4201; or

(2) another license under this code or another insurance law of this state.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 2G.003, eff. April 1, 2009.

Sec. 1272.059. CONTRACTS WITH DELEGATED THIRD PARTY. A delegation agreement required by Section 1272.052 must provide that:

(1) any agreement under which the delegated entity directly or indirectly delegates a function required by this chapter, Chapter 843, 1271, or 1367, Subchapter A, Chapter 1452, or Subchapter B,

Chapter 1507, including the handling of funds, if applicable, to a delegated third party must be in writing; and

(2) the delegated entity, in contracting with a delegated third party directly or through a third party, shall require the delegated third party to comply with the requirements of Section 1272.057 and any rules adopted by the commissioner implementing that section.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.074(g), eff. September 1, 2005.

Sec. 1272.060. UTILIZATION REVIEW. A delegation agreement required by Section 1272.052 must provide that:

(1) enrollees shall receive notification at the time of enrollment of which entity is responsible for performing utilization review;

(2) the delegated entity or third party performing utilization review shall perform that review in accordance with Chapter 4201; and

(3) the delegated entity or third party shall forward utilization review decisions made by the entity or third party to the health maintenance organization on a monthly basis.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2G.004, eff. April 1, 2009.

Sec. 1272.061. RIGHTS AND DUTIES OF DELEGATED ENTITY AND HEALTH MAINTENANCE ORGANIZATION. A delegation agreement required by Section 1272.052 must provide that the delegated entity acknowledges and agrees that:

(1) the health maintenance organization:

(A) is required to establish, operate, and maintain a health care delivery system, quality assurance system, provider credentialing system, and other systems and programs that meet statutory and regulatory standards;

(B) is directly accountable for compliance with those standards; and

(C) is not precluded from contractually requesting that the delegated entity provide proof of financial viability;

(2) the role of another delegated entity with which the delegated entity subcontracts through a delegated third party is limited to performing certain delegated functions of the health maintenance organization, using standards that are approved by the health maintenance organization and that are in compliance with applicable statutes and rules and subject to the health maintenance organization's oversight and monitoring of the entity's performance; and

(3) if the delegated entity fails to meet monitoring standards established to ensure that functions delegated or assigned to the entity under the delegation agreement are in full compliance with all statutory and regulatory requirements, the health maintenance organization may cancel delegation of any or all delegated functions.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1272.062. INFORMATION TO BE PROVIDED BY DELEGATED ENTITY TO HEALTH MAINTENANCE ORGANIZATION. (a) A delegation agreement required by Section 1272.052 must provide that:

(1) except as provided by Subsection (b), the delegated entity shall make available to the health maintenance organization samples of contracts with physicians and providers to ensure compliance with the contractual requirements described by Sections 1272.054 and 1272.055; and

(2) the delegated entity shall provide to the health maintenance organization, in a format usable for audit purposes and not more frequently than quarterly unless otherwise specified in the delegation agreement, the data necessary for the health maintenance organization to comply with the department's reporting requirements with respect to any delegated functions performed under the delegation agreement, including:

(A) a summary describing the methods, including capitation, fee-for-service, or other risk arrangements, that the delegated entity used to pay the entity's physicians and providers,

and including the percentage of physicians and providers paid for each payment category;

(B) the period that claims and debts for medical services owed by the delegated entity have been pending and the aggregate dollar amount of those claims and debts;

(C) information to enable the health maintenance organization to file claims for reinsurance, coordination of benefits, and subrogation, if required by the delegation agreement; and

(D) documentation, except for information, documents, and deliberations related to peer review that are confidential or privileged under Subchapter A, Chapter 160, Occupations Code, that relates to:

(i) a regulatory agency's inquiry or investigation of the delegated entity or an individual physician or provider with whom the entity contracts that relates to an enrollee of the health maintenance organization; and

(ii) the final resolution of a regulatory agency's inquiry or investigation.

(b) A delegation agreement may not require a delegated entity to make available to the health maintenance organization contractual provisions relating to financial arrangements with the entity's physicians and providers.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1272.063. ENROLLEE COMPLAINTS. (a) A delegation agreement required by Section 1272.052 must provide that:

(1) if the delegated entity receives a complaint that does not involve emergency care, the entity shall report the complaint to the health maintenance organization not later than the second business day after the date the entity receives the complaint; and

(2) if the delegated entity receives a complaint involving emergency care, the entity shall immediately forward the complaint to the health maintenance organization.

(b) Subsection (a) does not prohibit a delegated entity from attempting to resolve a complaint.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1272.064. RULES. The commissioner may adopt rules as necessary to implement this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

SUBCHAPTER C. INFORMATION REPORTING TO DELEGATED ENTITY

Sec. 1272.101. APPLICABILITY OF SUBCHAPTER. This subchapter does not apply to a group model health maintenance organization, as defined by Section 843.111.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1272.102. REPORTING REQUIRED. (a) The commissioner shall determine the information a health maintenance organization shall provide to a delegated entity with which the health maintenance organization has entered into a delegation agreement.

(b) The information must include:

(1) for each enrollee who is eligible or assigned to receive services from the delegated entity:

(A) the enrollee's name, birth date or social security number, age, and sex;

(B) the benefit plan and any riders to that plan that are applicable to the enrollee; and

(C) the enrollee's employer;

(2) the name and birth date or social security number of each enrollee added or terminated since the health maintenance organization last provided the information;

(3) if the health maintenance organization pays any claims on behalf of the delegated entity, a summary of the number and amount of:

(A) claims paid during the previous reporting period; and

(B) pharmacy prescriptions paid for each enrollee during the previous reporting period for which the delegated entity has taken partial risk;

(4) information that enables the delegated entity to file claims for reinsurance, coordination of benefits, and subrogation;

(5) patient complaint data that relates to the delegated entity;

(6) detailed risk-pool data, reported quarterly and on settlement;

(7) if hospital or facility costs impact the delegated entity's costs, the percent of premium attributable to hospital or facility costs, reported quarterly; and

(8) if there are changes in hospital or facility contracts with the health maintenance organization, the projected impact of those changes on the percent of premium attributable to hospital and facility costs during the 30-day period following those changes.

(c) Notwithstanding Subsection (b)(3), a delegated entity may, on request, receive additional nonproprietary information regarding claims paid by a health maintenance organization on behalf of the entity.

(d) A health maintenance organization shall provide information required under Subsections (b)(1)-(5) in standard electronic format at least monthly unless the delegation agreement provides otherwise.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1272.103. RULES. The commissioner may adopt rules as necessary to implement this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

SUBCHAPTER D. RESERVE REQUIREMENTS

Sec. 1272.151. APPLICABILITY OF SUBCHAPTER. This subchapter does not apply to a group model health maintenance organization, as defined by Section 843.111.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1272.152. GENERAL RESERVE REQUIREMENTS. (a) A delegated network shall maintain reserves adequate for the liabilities and risks assumed by the network, as computed in accordance with accepted standards, practices, and procedures relating to the liabilities and risks for which the reserves are maintained, including known and unknown components and anticipated expenses of providing benefits or services.

(b) Except as provided by Sections 1272.153 and 1272.154, a delegated network shall maintain reserves as described by Subsection (c) only with respect to the portion of services assumed under the delegation agreement that is outside the scope of the network's license for medical care or hospital or other institutional services, as applicable.

(c) A delegated network shall maintain financial reserves equal to the greater of:

(1) 80 percent of the amount of liabilities and risks for which reserves must be maintained under this subchapter and that have been incurred but not paid by the network; or

(2) an amount equal to two months of the premium amount assumed by the network for services with respect to which reserves must be maintained under this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1272.153. RESERVE REQUIREMENTS FOR MEDICAL CARE AND HOSPITAL OR INSTITUTIONAL SERVICES. A delegated network that assumes under a delegation agreement both medical care and hospital or institutional services shall maintain reserves adequate to cover the liabilities and risks associated with medical care or hospital or institutional services, whichever category of services is allocated the largest portion of the premium by the health maintenance organization.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1272.154. RESERVE REQUIREMENTS FOR PRESCRIPTION DRUGS. A delegated network that assumes financial risk for medical care or hospital or institutional services and for prescription drugs, as defined by Section 551.003, Occupations Code, shall maintain, in addition to any other reserves required under this subchapter, reserves adequate to cover the liabilities and risks associated with the prescription drug benefits.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1272.155. FORM OF RESERVES. The reserves required under this subchapter must be:

- (1) secured by and consist only of United States legal tender or bonds of the United States or this state;
- (2) held at a financial institution in this state that is chartered by the United States or this state; and
- (3) held in trust for, for the benefit of, or to provide health care services to enrollees under the delegation agreement.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1272.156. ESCROW ACCOUNT. (a) A delegated network required to maintain reserves under this subchapter shall establish an escrow account to pay claims and deposit the reserves into the escrow account on:

- (1) notification of the network's intent to terminate or refuse to renew a contract under which the network assumed liabilities and risks from a health maintenance organization; or
- (2) modification of a contract under which the network assumed liabilities and risks from a health maintenance organization if the modified contract eliminates those liabilities and risks.

(b) The delegated network shall notify the commissioner on establishing an escrow account under this section.

(c) On the 271st day after the date the reserves are deposited into the escrow account, the delegated network is entitled to the release of funds remaining in escrow. Funds released from the escrow account shall be distributed to each individual who contributed to the reserves deposited into the account in proportion to the individual's total contribution.

(d) The commissioner shall take any action necessary to ensure the release of funds remaining in escrow after the date specified by Subsection (c).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

SUBCHAPTER E. COMPLIANCE

Sec. 1272.201. APPLICABILITY OF SUBCHAPTER. This subchapter does not apply to a group model health maintenance organization, as defined by Section 843.111.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1272.202. NOTICE OF NONCOMPLIANCE OR HAZARDOUS OPERATING CONDITION. (a) If a health maintenance organization becomes aware of information that indicates a delegated entity with which the health maintenance organization has entered into a delegation agreement is not operating in accordance with the agreement or is operating in a condition that renders continuing the entity's business hazardous to the enrollees, the health maintenance organization shall in writing:

- (1) notify the entity of those findings; and
- (2) request a written explanation and documentation supporting that explanation of the entity's apparent noncompliance or the existence of the hazardous condition.

(b) A health maintenance organization shall provide to the commissioner a copy of each notice and request submitted to a delegated entity under this section and each response or other documentation the health maintenance organization receives or generates in response to the notice and request.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1272.203. RESPONSE TO NOTICE. A delegated entity shall respond in writing to a request from a health maintenance organization under Section 1272.202 not later than the 30th day after the date the entity receives the request.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1272.204. COOPERATION OF HEALTH MAINTENANCE ORGANIZATION. A health maintenance organization shall cooperate with a delegated entity to correct a failure by the entity to comply with the department's regulatory requirements relating to:

- (1) a function delegated to the entity by the health maintenance organization; or
- (2) a matter necessary for the health maintenance organization to ensure compliance with each statutory or regulatory requirement.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1272.205. EXAMINATION BY DEPARTMENT; REPORT. (a) On receipt of a notice under Section 1272.202 or if complaints are filed with the department, the department may conduct an examination regarding:

(1) any matter contained in the notice; and

(2) any other matter relating to the financial solvency of the delegated entity or the entity's ability to meet the entity's responsibilities in connection with a function delegated to the entity by the health maintenance organization.

(b) Except as provided by Subsection (c), the department, on completion of an examination under this section, shall report to the delegated entity and the health maintenance organization:

(1) the results of the examination; and

(2) any action the department determines is necessary to ensure that:

(A) the health maintenance organization meets the health maintenance organization's responsibilities under this code, any other insurance laws of this state, and rules adopted by the commissioner; and

(B) the entity is able to meet the entity's responsibilities in connection with a function delegated to the entity by the health maintenance organization.

(c) The department may not report to the health maintenance organization information relating to fee schedules, prices, or cost of care or other information not relevant to the monitoring plan.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1272.206. RESPONSE TO DEPARTMENT REPORT; CORRECTIVE PLAN. The delegated entity and health maintenance organization shall respond to the department's report under Section 1272.205(b) and submit a corrective plan to the department not later than the 30th day after the date of receipt of the report.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1272.207. REQUEST FOR CORRECTIVE ACTION. The department may request at any time that a delegated entity take corrective action to comply with the department's statutory and regulatory requirements that:

- (1) relate to a function delegated by the health maintenance organization to the entity; or
- (2) are necessary to ensure the health maintenance organization's compliance with each statutory or regulatory requirement.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1272.208. AUTHORITY OF COMMISSIONER TO ISSUE ORDER. (a) Regardless of whether a delegated entity complies with a request for corrective action under Section 1272.207, the commissioner may order a health maintenance organization with which the entity has entered into a delegation agreement to take any action the commissioner determines is necessary to ensure that the health maintenance organization is complying with this chapter, Chapter 843, 1271, or 1367, Subchapter A, Chapter 1452, or Subchapter B, Chapter 1507.

(b) Actions the commissioner may order a health maintenance organization to take under this section include:

- (1) reassuming the functions delegated to the delegated entity, including claims payments for services previously provided to enrollees;
- (2) temporarily or permanently ceasing assignment of new enrollees to the entity;
- (3) temporarily or permanently transferring enrollees to alternative delivery systems to receive services; or
- (4) terminating the delegation agreement with the entity.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. [2018](#)), Sec. 11.074(h), eff. September 1, 2005.

Sec. 1272.209. PUBLIC DOCUMENTS. (a) Except as provided by Subsection (b), a report required under Section 1272.205(b) or corrective plan required under Section 1272.206 is a public document.

(b) Health care provider fee schedules, prices, costs of care, or other information that is not relevant to the monitoring plan or is confidential by law is not a public document under this section.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1272.210. RECORD OF COMPLAINTS; REPORT. (a) The department shall:

(1) maintain enrollee and provider complaints in a manner that identifies complaints made about limited provider networks and delegated entities; and

(2) periodically issue a report on the complaints that includes a list of complaints organized by:

(A) category;

(B) action taken on the complaint; and

(C) entity or network name and type.

(b) The department shall make available to the public the report and information to assist the public in evaluating the information contained in the report.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1272.211. RULES. The commissioner may adopt rules as necessary to implement this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

SUBCHAPTER F. PENALTIES

Sec. 1272.251. APPLICABILITY OF SUBCHAPTER. This subchapter does not apply to a group model health maintenance organization, as defined by Section 843.111.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1272.252. SUSPENSION OR REVOCATION OF LICENSE OF THIRD-PARTY ADMINISTRATOR OR UTILIZATION REVIEW AGENT. Notwithstanding any other provision of this code or another insurance law of this state,

the commissioner may suspend or revoke the license of a third-party administrator or utilization review agent that fails to comply with Subchapter B, C, or E.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1272.253. SANCTIONS AND PENALTIES AGAINST HEALTH MAINTENANCE ORGANIZATION. The commissioner may impose sanctions or penalties under Chapters 82, 83, and 84 on a health maintenance organization that does not provide in a timely manner information required by Subchapter C.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1272.254. CONTRACTUAL PENALTIES REQUIRED. A health maintenance organization by contract shall establish penalties for a delegated entity that does not provide in a timely manner information required under a monitoring plan established under Section 1272.053.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1272.255. RULES. The commissioner may adopt rules as necessary to implement this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

SUBCHAPTER G. PROVISION OF SERVICES BY LIMITED PROVIDER NETWORK OR DELEGATED ENTITY

Sec. 1272.301. ACCESS TO OUT-OF-NETWORK SERVICES. (a) A contract between a health maintenance organization and a limited provider network or delegated entity must provide that:

(1) if medically necessary covered services are not available through network physicians or providers, the limited provider network or delegated entity, on the request of a network physician or provider, shall:

(A) allow a referral to a non-network physician or provider; and

(B) fully reimburse the non-network physician or provider at the usual and customary rate or an agreed rate; and

(2) before the limited provider network or delegated entity may deny a referral to a non-network physician or provider, a specialist of the same or similar specialty as the type of physician or provider to whom the referral is requested must conduct a review of the request.

(b) The limited provider network or delegated entity shall allow the referral within the time appropriate to the circumstances relating to the delivery of the services and the condition of the enrollee who is a patient, but not later than the fifth business day after the date the network or entity receives any reasonably requested documentation.

(c) An enrollee may not be required to change the enrollee's primary care physician or specialist providers to receive medically necessary covered services that are not available within the limited provider network or through the delegated entity.

(d) A denial of out-of-network services under this section is subject to appeal under Chapter 4201.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2G.005, eff. April 1, 2009.

Sec. 1272.302. CONTINUITY OF CARE. (a) In this section, "special circumstance" means a condition regarding which a treating physician or provider reasonably believes that discontinuing care by that physician or provider could cause harm to an enrollee who is a patient. Examples of an enrollee who has a special circumstance include an enrollee with a disability, acute condition, or life-threatening illness and an enrollee who is past the 24th week of pregnancy.

(b) A contract between a health maintenance organization and a limited provider network or delegated entity must require that each contract between the network or entity and a physician or provider must:

(1) require that reasonable advance notice be given to an enrollee of an impending termination from the network or entity of a

physician or provider who is currently treating the enrollee; and

(2) provide that the termination of the physician's or provider's contract, except for reason of medical competence or professional behavior, does not release the network or entity from the obligation to reimburse the physician or provider for treatment of an enrollee who has a special circumstance at a rate that is not less than the contract rate for that enrollee's care in exchange for continuity of ongoing treatment of the enrollee then receiving medically necessary treatment in accordance with the dictates of medical prudence.

(c) The treating physician or provider shall identify a special circumstance. That physician or provider must:

(1) request that the enrollee be permitted to continue treatment under the physician's or provider's care; and

(2) agree not to seek payment from the enrollee who is a patient of any amount for which the enrollee would not be responsible if the physician or provider continued to be included in the limited provider network or delegated entity.

(d) Except as provided by Subsection (e), this section does not extend the obligation of a limited provider network or delegated entity to reimburse a terminated physician or provider for ongoing treatment of an enrollee after:

(1) the 90th day after the effective date of the termination; or

(2) if the enrollee has been diagnosed with a terminal illness at the time of termination, the expiration of the nine-month period after the effective date of the termination.

(e) If an enrollee is past the 24th week of pregnancy at the time of termination, the obligation of the limited provider network or delegated entity to reimburse the terminated physician or provider or, if applicable, the enrollee extends through delivery of the child, immediate postpartum care, and a follow-up checkup within the six-week period after delivery.

(f) A contract between a limited provider network or delegated entity and a physician or provider must provide procedures for resolving disputes regarding the necessity for continued treatment by a physician or provider.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

CHAPTER 1273. POINT-OF-SERVICE PLANS**SUBCHAPTER A. BLENDED CONTRACTS**

Sec. 1273.001. DEFINITIONS. In this subchapter:

(1) "Blended contract" means a single document, including a single contract policy, certificate, or evidence of coverage, that provides a combination of indemnity and health maintenance organization benefits.

(2) "Health maintenance organization" has the meaning assigned by Section 843.002.

(3) "Insurer" means an insurance company, association, or organization authorized to engage in business in this state under Chapter 841, 842, 861, 881, 882, 883, 884, 885, 886, 887, 888, 941, 942, or 982.

(4) "Point-of-service plan" means an arrangement under which:

(A) an enrollee chooses to obtain benefits or services through:

(i) a health maintenance organization delivery network, including a limited provider network; or

(ii) a non-network delivery system outside the health maintenance organization delivery network, including an exclusive provider benefit plan under Chapter 1301 or a limited provider network, that is administered under an indemnity benefit arrangement for the cost of health care services; or

(B) indemnity benefits for the cost of health care services are provided by an insurer or group hospital service corporation in conjunction with network benefits arranged or provided by a health maintenance organization.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 288 (H.B. [1772](#)), Sec. 1, eff. September 1, 2011.

Sec. 1273.002. POINT-OF-SERVICE PLAN. An insurer may contract with a health maintenance organization to provide benefits under a point-of-service plan, including optional coverage for out-of-area services or out-of-network care.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1273.003. BLENDED CONTRACT. (a) A health maintenance organization and an insurer may offer a blended contract. The use of a blended contract is limited to point-of-service arrangements between a health maintenance organization and an insurer.

(b) A blended contract delivered, issued, or used in this state is subject to, and must be filed with the department for approval as provided by, Chapter 1701 and Section 1271.101.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1273.004. LIMITED BENEFITS AND SERVICES; COST-SHARING PROVISIONS. Indemnity benefits and services provided under a point-of-service plan may be limited to those services described by the blended contract and may be subject to different cost-sharing provisions. The cost-sharing provisions for indemnity benefits may be higher than the cost-sharing provisions for in-network health maintenance organization coverage. For an enrollee in a limited provider network, higher cost-sharing may be imposed only when the enrollee obtains benefits or services outside the health maintenance organization delivery network.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1273.005. RULES. The commissioner may adopt rules to implement this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

SUBCHAPTER B. AVAILABILITY OF HEALTH BENEFIT COVERAGE OPTIONS

Sec. 1273.051. DEFINITIONS. In this subchapter:

(1) "Employee" means an individual employed by an employer.

(2) "Health benefit plan" has the meaning assigned by Section 1501.002.

(3) "Non-network plan" means health benefit coverage that provides an enrollee an opportunity to obtain health care services through a health delivery system other than a health maintenance

organization delivery network, as defined by Section 843.002.

(4) "Point-of-service plan" means an arrangement under which an enrollee chooses to obtain benefits or services through:

(A) a health maintenance organization delivery network, including a limited provider network; or

(B) a non-network delivery system outside the health maintenance organization delivery network, including a limited provider network, that is administered under an indemnity benefit arrangement for the cost of health care services.

(5) "Preferred provider benefit plan" means an insurance policy issued under Chapter 1301.

(6) "Small employer health benefit plan" has the meaning assigned by Section 1501.002.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1273.052. OFFER OF COVERAGE THROUGH NON-NETWORK PLAN REQUIRED. (a) Except as provided by Subsection (b), if the only health benefit coverage offered under an employer's health benefit plan is a network-based delivery system of coverage offered by one or more health maintenance organizations, each health maintenance organization offering coverage must offer to all eligible employees, at the time of enrollment and at least annually, the opportunity to obtain coverage through a non-network plan.

(b) Each health maintenance organization to which Subsection (a) applies may enter into an agreement designating one or more of those health maintenance organizations to offer the coverage required by Subsection (a) for eligible employees of the employer.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1273.053. COVERAGE OPTIONS. The coverage required to be offered under this subchapter may be provided through:

(1) a point-of-service plan;

(2) a preferred provider benefit plan; or

(3) any coverage arrangement that provides an enrollee with access to services outside the health maintenance organization's or limited provider network's delivery network.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1273.054. PREMIUM FOR COVERAGE OPTIONS. The premium for coverage required to be offered under this subchapter must be based on the actuarial value of that coverage and may be different from the premium for coverage otherwise offered by the health maintenance organization.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1273.055. COST-SHARING PROVISIONS. (a) Different cost-sharing provisions may be imposed for a point-of-service plan offered under this subchapter, and those provisions may be higher than the cost-sharing provisions for in-network health maintenance organization coverage. For an enrollee in a limited provider network, higher cost-sharing may be imposed only when the enrollee obtains benefits or services outside the health maintenance organization delivery network.

(b) An employee who chooses the non-network plan is responsible for any additional costs for the non-network plan, and the employer may impose a reasonable administrative fee for providing the non-network plan.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1273.056. EXCEPTIONS. This subchapter does not apply to:

- (1) a small employer health benefit plan; or
- (2) a group model health maintenance organization that is a nonprofit, state-certified health maintenance organization that:
 - (A) provides the majority of its professional services through a single group medical practice that is governed by a board composed entirely of physicians; and
 - (B) educates medical students or resident physicians through a contract with the medical school component of a Texas state-supported college or university accredited by the Accreditation Council on Graduate Medical Education or the American Osteopathic Association.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1273.057. RULES. The commissioner shall adopt rules necessary to administer this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

CHAPTER 1274. ELECTRONIC TRANSMISSION OF ELIGIBILITY AND PAYMENT STATUS

Sec. 1274.001. DEFINITIONS. In this chapter:

(1) "Enrollee" means an individual who is eligible for coverage under a health benefit plan, including a covered dependent.

(2) "Health benefit plan" means a group, blanket, or franchise insurance policy, a certificate issued under a group policy, a group hospital service contract, or a group subscriber contract or evidence of coverage issued by a health maintenance organization that provides benefits for health care services. The term does not include:

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

(B) credit-only insurance coverage;

(C) disability insurance coverage;

(D) coverage only for a specified disease or illness;

(E) Medicare services under a federal contract;

(F) Medicare supplement and Medicare Select policies regulated in accordance with federal law;

(G) long-term care coverage or benefits, nursing home care coverage or benefits, home health care coverage or benefits, community-based care coverage or benefits, or any combination of those coverages or benefits;

(H) coverage that provides limited-scope dental or vision benefits;

(I) coverage provided by a single service health maintenance organization;

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

(K) workers' compensation insurance coverage or similar

insurance coverage;

(L) automobile medical payment insurance coverage;

(M) a jointly managed trust authorized under 29 U.S.C. Section 141 et seq. that contains a plan of benefits for employees that is negotiated in a collective bargaining agreement governing wages, hours, and working conditions of the employees that is authorized under 29 U.S.C. Section 157;

(N) hospital indemnity or other fixed indemnity insurance coverage;

(O) reinsurance contracts issued on a stop-loss, quota-share, or similar basis;

(P) liability insurance coverage, including general liability insurance and automobile liability insurance coverage; or

(Q) coverage that provides other limited benefits specified by federal regulations.

(3) "Health benefit plan issuer" means a health maintenance organization operating under Chapter 843, a preferred provider organization operating under Chapter 1301, an approved nonprofit health corporation that holds a certificate of authority under Chapter 844, and any other entity that issues a health benefit plan, including:

(A) an insurance company;

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

(C) a fraternal benefit society operating under Chapter 885; or

(D) a stipulated premium company operating under Chapter 884.

(4) "Health care provider" means:

(A) a person, other than a physician, who is licensed or otherwise authorized to provide a health care service in this state, including:

(i) a pharmacist or dentist; or

(ii) a pharmacy, hospital, or other institution or organization;

(B) a person who is wholly owned or controlled by a provider or by a group of providers who are licensed or otherwise authorized to provide the same health care service; or

(C) a person who is wholly owned or controlled by one or more hospitals and physicians, including a physician-hospital

organization.

(5) "Participating provider" means:

(A) a physician or health care provider who contracts with a health benefit plan issuer to provide medical care or health care to enrollees in a health benefit plan; or

(B) a physician or health care provider who accepts and treats a patient on a referral from a physician or provider described by Paragraph (A).

(6) "Physician" means:

(A) an individual licensed to practice medicine in this state under Subtitle B, Title 3, Occupations Code;

(B) a professional association organized under the Texas Professional Association Act (Article 1528f, Vernon's Texas Civil Statutes);

(C) a nonprofit health corporation certified under Chapter 162, Occupations Code;

(D) a medical school or medical and dental unit, as defined or described by Section 61.003, 61.501, or 74.601, Education Code, that employs or contracts with physicians to teach or provide medical services or employs physicians and contracts with physicians in a practice plan; or

(E) another entity wholly owned by physicians.

Added by Acts 2005, 79th Leg., Ch. 880 (S.B. [1149](#)), Sec. 1, eff. September 1, 2005.

Sec. 1274.0015. EXEMPTION. This chapter does not apply to a single-service health maintenance organization that provides coverage only for dental or vision benefits.

Added by Acts 2005, 79th Leg., Ch. 880 (S.B. [1149](#)), Sec. 1, eff. September 1, 2005.

Sec. 1274.002. TRANSMISSION OF ENROLLEE ELIGIBILITY AND PAYMENT STATUS. (a) Each health benefit plan issuer shall, upon the participating provider's submission of the patient's name, relationship to the primary enrollee, and birth date, make available telephonically, electronically, or by an Internet website portal to each participating provider information maintained in the ordinary

course of business and sufficient for the provider to determine at the time of the enrollee's visit information concerning:

(1) the enrollee, including:

(A) the enrollee's identification number assigned by the health benefit plan issuer;

(B) the name of the enrollee and all covered dependents, if appropriate;

(C) the birth date of the enrollee and the birth dates of all covered dependents, if appropriate;

(D) the gender of the enrollee and the gender of each covered dependent, if appropriate; and

(E) the current enrollment and eligibility status of the enrollee under the health benefit plan;

(2) the enrollee's benefits, including:

(A) whether a specific type or category of service is a covered benefit; and

(B) excluded benefits or limitations, both group and individual; and

(3) the enrollee's financial information, including:

(A) copayment requirements, if any; and

(B) the unmet amount of the enrollee's deductible or enrollee financial responsibility.

(b) Information required to be made available under this section may be made available only to a participating provider who is authorized under state and federal law to receive personally identifiable information on an enrollee or dependent.

Added by Acts 2005, 79th Leg., Ch. 880 (S.B. [1149](#)), Sec. 1, eff. September 1, 2005.

Sec. 1274.003. CERTAIN CHARGES PROHIBITED. A health benefit plan issuer may not directly or indirectly charge or hold a physician, health care provider, or enrollee responsible for a fee for making available or accessing information under this chapter.

Added by Acts 2005, 79th Leg., Ch. 880 (S.B. [1149](#)), Sec. 1, eff. September 1, 2005.

Sec. 1274.004. RULES. (a) The commissioner shall adopt rules

as necessary to implement this chapter.

(b) Before adopting rules under this section, the commissioner shall consult and receive advice from the technical advisory committee on claims processing established under Chapter 1212.

Added by Acts 2005, 79th Leg., Ch. 880 (S.B. 1149), Sec. 1, eff. September 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2G.006, eff. April 1, 2009.

Sec. 1274.005. WAIVER OF CERTAIN PROVISIONS FOR CERTAIN FEDERAL PLANS. If the commissioner, in consultation with the commissioner of health and human services, determines that a provision of Section 1274.002 will cause a negative fiscal impact on the state with respect to providing benefits or services under Subchapter XIX, Social Security Act (42 U.S.C. Section 1396 et seq.), or Subchapter XXI, Social Security Act (42 U.S.C. Section 1397aa et seq.), the commissioner of insurance by rule shall waive the application of that provision to the providing of those benefits or services.

Added by Acts 2005, 79th Leg., Ch. 880 (S.B. 1149), Sec. 1, eff. September 1, 2005.

CHAPTER 1275. BALANCE BILLING PROHIBITIONS AND OUT-OF-NETWORK CLAIM DISPUTE RESOLUTION FOR CERTAIN PLANS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1275.001. DEFINITIONS. In this chapter:

(1) "Enrollee" means an individual enrolled in a health benefit plan to which this chapter applies.

(2) "Usual and customary rate" means the relevant allowable amount as described by the applicable master benefit plan document.

Added by Acts 2021, 87th Leg., R.S., Ch. 1034 (H.B. 3924), Sec. 1, eff. September 1, 2021.

Sec. 1275.002. APPLICABILITY OF CHAPTER. This chapter applies only to:

- (1) a health benefit plan offered by a nonprofit agricultural organization under Chapter 1682; and
- (2) a health benefit plan:
 - (A) that is a self-insured or self-funded plan established by an employer for the benefit of the employer's employees in accordance with the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.); and
 - (B) for which the plan sponsor has made an election, submitted to the commissioner in the form and manner prescribed by the commissioner, to apply this chapter to the plan for the relevant plan year.

Added by Acts 2021, 87th Leg., R.S., Ch. 1034 (H.B. [3924](#)), Sec. 1, eff. September 1, 2021.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 696 (H.B. [1592](#)), Sec. 1, eff. September 1, 2023.

Text of section effective until September 1, 2025

Sec. 1275.003. BALANCE BILLING PROHIBITION NOTICE. (a) The administrator of a health benefit plan to which this chapter applies shall provide written notice in accordance with this section in an explanation of benefits provided to the enrollee and the physician or health care provider in connection with a health care or medical service or supply or transport provided by an out-of-network provider. The notice must include:

- (1) a statement of the billing prohibition under Section 1275.051, 1275.052, 1275.053, or 1275.054, as applicable;
- (2) the total amount the physician or provider may bill the enrollee under the enrollee's health benefit plan and an itemization of copayments, coinsurance, deductibles, and other amounts included in that total; and
- (3) for an explanation of benefits provided to the physician or provider, information required by commissioner rule advising the physician or provider of the availability of mediation or arbitration, as applicable, under Chapter 1467.

(b) The administrator shall provide the explanation of benefits with the notice required by this section to a physician or health care provider not later than the date the administrator makes a

payment under Section 1275.051, 1275.052, 1275.053, or 1275.054, as applicable.

Added by Acts 2021, 87th Leg., R.S., Ch. 1034 (H.B. 3924), Sec. 1, eff. September 1, 2021.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 981 (S.B. 2476), Sec. 4(a), eff. September 1, 2023.

Acts 2023, 88th Leg., R.S., Ch. 981 (S.B. 2476), Sec. 4(b), eff. September 1, 2025.

Text of section effective on September 1, 2025

Sec. 1275.003. BALANCE BILLING PROHIBITION NOTICE. (a) The administrator of a health benefit plan to which this chapter applies shall provide written notice in accordance with this section in an explanation of benefits provided to the enrollee and the physician or health care provider in connection with a health care or medical service or supply provided by an out-of-network provider. The notice must include:

(1) a statement of the billing prohibition under Section 1275.051, 1275.052, or 1275.053, as applicable;

(2) the total amount the physician or provider may bill the enrollee under the enrollee's health benefit plan and an itemization of copayments, coinsurance, deductibles, and other amounts included in that total; and

(3) for an explanation of benefits provided to the physician or provider, information required by commissioner rule advising the physician or provider of the availability of mediation or arbitration, as applicable, under Chapter 1467.

(b) The administrator shall provide the explanation of benefits with the notice required by this section to a physician or health care provider not later than the date the administrator makes a payment under Section 1275.051, 1275.052, or 1275.053, as applicable.

Added by Acts 2021, 87th Leg., R.S., Ch. 1034 (H.B. 3924), Sec. 1, eff. September 1, 2021.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 981 (S.B. 2476), Sec. 4(a), eff. September 1, 2023.

Acts 2023, 88th Leg., R.S., Ch. 981 (S.B. 2476), Sec. 4(b), eff. September 1, 2025.

Sec. 1275.004. OUT-OF-NETWORK CLAIM DISPUTE RESOLUTION. Chapter 1467 applies to a health benefit plan to which this chapter applies, and the administrator of a health benefit plan to which this chapter applies is an administrator for purposes of that chapter.

Added by Acts 2021, 87th Leg., R.S., Ch. 1034 (H.B. 3924), Sec. 1, eff. September 1, 2021.

SUBCHAPTER B. PAYMENTS FOR CERTAIN SERVICES; BALANCE BILLING PROHIBITIONS

Sec. 1275.051. EMERGENCY CARE PAYMENTS. (a) In this section, "emergency care" has the meaning assigned by Section 1301.155.

(b) The administrator of a health benefit plan to which this chapter applies shall pay for covered emergency care performed by or a covered supply related to that care provided by an out-of-network provider at the usual and customary rate or at an agreed rate. The administrator shall make a payment required by this subsection directly to the provider not later than, as applicable:

(1) the 30th day after the date the administrator receives an electronic claim for those services that includes all information necessary for the administrator to pay the claim; or

(2) the 45th day after the date the administrator receives a nonelectronic claim for those services that includes all information necessary for the administrator to pay the claim.

(c) For emergency care subject to this section or a supply related to that care, an out-of-network provider or a person asserting a claim as an agent or assignee of the provider may not bill an enrollee in, and the enrollee does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, and deductible under the enrollee's health benefit plan that:

(1) is based on:

(A) the amount initially determined payable by the administrator; or

(B) if applicable, a modified amount as determined

under the administrator's internal appeal process; and

(2) is not based on any additional amount determined to be owed to the provider under Chapter 1467.

Added by Acts 2021, 87th Leg., R.S., Ch. 1034 (H.B. 3924), Sec. 1, eff. September 1, 2021.

Sec. 1275.052. OUT-OF-NETWORK FACILITY-BASED PROVIDER PAYMENTS.

(a) In this section, "facility-based provider" means a physician or health care provider who provides health care or medical services to patients of a health care facility.

(b) Except as provided by Subsection (d), the administrator of a health benefit plan to which this chapter applies shall pay for a covered health care or medical service performed for or a covered supply related to that service provided to an enrollee by an out-of-network provider who is a facility-based provider at the usual and customary rate or at an agreed rate if the provider performed the service at a health care facility that is a participating provider. The administrator shall make a payment required by this subsection directly to the provider not later than, as applicable:

(1) the 30th day after the date the administrator receives an electronic claim for those services that includes all information necessary for the administrator to pay the claim; or

(2) the 45th day after the date the administrator receives a nonelectronic claim for those services that includes all information necessary for the administrator to pay the claim.

(c) Except as provided by Subsection (d), an out-of-network provider who is a facility-based provider or a person asserting a claim as an agent or assignee of the provider may not bill an enrollee receiving a health care or medical service or supply described by Subsection (b) in, and the enrollee does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, and deductible under the enrollee's health benefit plan that:

(1) is based on:

(A) the amount initially determined payable by the administrator; or

(B) if applicable, a modified amount as determined under the administrator's internal appeal process; and

(2) is not based on any additional amount determined to be owed to the provider under Chapter 1467.

(d) This section does not apply to a nonemergency health care or medical service:

(1) that an enrollee elects to receive in writing in advance of the service with respect to each out-of-network provider providing the service; and

(2) for which an out-of-network provider, before providing the service, provides a complete written disclosure to the enrollee that:

(A) explains that the provider does not have a contract with the enrollee's health benefit plan;

(B) discloses projected amounts for which the enrollee may be responsible; and

(C) discloses the circumstances under which the enrollee would be responsible for those amounts.

Added by Acts 2021, 87th Leg., R.S., Ch. 1034 (H.B. [3924](#)), Sec. 1, eff. September 1, 2021.

Sec. 1275.053. OUT-OF-NETWORK DIAGNOSTIC IMAGING PROVIDER OR LABORATORY SERVICE PROVIDER PAYMENTS. (a) In this section, "diagnostic imaging provider" and "laboratory service provider" have the meanings assigned by Section 1467.001.

(b) Except as provided by Subsection (d), the administrator of a health benefit plan to which this chapter applies shall pay for a covered health care or medical service performed for or a covered supply related to that service provided to an enrollee by an out-of-network provider who is a diagnostic imaging provider or laboratory service provider at the usual and customary rate or at an agreed rate if the provider performed the service in connection with a health care or medical service performed by a participating provider. The administrator shall make a payment required by this subsection directly to the provider not later than, as applicable:

(1) the 30th day after the date the administrator receives an electronic claim for those services that includes all information necessary for the administrator to pay the claim; or

(2) the 45th day after the date the administrator receives a nonelectronic claim for those services that includes all

information necessary for the administrator to pay the claim.

(c) Except as provided by Subsection (d), an out-of-network provider who is a diagnostic imaging provider or laboratory service provider or a person asserting a claim as an agent or assignee of the provider may not bill an enrollee receiving a health care or medical service or supply described by Subsection (b) in, and the enrollee does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, and deductible under the enrollee's health benefit plan that:

(1) is based on:

(A) the amount initially determined payable by the administrator; or

(B) if applicable, the modified amount as determined under the administrator's internal appeal process; and

(2) is not based on any additional amount determined to be owed to the provider under Chapter 1467.

(d) This section does not apply to a nonemergency health care or medical service:

(1) that an enrollee elects to receive in writing in advance of the service with respect to each out-of-network provider providing the service; and

(2) for which an out-of-network provider, before providing the service, provides a complete written disclosure to the enrollee that:

(A) explains that the provider does not have a contract with the enrollee's health benefit plan;

(B) discloses projected amounts for which the enrollee may be responsible; and

(C) discloses the circumstances under which the enrollee would be responsible for those amounts.

Added by Acts 2021, 87th Leg., R.S., Ch. 1034 (H.B. [3924](#)), Sec. 1, eff. September 1, 2021.

For expiration of this section, see Subsection (f).

Sec. 1275.054. OUT-OF-NETWORK EMERGENCY MEDICAL SERVICES PROVIDER PAYMENTS. (a) In this section, "emergency medical services provider" has the meaning assigned by Section 773.003, Health and Safety Code, except that the term does not include an air ambulance.

(b) Except as provided by Subsection (c), the administrator of a health benefit plan to which this chapter applies shall pay for a covered health care or medical service performed for, or a covered supply or covered transport related to that service provided to, an enrollee by an out-of-network provider who is an emergency medical services provider at:

(1) if the political subdivision has submitted the rate to the department under Section 38.006, the rate set, controlled, or regulated by the political subdivision in which:

(A) the service originated; or

(B) the transport originated if transport is provided;

or

(2) if the political subdivision has not submitted the rate to the department, the lesser of:

(A) the provider's billed charge; or

(B) 325 percent of the current Medicare rate, including any applicable extenders and modifiers.

(c) The administrator shall adjust a payment required by Subsection (b)(1) each plan year by increasing the payment by the lesser of the Medicare Inflation Index or 10 percent of the provider's previous calendar year rates.

(d) The administrator shall make a payment required by this section directly to the provider not later than, as applicable:

(1) the 30th day after the date the administrator receives an electronic claim for those services that includes all information necessary for the administrator to pay the claim; or

(2) the 45th day after the date the administrator receives a nonelectronic claim for those services that includes all information necessary for the administrator to pay the claim.

(e) An out-of-network provider who is an emergency medical services provider or a person asserting a claim as an agent or assignee of the provider may not bill an enrollee receiving a health care or medical service or supply or transport described by Subsection (b) in, and the enrollee does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, and deductible under the enrollee's health benefit plan that is based on:

(1) the amount initially determined payable by the administrator; or

(2) if applicable, the modified amount as determined under

the administrator's internal appeal process.

(f) This section expires September 1, 2025.

Added by Acts 2023, 88th Leg., R.S., Ch. 981 (S.B. 2476), Sec. 5, eff. September 1, 2023.

SUBTITLE D. PROVIDER PLANS
CHAPTER 1301. PREFERRED PROVIDER BENEFIT PLANS
SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1301.001. DEFINITIONS. In this chapter:

(1) "Exclusive provider benefit plan" means a benefit plan in which an insurer excludes benefits to an insured for some or all services, other than emergency care services required under Section 1301.155, provided by a physician or health care provider who is not a preferred provider.

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

(2) "Health insurance policy" means a group or individual insurance policy, certificate, or contract providing benefits for medical or surgical expenses incurred as a result of an accident or sickness.

(3) "Hospital" means a licensed public or private institution as defined by Chapter 241, Health and Safety Code, or Subtitle C, Title 7, Health and Safety Code.

(4) "Institutional provider" means a hospital, nursing home, or other medical or health-related service facility that provides care for the sick or injured or other care that may be covered in a health insurance policy.

(5) "Insurer" means a life, health, and accident insurance company, health and accident insurance company, health insurance company, or other company operating under Chapter 841, 842, 884, 885, 982, or 1501, that is authorized to issue, deliver, or issue for delivery in this state health insurance policies.

(5-a) "Out-of-network provider" means a physician or health care provider who is not a preferred provider.

(6) "Physician" means a person licensed to practice

medicine in this state.

(6-a) "Post-emergency stabilization care" means health care services that are furnished by an out-of-network provider, including an out-of-network hospital, freestanding emergency medical care facility, or comparable emergency facility, regardless of the department of the facility in which the services are furnished, after an insured is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the emergency care, as defined by Section 1301.155, is furnished.

(7) "Practitioner" means a person who practices a healing art and is a practitioner described by Section 1451.001 or 1451.101.

(7-a) "Preauthorization" means a determination by an insurer that medical care or health care services proposed to be provided to a patient are medically necessary and appropriate.

(8) "Preferred provider" means a physician or health care provider, or an organization of physicians or health care providers, who contracts with an insurer to provide medical care or health care to insureds covered by a health insurance policy.

(9) "Preferred provider benefit plan" means a benefit plan in which an insurer provides, through its health insurance policy, for the payment of a level of coverage that is different from the basic level of coverage provided by the health insurance policy if the insured person uses a preferred provider.

(10) "Service area" means a geographic area or areas specified in a health insurance policy or preferred provider contract in which a network of preferred providers is offered and available.

(11) "Verification" means a reliable representation by an insurer to a physician or health care provider that the insurer will pay the physician or provider for proposed medical care or health care services if the physician or provider renders those services to the patient for whom the services are proposed. The term includes precertification, certification, recertification, and any other term that would be a reliable representation by an insurer to a physician or provider.

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

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.033(a), eff.

September 1, 2005.

Acts 2009, 81st Leg., R.S., Ch. 1273 (H.B. 1357), Sec. 4, eff. March 1, 2010.

Acts 2011, 82nd Leg., R.S., Ch. 288 (H.B. 1772), Sec. 2, eff. September 1, 2011.

Acts 2011, 82nd Leg., R.S., Ch. 798 (H.B. 2292), Sec. 7, eff. September 1, 2011.

Acts 2013, 83rd Leg., R.S., Ch. 915 (H.B. 1358), Sec. 2, eff. September 1, 2013.

Acts 2015, 84th Leg., R.S., Ch. 275 (H.B. 574), Sec. 4, eff. September 1, 2015.

Acts 2023, 88th Leg., R.S., Ch. 740 (H.B. 3359), Sec. 1, eff. September 1, 2023.

Sec. 1301.002. NONAPPLICABILITY TO DENTAL CARE BENEFITS. This chapter does not apply to a provision for dental care benefits in a health insurance policy.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1301.003. PREFERRED PROVIDER BENEFIT PLANS AND EXCLUSIVE PROVIDER BENEFIT PLANS PERMITTED. A preferred provider benefit plan or an exclusive provider benefit plan that meets the requirements of this chapter is not:

- (1) unjust under Chapter 1701;
- (2) unfair discrimination under Subchapter A or B, Chapter 544; or
- (3) a violation of Subchapter B or C, Chapter 1451.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 288 (H.B. 1772), Sec. 3, eff. September 1, 2011.

Sec. 1301.0041. APPLICABILITY. (a) Except as otherwise specifically provided by this chapter, this chapter applies to each preferred provider benefit plan in which an insurer provides, through the insurer's health insurance policy, for the payment of a level of

coverage that is different depending on whether an insured uses a preferred provider or a nonpreferred provider.

(b) Unless otherwise specified, an exclusive provider benefit plan is subject to this chapter in the same manner as a preferred provider benefit plan.

Text of subsection effective until April 1, 2025

(c) This chapter does not apply to:

(1) the child health plan program under Chapter 62, Health and Safety Code; or

(2) a Medicaid managed care program under Chapter 533, Government Code.

Text of subsection effective on April 1, 2025

(c) This chapter does not apply to:

(1) the child health plan program under Chapter 62, Health and Safety Code; or

(2) a Medicaid managed care program under Chapter 540 or 540A, Government Code, as applicable.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 3B.0271(b), eff. September 1, 2007.

Added by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. [3167](#)), Sec. 9.0271(b), eff. September 1, 2007.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 288 (H.B. [1772](#)), Sec. 4, eff. September 1, 2011.

Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. [4611](#)), Sec. 2.122, eff. April 1, 2025.

Sec. 1301.0042. APPLICABILITY OF INSURANCE LAW. (a) Except as provided by Subsection (b), a provision of this code or another insurance law of this state that applies to a preferred provider benefit plan applies to an exclusive provider benefit plan except to the extent that the commissioner determines the provision to be inconsistent with the function and purpose of an exclusive provider benefit plan.

(b) An exclusive provider benefit plan may not provide dental care benefits.

Added by Acts 2011, 82nd Leg., R.S., Ch. 288 (H.B. [1772](#)), Sec. 5, eff.

September 1, 2011.

Sec. 1301.0045. CONSTRUCTION OF CHAPTER. (a) Except as provided by Section 1301.0046, this chapter may not be construed to limit the level of reimbursement or the level of coverage, including deductibles, copayments, coinsurance, or other cost-sharing provisions, that are applicable to preferred providers or, for plans other than exclusive provider benefit plans, nonpreferred providers.

Text of subsection effective until September 1, 2025

(b) Except as provided by Sections 1301.0052, 1301.0053, 1301.155, 1301.164, 1301.165, and 1301.166, this chapter may not be construed to require an exclusive provider benefit plan to compensate a nonpreferred provider for services provided to an insured.

Text of subsection effective on September 1, 2025

(b) Except as provided by Sections 1301.0052, 1301.0053, 1301.155, 1301.164, and 1301.165, this chapter may not be construed to require an exclusive provider benefit plan to compensate a nonpreferred provider for services provided to an insured.

Added by Acts 2005, 79th Leg., Ch. 1221 (H.B. 1030), Sec. 1, eff. September 1, 2005.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 288 (H.B. 1772), Sec. 6, eff. September 1, 2011.

Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 1.05, eff. September 1, 2019.

Acts 2023, 88th Leg., R.S., Ch. 981 (S.B. 2476), Sec. 6(a), eff. September 1, 2023.

Acts 2023, 88th Leg., R.S., Ch. 981 (S.B. 2476), Sec. 6(b), eff. September 1, 2025.

Sec. 1301.0046. COINSURANCE REQUIREMENTS FOR SERVICES OF NONPREFERRED PROVIDERS. The insured's coinsurance applicable to payment to nonpreferred providers may not exceed 50 percent of the total covered amount applicable to the medical or health care services. This section does not apply to an exclusive provider benefit plan.

Added by Acts 2005, 79th Leg., Ch. 1221 (H.B. 1030), Sec. 1, eff. September 1, 2005.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 288 (H.B. 1772), Sec. 7, eff. September 1, 2011.

Sec. 1301.005. AVAILABILITY OF PREFERRED PROVIDERS; SERVICE AREA LIMITATIONS. (a) An insurer offering a preferred provider benefit plan shall ensure that both preferred provider benefits and basic level benefits, including benefits for emergency care, as defined by Section 1301.155, and post-emergency stabilization care, are reasonably available to all insureds within a designated service area. This subsection does not apply to an exclusive provider benefit plan.

(b) If services are not available through a preferred provider within a designated service area under a preferred provider benefit plan or an exclusive provider benefit plan, an insurer shall reimburse a physician or health care provider who is not a preferred provider at the same percentage level of reimbursement as a preferred provider would have been reimbursed had the insured been treated by a preferred provider.

(c) Subsection (b) does not require reimbursement at a preferred level of coverage solely because an insured resides out of the service area and chooses to receive services from a provider other than a preferred provider for the insured's own convenience.

(d) A service area, other than a statewide service area, may include noncontiguous geographic areas but may not divide a county.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 288 (H.B. 1772), Sec. 8, eff. September 1, 2011.

Acts 2023, 88th Leg., R.S., Ch. 740 (H.B. 3359), Sec. 2, eff. September 1, 2023.

Acts 2023, 88th Leg., R.S., Ch. 740 (H.B. 3359), Sec. 3, eff. September 1, 2023.

Sec. 1301.0051. EXCLUSIVE PROVIDER BENEFIT PLANS: QUALITY

IMPROVEMENT AND UTILIZATION MANAGEMENT. (a) An insurer that offers an exclusive provider benefit plan shall establish procedures to ensure that health care services are provided to insureds under reasonable standards of quality of care that are consistent with prevailing professionally recognized standards of care or practice. The procedures must include:

(1) mechanisms to ensure availability, accessibility, quality, and continuity of care;

(2) subject to Section 1301.059, a continuing quality improvement program to monitor and evaluate services provided under the plan, including primary and specialist physician services and ancillary and preventive health care services, provided in institutional or noninstitutional settings;

(3) a method of recording formal proceedings of quality improvement program activities and maintaining quality improvement program documentation in a confidential manner;

(4) subject to Section 1301.059, a physician review panel to assist the insurer in reviewing medical guidelines or criteria;

(5) a patient record system that facilitates documentation and retrieval of clinical information for the insurer's evaluation of continuity and coordination of services and assessment of the quality of services provided to insureds under the plan;

(6) a mechanism for making available to the commissioner the clinical records of insureds for examination and review by the commissioner on request of the commissioner; and

(7) a specific procedure for the periodic reporting of quality improvement program activities to:

(A) the governing body and appropriate staff of the insurer; and

(B) physicians and health care providers that provide health care services under the plan.

(b) Minutes of a formal proceeding of the quality improvement program established under Subsection (a) shall be made available to the commissioner on request of the commissioner.

(c) Insured records made available to the commissioner under Subsection (a)(6) are confidential and privileged, and are not subject to Chapter 552, Government Code, or to subpoena, except to the extent necessary for the commissioner to enforce this chapter.

Added by Acts 2011, 82nd Leg., R.S., Ch. 288 (H.B. 1772), Sec. 9, eff.

September 1, 2011.

Sec. 1301.0052. EXCLUSIVE PROVIDER BENEFIT PLANS: REFERRALS FOR MEDICALLY NECESSARY SERVICES. (a) If a covered service is medically necessary and is not available through a preferred provider, the issuer of an exclusive provider benefit plan, on the request of a preferred provider, shall:

(1) approve the referral of an insured to a nonpreferred provider within a reasonable period; and

(2) fully reimburse the nonpreferred provider at the usual and customary rate or at a rate agreed to by the issuer and the nonpreferred provider.

(b) An exclusive provider benefit plan must provide for a review by a health care provider with expertise in the same specialty as or a specialty similar to the type of health care provider to whom a referral is requested under Subsection (a) before the issuer of the plan may deny the referral.

Added by Acts 2011, 82nd Leg., R.S., Ch. 288 (H.B. [1772](#)), Sec. 9, eff. September 1, 2011.

Sec. 1301.0053. EXCLUSIVE PROVIDER BENEFIT PLANS: EMERGENCY CARE. (a) If an out-of-network provider provides emergency care as defined by Section 1301.155 or post-emergency stabilization care to an enrollee in an exclusive provider benefit plan, the issuer of the plan shall reimburse the out-of-network provider at the usual and customary rate or at a rate agreed to by the issuer and the out-of-network provider for the provision of the services and any supply related to those services. The insurer shall make a payment required by this subsection directly to the provider not later than, as applicable:

(1) the 30th day after the date the insurer receives an electronic clean claim as defined by Section 1301.101 for those services that includes all information necessary for the insurer to pay the claim; or

(2) the 45th day after the date the insurer receives a nonelectronic clean claim as defined by Section 1301.101 for those services that includes all information necessary for the insurer to

pay the claim.

(b) For emergency care or post-emergency stabilization care subject to this section or a supply related to that care, an out-of-network provider or a person asserting a claim as an agent or assignee of the provider may not bill an insured in, and the insured does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, and deductible under the insured's exclusive provider benefit plan that:

(1) is based on:

(A) the amount initially determined payable by the insurer; or

(B) if applicable, a modified amount as determined under the insurer's internal appeal process; and

(2) is not based on any additional amount determined to be owed to the provider under Chapter 1467.

(c) This section may not be construed to require the imposition of a penalty under Section 1301.137.

(d) Post-emergency stabilization care that is subject to this section and a supply related to that care are subject to Chapter 1467 in the same manner as if the care and supply are emergency care, as defined by Section 1301.155.

(e) This section does not apply to claims for post-emergency stabilization care if all of the conditions described by 42 U.S.C. Section 300gg-111(a)(3)(C)(ii)(II) are met.

Added by Acts 2011, 82nd Leg., R.S., Ch. 288 (H.B. [1772](#)), Sec. 9, eff. September 1, 2011.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. [1264](#)), Sec. 1.06, eff. September 1, 2019.

Acts 2023, 88th Leg., R.S., Ch. 740 (H.B. [3359](#)), Sec. 4, eff. September 1, 2023.

Sec. 1301.0055. NETWORK ADEQUACY STANDARDS. (a) The commissioner shall by rule adopt network adequacy standards that:

(1) require an insurer offering a preferred provider benefit plan to:

(A) monitor compliance with network adequacy standards, including provisions of this chapter relating to network adequacy, on

an ongoing basis, reporting any material deviation from network adequacy standards to the department within 30 days of the date the material deviation occurred; and

(B) promptly take any corrective action required to ensure that the network is compliant not later than the 90th day after the date the material deviation occurred unless:

(i) there are no uncontracted licensed physicians or health care providers in the affected county; or

(ii) the insurer requests a waiver under this subsection;

(2) ensure availability of, and accessibility to, a full range of contracted physicians and health care providers to provide current and projected utilization of health care services for adult and minor insureds;

(3) may allow a waiver for a departure from network adequacy standards for a period not to exceed one year if the commissioner determines after receiving public testimony at a public hearing under Section 1301.00565 that good cause is shown and posts on the department's Internet website the name of the preferred provider benefit plan, the insurer offering the plan, each affected county, the specific network adequacy standards waived, and the insurer's access plan;

(4) require disclosure by the insurer of the information described by Subdivision (3) in all promotion and advertisement of the preferred provider benefit plan for which a waiver is allowed under that subdivision;

(5) except as provided by Subdivision (6), limit a waiver from being issued to a preferred provider benefit plan:

(A) more than twice consecutively for the same network adequacy standard in the same county unless the insurer demonstrates, in addition to the good cause described by Subdivision (3), multiple good faith attempts to bring the plan into compliance with the network adequacy standard during each of the prior consecutive waiver periods; or

(B) more than a total of four times within a 21-year period for each county in a service area for issues that may be remedied through good faith efforts; and

(6) authorize the commissioner to issue a waiver that would otherwise be unavailable under Subdivision (5) if the waiver request demonstrates, and the department confirms annually, that there are no

uncontracted physicians or health care providers in the area to meet the specific standard for a county in a service area.

(b) The standards described by Subsection (a)(2) must include factors regarding time, distance, and appointment availability. The factors must:

(1) require that all insureds are able to receive an appointment with a preferred provider within the maximum travel times and distances established under Sections 1301.00553 and 1301.00554;

(2) require that all insureds are able to receive an appointment with a preferred provider within the maximum appointment wait times established under Section 1301.00555;

(3) require a preferred provider benefit plan to ensure sufficient choice, access, and quality of physicians and health care providers, in number, size, and geographic distribution, to be capable of providing the health care services covered by the plan from preferred providers to all insureds within the insurer's designated service area, taking into account the insureds' characteristics, medical conditions, and health care needs, including:

(A) the current utilization of covered health care services within the counties of the service area; and

(B) an actuarial projection of utilization of covered health care services, physicians, and health care providers needed within the counties of the service area to meet the needs of the number of projected insureds;

(4) require a sufficient number of preferred providers of emergency medicine, anesthesiology, pathology, radiology, neonatology, oncology, including medical, surgical, and radiation oncology, surgery, and hospitalist, intensivist, and diagnostic services, including radiology and laboratory services, at each preferred hospital, ambulatory surgical center, or freestanding emergency medical care facility that credentials the particular specialty to ensure all insureds are able to receive covered benefits, including access to clinical trials covered by the health benefit plan, at that preferred location;

(5) require that all insureds have the ability to access a preferred institutional provider listed in Section 1301.00553 within the maximum travel times and distances established under Section 1301.00553 for the corresponding county classification;

(6) require that insureds have the option of facilities, if

available, of pediatric, for-profit, nonprofit, and tax-supported institutions, with special consideration to contracting with:

(A) teaching hospitals that provide indigent care or care for uninsured individuals as a significant percentage of their overall patient load; and

(B) teaching facilities that specialize in providing care for rare and complex medical conditions and conducting clinical trials;

(7) require that there is an adequate number of preferred provider physicians who have admitting privileges at one or more preferred provider hospitals located within the insurer's designated service area to make any necessary hospital admissions;

(8) provide for necessary hospital services by requiring contracting with general, pediatric, specialty, and psychiatric hospitals on a preferred benefit basis within the insurer's designated service area, as applicable;

(9) ensure that emergency care, as defined by Section 1301.155, is available and accessible 24 hours a day, seven days a week, by preferred providers;

(10) ensure that covered urgent care is available and accessible from preferred providers within the insurer's designated service area within 24 hours for medical and behavioral health conditions;

(11) require an adequate number of preferred providers to be available and accessible to insureds 24 hours a day, seven days a week, within the insurer's designated service area; and

(12) require sufficient numbers and classes of preferred providers to ensure choice, access, and quality of care across the insurer's designated service area.

(c) Subsection (b)(6) does not apply to an exclusive provider benefit plan if the plan has:

(1) contracted with preferred provider hospitals in sufficient number capable of meeting the covered inpatient and outpatient health care benefits for current and actuarially projected utilization in accordance with Subsection (b)(3); or

(2) received a waiver under Subsection (a).

Added by Acts 2009, 81st Leg., R.S., Ch. 1290 (H.B. [2256](#)), Sec. 2, eff. June 19, 2009.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 740 (H.B. 3359), Sec. 5, eff. September 1, 2023.

Sec. 1301.00553. MAXIMUM TRAVEL TIME AND DISTANCE STANDARDS BY PREFERRED PROVIDER TYPE. (a) In this section, "maximum distance" means the miles calculated to drive by automobile within a service area to a particular type of preferred provider.

(b) For purposes of this section, each county in this state is classified as a large metro, metro, micro, or rural county, or a county with extreme access considerations as determined by the federal Centers for Medicare and Medicaid Services by population and density thresholds as of March 1, 2023.

(c) Maximum travel time in minutes and maximum distance in miles for preferred provider benefit plans by preferred provider type for each large metro county are:

(1) for the following physicians, as designated by physician specialty:

	Time	Distance
Allergy and Immunology	30	15
Cardiology	20	10
Cardiothoracic Surgery	30	15
Dermatology	20	10
Emergency Medicine	20	10
Endocrinology	30	15
Ear, Nose, and Throat/Otolaryngology	30	15
Gastroenterology	20	10
General Surgery	20	10
Gynecology and Obstetrics	10	5
Infectious Diseases	30	15
Nephrology	30	15
Neurology	20	10
Neurosurgery	30	15
Oncology: Medical, Surgical	20	10
Oncology: Radiation	30	15
Ophthalmology	20	10
Orthopedic Surgery	20	10
Physical Medicine and Rehabilitation	30	15
Plastic Surgery	30	15

Primary Care: Adults	10	5
Primary Care: Pediatric	10	5
Psychiatry	20	10
Pulmonology	20	10
Rheumatology	30	15
Urology	20	10
Vascular Surgery	30	15

(2) for health care practitioners in the following disciplines:

	Time	Distance
Chiropractic	30	15
Occupational Therapy	20	10
Physical Therapy	20	10
Podiatry	20	10
Speech Therapy	20	10

(3) for the following types of institutional providers:

	Time	Distance
Acute Inpatient Hospitals (Emergency Services Available 24/7)	20	10
Cardiac Catheterization Services	30	15
Cardiac Surgery Program	30	15
Critical Care Services: Intensive Care Units	20	10
Diagnostic Radiology (Freestanding; Hospital Outpatient; Ambulatory Health Facilities with Diagnostic Radiology)	20	10
Inpatient or Residential Behavioral Health Facility Services	30	15
Mammography	20	10
Outpatient Infusion/Chemotherapy	20	10
Skilled Nursing Facilities	20	10
Surgical Services (Outpatient or Ambulatory Surgical Center)	20	10

(4) for the following settings:

Time	Distance
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Outpatient Clinical Behavioral Health (Licensed, Accredited, or Certified)	10	5
Urgent Care	20	10

(d) Maximum travel time in minutes and maximum distance in miles for preferred provider benefit plans by preferred provider type for each metro county are:

(1) for the following physicians, as designated by physician specialty:

	Time	Distance
Allergy and Immunology	45	30
Cardiology	30	20
Cardiothoracic Surgery	60	40
Dermatology	45	30
Emergency Medicine	45	30
Endocrinology	60	40
Ear, Nose, and Throat/Otolaryngology	45	30
Gastroenterology	45	30
General Surgery	30	20
Gynecology and Obstetrics	15	10
Infectious Diseases	60	40
Nephrology	45	30
Neurology	45	30
Neurosurgery	60	40
Oncology: Medical, Surgical	45	30
Oncology: Radiation	60	40
Ophthalmology	30	20
Orthopedic Surgery	30	20
Physical Medicine and Rehabilitation	45	30
Plastic Surgery	60	40
Primary Care: Adults	15	10
Primary Care: Pediatric	15	10
Psychiatry	45	30
Pulmonology	45	30
Rheumatology	60	40
Urology	45	30
Vascular Surgery	60	40

(2) for health care practitioners in the following disciplines:

	Time	Distance
Chiropractic	45	30
Occupational Therapy	45	30
Physical Therapy	45	30
Podiatry	45	30
Speech Therapy	45	30

(3) for the following types of institutional providers:

	Time	Distance
Acute Inpatient Hospitals (Emergency Services Available 24/7)	45	30
Cardiac Catheterization Services	60	40
Cardiac Surgery Program	60	40
Critical Care Services: Intensive Care Units	45	30
Diagnostic Radiology (Freestanding; Hospital Outpatient; Ambulatory Health Facilities with Diagnostic Radiology)	45	30
Inpatient or Residential Behavioral Health Facility Services	70	45
Mammography	45	30
Outpatient Infusion/Chemotherapy	45	30
Skilled Nursing Facilities	45	30
Surgical Services (Outpatient or Ambulatory Surgical Center)	45	30

(4) for the following settings:

	Time	Distance
Outpatient Clinical Behavioral Health (Licensed, Accredited, or Certified)	15	10
Urgent Care	45	30

(e) Maximum travel time in minutes and maximum distance in miles for preferred provider benefit plans by preferred provider type

for each micro county are:

(1) for the following physicians, as designated by physician specialty:

	Time	Distance
Allergy and Immunology	80	60
Cardiology	50	35
Cardiothoracic Surgery	100	75
Dermatology	60	45
Emergency Medicine	80	60
Endocrinology	100	75
Ear, Nose, and Throat/Otolaryngology	80	60
Gastroenterology	60	45
General Surgery	50	35
Gynecology and Obstetrics	30	20
Infectious Diseases	100	75
Nephrology	80	60
Neurology	60	45
Neurosurgery	100	75
Oncology: Medical, Surgical	60	45
Oncology: Radiation	100	75
Ophthalmology	50	35
Orthopedic Surgery	50	35
Physical Medicine and Rehabilitation	80	60
Plastic Surgery	100	75
Primary Care: Adults	30	20
Primary Care: Pediatric	30	20
Psychiatry	60	45
Pulmonology	60	45
Rheumatology	100	75
Urology	60	45
Vascular Surgery	100	75

(2) for health care practitioners in the following disciplines:

	Time	Distance
Chiropractic	80	60
Occupational Therapy	80	60
Physical Therapy	80	60
Podiatry	60	45
Speech Therapy	80	60

(3) for the following types of institutional providers:

	Time	Distance
Acute Inpatient Hospitals (Emergency Services Available 24/7)	80	60
Cardiac Catheterization Services	160	120
Cardiac Surgery Program	160	120
Critical Care Services: Intensive Care Units	160	120
Diagnostic Radiology (Freestanding; Hospital Outpatient; Ambulatory Health Facilities with Diagnostic Radiology)	80	60
Inpatient or Residential Behavioral Health Facility Services	100	75
Mammography	80	60
Outpatient Infusion/Chemotherapy	80	60
Skilled Nursing Facilities	80	60
Surgical Services (Outpatient or Ambulatory Surgical Center)	80	60

(4) for the following settings:

	Time	Distance
Outpatient Clinical Behavioral Health (Licensed, Accredited, or Certified)	30	20
Urgent Care	80	60

(f) Maximum travel time in minutes and maximum distance in miles for preferred provider benefit plans by preferred provider type for each rural county are:

(1) for the following physicians, as designated by physician specialty:

	Time	Distance
Allergy and Immunology	90	75
Cardiology	75	60
Cardiothoracic Surgery	110	90
Dermatology	75	60
Emergency Medicine	75	60

Endocrinology	110	90
Ear, Nose, and Throat/Otolaryngology	90	75
Gastroenterology	75	60
General Surgery	75	60
Gynecology and Obstetrics	40	30
Infectious Diseases	110	90
Nephrology	90	75
Neurology	75	60
Neurosurgery	110	90
Oncology: Medical, Surgical	75	60
Oncology: Radiation	110	90
Ophthalmology	75	60
Orthopedic Surgery	75	60
Physical Medicine and Rehabilitation	90	75
Plastic Surgery	110	90
Primary Care: Adults	40	30
Primary Care: Pediatric	40	30
Psychiatry	75	60
Pulmonology	75	60
Rheumatology	110	90
Urology	75	60
Vascular Surgery	110	90

(2) for health care practitioners in the following disciplines:

	Time	Distance
Chiropractic	90	75
Occupational Therapy	75	60
Physical Therapy	75	60
Podiatry	75	60
Speech Therapy	75	60

(3) for the following types of institutional providers:

	Time	Distance
Acute Inpatient Hospitals (Emergency Services Available 24/7)	75	60
Cardiac Catheterization Services	145	120
Cardiac Surgery Program	145	120

Critical Care Services: Intensive Care Units	145	120
Diagnostic Radiology (Freestanding; Hospital Outpatient; Ambulatory Health Facilities with Diagnostic Radiology)	75	60
Inpatient or Residential Behavioral Health Facility Services	90	75
Mammography	75	60
Outpatient Infusion/Chemotherapy	75	60
Skilled Nursing Facilities	75	60
Surgical Services (Outpatient or Ambulatory Surgical Center)	75	60

(4) for the following settings:

	Time	Distance
Outpatient Clinical Behavioral Health (Licensed, Accredited, or Certified)	40	30
Urgent Care	75	60

(g) Maximum travel time in minutes and maximum distance in miles for preferred provider benefit plans by preferred provider type for each county with extreme access considerations are:

(1) for the following physicians, as designated by physician specialty:

	Time	Distance
Allergy and Immunology	125	110
Cardiology	95	85
Cardiothoracic Surgery	145	130
Dermatology	110	100
Emergency Medicine	110	100
Endocrinology	145	130
Ear, Nose, and Throat/Otolaryngology	125	110
Gastroenterology	110	100
General Surgery	95	85
Gynecology and Obstetrics	70	60
Infectious Diseases	145	130
Nephrology	125	110

Neurology	110	100
Neurosurgery	145	130
Oncology: Medical, Surgical	110	100
Oncology: Radiation	145	130
Ophthalmology	95	85
Orthopedic Surgery	95	85
Physical Medicine and Rehabilitation	125	110
Plastic Surgery	145	130
Primary Care: Adults	70	60
Primary Care: Pediatric	70	60
Psychiatry	110	100
Pulmonology	110	100
Rheumatology	145	130
Urology	110	100
Vascular Surgery	145	130

(2) for health care practitioners in the following disciplines:

	Time	Distance
Chiropractic	125	110
Occupational Therapy	110	100
Physical Therapy	110	100
Podiatry	110	100
Speech Therapy	110	100

(3) for the following institutional providers:

	Time	Distance
Acute Inpatient Hospitals (Emergency Services Available 24/7)	110	100
Cardiac Catheterization Services	155	140
Cardiac Surgery Program	155	140
Critical Care Services: Intensive Care Units	155	140
Diagnostic Radiology (Freestanding; Hospital Outpatient; Ambulatory Health Facilities with Diagnostic Radiology)	110	100
Inpatient or Residential Behavioral Health Facility Services	155	140

Mammography	110	100
Outpatient Infusion/Chemotherapy	110	100
Skilled Nursing Facilities	95	85
Surgical Services (Outpatient or Ambulatory Surgical Center)	110	100

(4) for the following settings:

	Time	Distance
Outpatient Clinical Behavioral Health (Licensed, Accredited, or Certified)	70	60
Urgent Care	110	100

Added by Acts 2023, 88th Leg., R.S., Ch. 740 (H.B. [3359](#)), Sec. 6, eff. September 1, 2023.

Sec. 1301.00554. OTHER MAXIMUM DISTANCE STANDARD REQUIREMENTS; COMMISSIONER AUTHORITY. (a) In this section, "maximum distance" has the meaning assigned by Section 1301.00553.

(b) For a physician specialty not specifically listed in Section 1301.00553, the maximum distance, in any county classification, is 75 miles.

(c) When necessary due to utilization or supply patterns, the commissioner by rule may decrease the base maximum travel time and distance standards listed in this section or Section 1301.00553 for specific counties.

Added by Acts 2023, 88th Leg., R.S., Ch. 740 (H.B. [3359](#)), Sec. 6, eff. September 1, 2023.

Sec. 1301.00555. MAXIMUM APPOINTMENT WAIT TIME STANDARDS. An insurer must ensure that:

(1) routine care is available and accessible from preferred providers:

- (A) within three weeks for medical conditions; and
- (B) within two weeks for behavioral health conditions;

and

(2) preventive health care services are available and accessible from preferred providers:

(A) within two months for a child, or earlier if necessary for compliance with recommendations for specific preventive health care services; and

(B) within three months for an adult.

Added by Acts 2023, 88th Leg., R.S., Ch. 740 (H.B. 3359), Sec. 6, eff. September 1, 2023.

Sec. 1301.0056. EXAMINATIONS AND FEES. (a) The commissioner shall by rule adopt a process for the commissioner to examine a preferred provider benefit plan before an insurer offers the plan for delivery to insureds to determine whether the plan meets the quality of care and network adequacy standards of this chapter. An insurer may not offer a preferred provider benefit plan or an exclusive provider benefit plan before the commissioner determines that the network meets the quality of care and network adequacy standards of this chapter or the insurer receives a waiver under Section 1301.0055.

(a-1) An insurer is subject to a qualifying examination of the insurer's preferred provider benefit plans and subsequent quality of care and network adequacy examinations by the commissioner at least once every three years, in connection with a public hearing under Section 1301.0056 concerning a material deviation from network adequacy standards by a previously authorized plan or a request for a waiver of a network adequacy standard, and whenever the commissioner considers an examination necessary. Documentation provided to the commissioner during an examination conducted under this section is confidential and is not subject to disclosure as public information under Chapter 552, Government Code.

(b) An insurer examined under this section shall pay the cost of the examination in an amount determined by the commissioner.

(c) The department shall collect an assessment in an amount determined by the commissioner from the insurer at the time of the examination to cover all expenses attributable directly to the examination, including the salaries and expenses of department employees and all reasonable expenses of the department necessary for the administration of this chapter.

(d) The department shall deposit an assessment collected under this section to the credit of the account described by Section 401.156(a). Money deposited under this subsection shall be used to pay the salaries and expenses of examiners and all other expenses relating to the examination of insurers under this section.

(e) Rules adopted under this section must require insurers to provide access to or submit data or information necessary for the commissioner to evaluate and make a determination of compliance with quality of care and network adequacy standards. The rules must require insurers to provide access to or submit data or information that includes:

(1) a searchable and sortable database of network physicians and health care providers by national provider identifier, county, physician specialty, hospital privileges and credentials, and type of health care provider or licensure, as applicable;

(2) actuarial data of current and projected number of insureds by county;

(3) actuarial data of current and projected utilization of each preferred provider type listed in Section 1301.00553 and described by Section 1301.00554 by county; and

(4) any other data or information considered necessary by the commissioner to make a determination to authorize the use of the preferred provider benefit plan in the most efficient and effective manner possible.

Added by Acts 2011, 82nd Leg., R.S., Ch. 288 (H.B. [1772](#)), Sec. 9, eff. September 1, 2011.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 1316 (H.B. [3911](#)), Sec. 1, eff. September 1, 2019.

Acts 2023, 88th Leg., R.S., Ch. 740 (H.B. [3359](#)), Sec. 7, eff. September 1, 2023.

Sec. 1301.00565. PUBLIC HEARING ON NETWORK ADEQUACY STANDARDS WAIVERS. (a) In this section, "good faith effort" means honesty in fact, timely participation, observance of reasonable commercial standards of fair dealing, and prioritizing patients' access to in-network care.

(b) The commissioner shall set a public hearing for a

determination of whether there is good cause for a waiver when an insurer:

(1) requests a waiver that does not satisfy Section 1301.0055(a)(6);

(2) requests a waiver that the commissioner does not deny; and

(3) does not complete corrective action for a material deviation reported under Section 1301.0055.

(c) The commissioner shall notify affected physicians and health care providers that may be the subject of a discussion of good faith efforts on behalf of the insurer to meet network adequacy standards and provide the physicians and health care providers with an opportunity to submit evidence, including written testimony, and to attend the public hearing and offer testimony either in person or virtually. An out-of-network physician or hospital, including a physician group or health care system referenced in the insurer's waiver request or notice of material deviation, may not be identified by name at the hearing unless the physician or hospital consents to the identification in advance of the hearing.

(d) At the hearing, the commissioner shall consider all written and oral testimony and evidence submitted by the insurer and the public pertinent to the requested waiver, including:

(1) the total number of physicians or health care providers in each preferred provider type listed in Section 1301.00553 within the county and service area being submitted for the waiver and whether the insurer made a good faith effort to contract with those required preferred provider types to meet network adequacy standards of this chapter;

(2) the total number of facilities, and availability of pediatric, for-profit, nonprofit, tax-supported, and teaching facilities, within the county and service area being submitted for a waiver and whether the insurer made a good faith effort to contract with these facilities and facility-based physicians and health care providers to meet network adequacy standards of this chapter;

(3) population, density, and geographical information to determine the possibility of meeting travel time and distance requirements within the county and service area being submitted for a waiver; and

(4) availability of services, population, and density within the county and service area being submitted for the waiver.

(e) The commissioner may not consider a prohibition on balance billing in determining whether to grant a waiver from network adequacy standards.

(f) The commissioner may not grant a waiver without a public hearing.

(g) Except as provided by this subsection, any evidence submitted to the commissioner as evidence for the public hearing that is proprietary in nature is confidential and not subject to disclosure as public information under Chapter 552, Government Code. Information related to provider directories, credentials, and privileges, estimates of patient populations, and actuarial estimates of needed providers to meet the estimated patient population is not protected under this subsection.

(h) A policyholder is entitled to seek judicial review of the commissioner's decision to grant a waiver under this section in a Travis County district court. Review by the district court under this subsection is de novo.

Added by Acts 2023, 88th Leg., R.S., Ch. 740 (H.B. [3359](#)), Sec. 8, eff. September 1, 2023.

Sec. 1301.00566. EFFECT OF NETWORK ADEQUACY STANDARDS WAIVER ON BALANCE BILLING PROHIBITIONS. After a network adequacy standards waiver is granted by the commissioner, an insurer may refer to the provisions prohibiting balance billing under Sections 1301.0053, 1301.155, 1301.164, or 1301.165, as applicable, in an access plan submitted to the department for the sole purpose of explaining how the insurer will coordinate care to limit the likelihood of a balance bill for services subject to those provisions and not to justify a departure from network adequacy standards.

Added by Acts 2023, 88th Leg., R.S., Ch. 740 (H.B. [3359](#)), Sec. 8, eff. September 1, 2023.

Sec. 1301.0057. ACCESS TO OUT-OF-NETWORK PROVIDERS. An insurer may not terminate, or threaten to terminate, an insured's participation in a preferred provider benefit plan solely because the insured uses an out-of-network provider.

Added by Acts 2015, 84th Leg., R.S., Ch. 275 (H.B. 574), Sec. 5, eff. September 1, 2015.

Sec. 1301.0058. PROTECTED COMMUNICATIONS BY PREFERRED PROVIDERS. (a) An insurer may not in any manner prohibit, attempt to prohibit, penalize, terminate, or otherwise restrict a preferred provider from communicating with an insured about the availability of out-of-network providers for the provision of the insured's medical or health care services.

(b) An insurer may not terminate the contract of or otherwise penalize a preferred provider solely because the provider's patients use out-of-network providers for medical or health care services.

(c) An insurer's contract with a preferred provider may require that, except in a case of a medical emergency as determined by the preferred provider, before the provider may make an out-of-network referral for an insured, the preferred provider inform the insured:

(1) that:

(A) the insured may choose a preferred provider or an out-of-network provider; and

(B) if the insured chooses the out-of-network provider the insured may incur higher out-of-pocket expenses; and

(2) whether the preferred provider has a financial interest in the out-of-network provider.

Added by Acts 2015, 84th Leg., R.S., Ch. 275 (H.B. 574), Sec. 5, eff. September 1, 2015.

Sec. 1301.006. AVAILABILITY OF AND ACCESSIBILITY TO HEALTH CARE SERVICES. (a) An insurer that markets a preferred provider benefit plan shall contract with physicians and health care providers to ensure that all medical and health care services and items contained in the package of benefits for which coverage is provided, including treatment of illnesses and injuries, will be provided under the health insurance policy in a manner ensuring availability of and accessibility to adequate personnel, specialty care, and facilities.

(b) A contract between an insurer that markets a plan regulated under this chapter and an institutional provider may not, as a condition of staff membership or privileges, require a physician or

other practitioner to enter into a preferred provider contract.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 10.01, eff. September 28, 2011.

Sec. 1301.0061. TERMS OF ENROLLEE ELIGIBILITY. (a) A contract between an insurer and a group policyholder under a preferred provider benefit plan must provide that:

(1) in addition to any other premiums for which the group policyholder is liable, the group policyholder is liable for an individual insured's premiums from the time the individual is no longer part of the group eligible for coverage under the policy until the end of the month in which the policyholder notifies the insurer that the individual is no longer part of the group eligible for coverage under the policy; and

(2) the individual remains covered under the policy until the end of that period.

(b) Each insurer that enters into a contract described by Subsection (a) shall notify the group policyholder periodically as provided by this section that the policyholder is liable for premiums on an individual who is no longer part of the group eligible for coverage until the insurer receives notification of termination of the individual's eligibility for coverage.

(c) If the insurer charges the group policyholder on a monthly basis for the premiums, the insurer shall include the notice required by Subsection (b) in each monthly statement sent to the group policyholder. If the insurer charges the group policyholder on other than a monthly basis for the premiums, the insurer shall notify the group policyholder periodically in the manner prescribed by the commissioner by rule.

(d) The notice required by Subsection (b) must include a description of methods preferred by the insurer for notification by a group policyholder of an individual's termination from coverage eligibility.

Added by Acts 2005, 79th Leg., Ch. 669 (S.B. 51), Sec. 1, eff. September 1, 2005.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1217 (S.B. 1143), Sec. 2, eff. September 1, 2009.

Sec. 1301.007. RULES. The commissioner shall adopt rules as necessary to:

- (1) implement this chapter; and
- (2) ensure reasonable accessibility and availability of preferred provider services to residents of this state.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 1221 (H.B. 1030), Sec. 2, eff. September 1, 2005.

Sec. 1301.008. CONFLICT WITH OTHER LAW. To the extent of any conflict between this chapter and Subchapter C, Chapter 1204, this chapter controls.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.037(c), eff. September 1, 2005.

Sec. 1301.009. ANNUAL REPORT. (a) Not later than March 1 of each year, an insurer shall file with the commissioner a report relating to the preferred provider benefit plan offered under this chapter and covering the preceding calendar year.

(b) The report shall:

- (1) be verified by at least two principal officers;
- (2) be in a form prescribed by the commissioner; and
- (3) include:
 - (A) a financial statement of the insurer, including its balance sheet and receipts and disbursements for the preceding calendar year, certified by an independent public accountant;
 - (B) the number of individuals enrolled during the preceding calendar year, the number of enrollees as of the end of that year, and the number of enrollments terminated during that year; and
 - (C) a statement of:
 - (i) an evaluation of enrollee satisfaction;

- (ii) an evaluation of quality of care;
- (iii) coverage areas;
- (iv) accreditation status;
- (v) premium costs;
- (vi) plan costs;
- (vii) premium increases;
- (viii) the range of benefits provided;
- (ix) copayments and deductibles;
- (x) the accuracy and speed of claims payment by the insurer for the plan;
- (xi) the credentials of physicians who are preferred providers;
- (xii) the number of preferred providers;
- (xiii) any waiver requests made and waivers of network adequacy standards granted under Section 1301.00565;
- (xiv) any material deviation from network adequacy standards reported to the department under Section 1301.0055; and
- (xv) any corrective actions, sanctions, or penalties assessed against the insurer by the department for deficiencies related to the preferred provider benefit plan.

(c) The annual report filed by the insurer shall be made publicly available on the department's website in a user-friendly format that allows consumers to make direct comparisons of the financial and other data reported by insurers under this section.

(d) An insurer providing group coverage of \$10 million or less in premiums or individual coverage of \$2 million or less in premiums is not required to report the data required under Subsection (b)(3)(C).

Added by Acts 2007, 80th Leg., R.S., Ch. 997 (S.B. [1731](#)), Sec. 10, eff. September 1, 2007.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 740 (H.B. [3359](#)), Sec. 9, eff. September 1, 2023.

Text of section effective until September 1, 2025

Sec. 1301.010. BALANCE BILLING PROHIBITION NOTICE. (a) An insurer shall provide written notice in accordance with this section in an explanation of benefits provided to the insured and the

physician or health care provider in connection with a medical care or health care service or supply or transport provided by an out-of-network provider. The notice must include:

- (1) a statement of the billing prohibition under Section 1301.0053, 1301.155, 1301.164, 1301.165, or 1301.166, as applicable;
- (2) the total amount the physician or provider may bill the insured under the insured's preferred provider benefit plan and an itemization of copayments, coinsurance, deductibles, and other amounts included in that total; and
- (3) for an explanation of benefits provided to the physician or provider, information required by commissioner rule advising the physician or provider of the availability of mediation or arbitration, as applicable, under Chapter 1467.

(b) An insurer shall provide the explanation of benefits with the notice required by this section to a physician or health care provider not later than the date the insurer makes a payment under Section 1301.0053, 1301.155, 1301.164, 1301.165, or 1301.166, as applicable.

Added by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. [1264](#)), Sec. 1.07, eff. September 1, 2019.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 981 (S.B. [2476](#)), Sec. 7(a), eff. September 1, 2023.

Acts 2023, 88th Leg., R.S., Ch. 981 (S.B. [2476](#)), Sec. 7(b), eff. September 1, 2025.

Text of section effective on September 1, 2025

Sec. 1301.010. BALANCE BILLING PROHIBITION NOTICE. (a) An insurer shall provide written notice in accordance with this section in an explanation of benefits provided to the insured and the physician or health care provider in connection with a medical care or health care service or supply provided by an out-of-network provider. The notice must include:

- (1) a statement of the billing prohibition under Section 1301.0053, 1301.155, 1301.164, or 1301.165, as applicable;
- (2) the total amount the physician or provider may bill the insured under the insured's preferred provider benefit plan and an itemization of copayments, coinsurance, deductibles, and other

amounts included in that total; and

(3) for an explanation of benefits provided to the physician or provider, information required by commissioner rule advising the physician or provider of the availability of mediation or arbitration, as applicable, under Chapter 1467.

(b) An insurer shall provide the explanation of benefits with the notice required by this section to a physician or health care provider not later than the date the insurer makes a payment under Section 1301.0053, 1301.155, 1301.164, or 1301.165, as applicable.

Added by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 1.07, eff. September 1, 2019.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 981 (S.B. 2476), Sec. 7(a), eff. September 1, 2023.

Acts 2023, 88th Leg., R.S., Ch. 981 (S.B. 2476), Sec. 7(b), eff. September 1, 2025.

SUBCHAPTER B. RELATIONS WITH PHYSICIANS OR HEALTH CARE PROVIDERS

Sec. 1301.051. DESIGNATION AS PREFERRED PROVIDER. (a) An insurer shall afford a fair, reasonable, and equivalent opportunity to apply to be and to be designated as a preferred provider to practitioners and institutional providers and to health care providers other than practitioners and institutional providers, if those other health care providers are included by the insurer as preferred providers, provided that the practitioners, institutional providers, or health care providers:

(1) are licensed to treat injuries or illnesses or to provide services covered by a health insurance policy; and

(2) comply with the terms established by the insurer for designation as preferred providers.

(b) An insurer may not unreasonably withhold a designation as a preferred provider.

(c) An insurer shall give a physician or health care provider who, on the person's initial application, is not designated as a preferred provider written reasons for denial of the designation.

(d) Unless otherwise limited by this code, this section does not prohibit an insurer from rejecting a physician's or health care provider's application for designation based on a determination that

the preferred provider benefit plan has sufficient qualified providers.

(e) An insurer may not withhold a designation to:

- (1) a podiatrist described by Section 1301.0521; or
- (2) an optometrist, therapeutic optometrist, or

ophthalmologist described by Section 1301.0522.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.034(a), eff. September 1, 2005.

Acts 2015, 84th Leg., R.S., Ch. 1271 (S.B. 684), Sec. 1, eff. September 1, 2015.

Sec. 1301.0515. ACUPUNCTURIST SERVICES. (a) An insurer offering a preferred provider benefit plan that includes acupuncture in the services covered by the plan may not refuse to provide reimbursement for the performance of a covered acupuncture service solely because the service is provided by an acupuncturist.

(b) This section does not require an insurer to offer acupuncture as a covered service.

Added by Acts 2005, 79th Leg., Ch. 622 (H.B. 2371), Sec. 2, eff. September 1, 2005.

Sec. 1301.0516. CHIROPRACTIC SERVICES. (a) An insurer offering a preferred provider benefit plan that covers a service that is within the scope of a chiropractor's license may not refuse to provide reimbursement for the performance of the covered service solely because the service is provided by a chiropractor.

(b) This section does not require an insurer to cover a particular medical or health care service.

(c) This section does not affect the right of an insurer to determine whether a medical or health care service is medically necessary.

(d) An insurer that violates this section is subject to an administrative penalty as provided by Chapter 84 of not more than \$1,000 for each claim that remains unpaid in violation of this section. Each day a violation continues constitutes a separate

violation.

Added by Acts 2019, 86th Leg., R.S., Ch. 116 (S.B. 1739), Sec. 2, eff. September 1, 2019.

Sec. 1301.052. DESIGNATION OF ADVANCED PRACTICE NURSE OR PHYSICIAN ASSISTANT AS PREFERRED PROVIDER. An insurer offering a preferred provider benefit plan may not refuse a request made by a physician participating as a preferred provider under the plan and an advanced practice nurse or physician assistant to have the advanced practice nurse or physician assistant included as a preferred provider under the plan if:

(1) the advanced practice nurse or physician assistant is authorized by the physician to provide care under Subchapter B, Chapter 157, Occupations Code; and

(2) the advanced practice nurse or physician assistant meets the quality of care standards previously established by the insurer for participation in the plan by advanced practice nurses and physician assistants.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1301.0521. DESIGNATION OF CERTAIN PODIATRISTS AS PREFERRED PROVIDERS. (a) Notwithstanding Section 1301.051, an insurer may not withhold the designation of preferred provider to a podiatrist licensed by the Texas Department of Licensing and Regulation who:

(1) joins the professional practice of a contracted preferred provider;

(2) applies to the insurer for designation as a preferred provider; and

(3) complies with the terms and conditions of eligibility to be a preferred provider.

(b) A podiatrist designated as a preferred provider under this section must comply with the terms of the preferred provider contract used by the insurer or the insurer's network provider.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.035(a), eff. September 1, 2005.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 467 (H.B. 4170), Sec. 19.013, eff. September 1, 2019.

Sec. 1301.0522. DESIGNATION OF CERTAIN OPTOMETRISTS, THERAPEUTIC OPTOMETRISTS, AND OPHTHALMOLOGISTS AS PREFERRED PROVIDERS. (a) Notwithstanding Section 1301.051, an insurer may not withhold the designation of preferred provider to an optometrist or therapeutic optometrist licensed by the Texas Optometry Board or an ophthalmologist licensed by the Texas Medical Board who:

(1) joins the professional practice of a contracted preferred provider;

(2) applies to the insurer for designation as a preferred provider; and

(3) complies with the terms and conditions of eligibility to be a preferred provider.

(b) An optometrist, therapeutic optometrist, or ophthalmologist designated as a preferred provider under this section must comply with the terms of the preferred provider contract used by the insurer or the insurer's network provider.

Added by Acts 2015, 84th Leg., R.S., Ch. 1271 (S.B. 684), Sec. 2, eff. September 1, 2015.

Sec. 1301.053. APPEAL RELATING TO DESIGNATION AS PREFERRED PROVIDER. (a) An insurer that does not designate a practitioner as a preferred provider shall provide a reasonable mechanism for reviewing that action. The review mechanism must incorporate, in an advisory role only, a review panel.

(b) A review panel must be composed of at least three individuals selected by the insurer from a list of participating practitioners and must include one member who is a practitioner in the same or similar specialty as the affected practitioner, if available. The practitioners contracting with the insurer in the applicable service area shall provide the list of practitioners to the insurer.

(c) On request, the insurer shall provide to the affected practitioner:

(1) the panel's recommendation, if any; and

(2) a written explanation of the insurer's determination, if that determination is contrary to the panel's recommendation.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1301.054. NOTICE TO PRACTITIONERS OF PREFERRED PROVIDER BENEFIT PLAN. (a) When sponsoring a preferred provider benefit plan, an insurer shall immediately notify each practitioner in the plan's service area of the insurer's intent to offer the plan and of the opportunity to participate. The notification must be made by publication or in writing to each practitioner.

(b) After establishing a preferred provider benefit plan, an insurer shall annually provide notice of and an opportunity to participate in the plan to practitioners in the plan's service area who do not participate in the plan.

(c) On request, an insurer shall provide to any physician or health care provider information concerning the application process and qualification requirements for participation as a preferred provider in the plan.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1301.055. COMPLAINT RESOLUTION. (a) Each contract under a preferred provider benefit plan between an insurer and a physician or other practitioner or a physicians' group must have a mechanism for resolving complaints initiated by an insured, a physician or other practitioner, or a physicians' group.

(b) A complaint resolution mechanism must provide for reasonable due process that includes, in an advisory role only, a review panel selected in the manner described by Section 1301.053(b).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1301.056. RESTRICTIONS ON PAYMENT AND REIMBURSEMENT. (a) An insurer or third-party administrator may not reimburse a physician or other practitioner, institutional provider, or organization of physicians and health care providers on a discounted fee basis for covered services that are provided to an insured unless:

(1) the insurer or third-party administrator has contracted with either:

(A) the physician or other practitioner, institutional provider, or organization of physicians and health care providers; or

(B) a preferred provider organization that has a network of preferred providers and that has contracted with the physician or other practitioner, institutional provider, or organization of physicians and health care providers;

(2) the physician or other practitioner, institutional provider, or organization of physicians and health care providers has agreed to the contract and has agreed to provide health care services under the terms of the contract; and

(3) the insurer or third-party administrator has agreed to provide coverage for those health care services under the health insurance policy.

(b) A party to a preferred provider contract, including a contract with a preferred provider organization, may not sell, lease, or otherwise transfer information regarding the payment or reimbursement terms of the contract without the express authority of and prior adequate notification to the other contracting parties. This subsection does not affect the authority of the commissioner of insurance or the commissioner of workers' compensation under this code or Title 5, Labor Code, to request and obtain information.

(c) An insurer or third-party administrator who violates this section:

(1) commits an unfair claim settlement practice in violation of Subchapter A, Chapter 542; and

(2) is subject to administrative penalties under Chapters 82 and 84.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 6.061, eff. September 1, 2005.

Sec. 1301.057. TERMINATION OF PARTICIPATION; EXPEDITED REVIEW PROCESS. (a) Before terminating a contract with a preferred provider, an insurer shall:

- (1) provide written reasons for the termination; and
- (2) if the affected provider is a practitioner, provide, on request, a reasonable review mechanism, except in a case involving:
 - (A) imminent harm to a patient's health;
 - (B) an action by a state medical or other physician licensing board or other government agency that effectively impairs the practitioner's ability to practice medicine; or
 - (C) fraud or malfeasance.

(b) The review mechanism described by Subsection (a)(2) must incorporate, in an advisory role only, a review panel selected in the manner described by Section 1301.053(b) and must be completed within a period not to exceed 60 days.

- (c) The insurer shall provide to the affected practitioner:
 - (1) the panel's recommendation, if any; and
 - (2) on request, a written explanation of the insurer's determination, if that determination is contrary to the panel's recommendation.

(d) On request, an insurer shall provide to a practitioner whose participation in a preferred provider benefit plan is being terminated:

- (1) an expedited review conducted in accordance with a process that complies with rules established by the commissioner; and
- (2) all information on which the insurer wholly or partly based the termination, including the economic profile of the preferred provider, the standards by which the provider is measured, and the statistics underlying the profile and standards.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2015, 84th Leg., R.S., Ch. 275 (H.B. 574), Sec. 6, eff. September 1, 2015.

Sec. 1301.058. ECONOMIC PROFILING. An insurer that conducts, uses, or relies on economic profiling to admit or terminate the participation of physicians or health care providers in a preferred provider benefit plan shall make available to a physician or health care provider on request the economic profile of that physician or health care provider, including the written criteria by which the physician or health care provider's performance is to be measured.

An economic profile must be adjusted to recognize the characteristics of a physician's or health care provider's practice that may account for variations from expected costs.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1301.059. QUALITY ASSESSMENT. (a) In this section, "quality assessment" means a mechanism used by an insurer to evaluate, monitor, or improve the quality and effectiveness of the medical care delivered by physicians or health care providers to persons covered by a health insurance policy to ensure that the care delivered is consistent with the care delivered by an ordinary, reasonable, and prudent physician or health care provider under the same or similar circumstances.

(b) An insurer may not engage in quality assessment except through a panel of at least three physicians selected by the insurer from among a list of physicians contracting with the insurer. The physicians contracting with the insurer in the applicable service area shall provide the list of physicians to the insurer.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1301.060. COMPENSATION ON DISCOUNTED FEE BASIS. A preferred provider contract must include a provision by which the physician or health care provider agrees that if the preferred provider is compensated on a discounted fee basis, the insured may be billed only on the discounted fee and not the full charge.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1301.061. PREFERRED PROVIDER NETWORKS. (a) An insurer may enter into an agreement with a preferred provider organization for the purposes of offering a network of preferred providers. The agreement may provide that either the insurer or the preferred provider organization on the insurer's behalf will comply with the notice requirements and other requirements imposed on the insurer by this subchapter.

(b) An insurer that enters into an agreement with a preferred

provider organization under this section shall meet the requirements of this chapter or ensure that those requirements are met.

(c) Each preferred provider benefit plan offered in this state must comply with this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.0271(a), eff. September 1, 2007.

Sec. 1301.062. PREFERRED PROVIDER CONTRACTS BETWEEN INSURERS AND PODIATRISTS. A preferred provider contract between an insurer and a podiatrist licensed by the Texas Department of Licensing and Regulation must provide that:

(1) the podiatrist may request a copy of the coding guidelines and payment schedules applicable to the compensation that the podiatrist will receive under the contract for services;

(2) the insurer shall provide a copy of the coding guidelines and payment schedules not later than the 30th day after the date of the podiatrist's request;

(3) the insurer may not unilaterally make material retroactive revisions to the coding guidelines and payment schedules; and

(4) the podiatrist may, practicing within the scope of the law regulating podiatry, furnish x-rays and nonprefabricated orthotics covered by the health insurance policy.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 467 (H.B. 4170), Sec. 19.014, eff. September 1, 2019.

Sec. 1301.0625. HEALTH CARE COLLABORATIVES. (a) Subject to the requirements of this chapter, a health care collaborative may be designated as a preferred provider under a preferred provider benefit plan and may offer enhanced benefits for care provided by the health care collaborative.

(b) A preferred provider contract between an insurer and a health care collaborative may use a payment methodology other than a

fee-for-service or discounted fee methodology. A reimbursement methodology used in a contract under this subsection is not subject to Chapter 843.

(c) A contract authorized by Subsection (b) must specify that the health care collaborative and the physicians or providers providing health care services on behalf of the collaborative will hold an insured harmless for payment of the cost of covered health care services if the insurer or the health care collaborative do not pay the physician or health care provider for the services.

(d) An insurer issuing an exclusive provider benefit plan authorized by another law of this state may limit access to only preferred providers participating in a health care collaborative if the limitation is consistent with all requirements applicable to exclusive provider benefit plans.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 4.03, eff. September 28, 2011.

Sec. 1301.063. CONTRACT PROVISIONS RELATING TO USE OF HOSPITALIST. (a) In this section, "hospitalist" means a physician who:

(1) serves as physician of record at a hospital for a hospitalized patient of another physician; and

(2) returns the care of the patient to that other physician at the end of the patient's hospitalization.

(b) A preferred provider contract between an insurer and a physician may not require the physician to use a hospitalist for a hospitalized patient.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1301.064. CONTRACT PROVISIONS RELATING TO PAYMENT OF CLAIMS. Subject to Subchapter C, a preferred provider contract must provide for payment to a physician or health care provider for health care services and benefits provided to an insured under the contract and to which the insured is entitled under the terms of the contract not later than:

(1) the 45th day after the date on which a claim for payment is received with the documentation reasonably necessary to

process the claim; or

(2) if applicable, within the number of calendar days specified by written agreement between the physician or health care provider and the insurer.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1301.0641. CONTRACT PROVISIONS PROHIBITING REJECTION OF BATCHED CLAIMS. (a) If requested by a preferred provider, an insurer shall include a provision in the preferred provider's contract providing that the insurer or the insurer's clearinghouse may not refuse to process or pay an electronically submitted clean claim, as defined by Subchapter C, because the claim is submitted together with or in a batch submission with a claim that is not a clean claim.

(b) In accordance with Chapters 82 and 84, the commissioner may issue a cease and desist order against or impose sanctions on an insurer that violates this section or a contract provision adopted under this section.

Added by Acts 2005, 79th Leg., Ch. 668 (S.B. 50), Sec. 2, eff. September 1, 2005.

Sec. 1301.0642. CONTRACT PROVISIONS ALLOWING CERTAIN ADVERSE MATERIAL CHANGES PROHIBITED. (a) In this section, "adverse material change" means a change to a preferred provider contract with a physician, health care practitioner, or organization of physicians or health care practitioners that would decrease the preferred provider's payment or compensation, change the provider's tier to a less preferred tier, or change the administrative procedures in a way that may reasonably be expected to significantly increase the provider's administrative expenses or decrease the provider's payment or compensation. The term does not include:

(1) a decrease in payment or compensation resulting solely from a change in a published governmental fee schedule on which the payment or compensation is based if the applicability of the schedule is clearly identified in the contract;

(2) a decrease in payment or compensation that was anticipated under the terms of the contract, if the amount and date

of applicability of the decrease is clearly identified in the contract;

(3) an administrative change that may significantly increase the provider's administrative expense, the specific applicability of which is clearly identified in the contract;

(4) a change that is required by federal or state law;

(5) a termination for cause; or

(6) a termination without cause at the end of the term of the contract.

(b) An adverse material change to a preferred provider contract may only be made during the term of the preferred provider contract with the mutual agreement of the parties. A provision in a preferred provider contract that allows the insurer to unilaterally make an adverse material change during the term of the contract is void and unenforceable.

(c) Any adverse material change to the preferred provider contract may not go into effect until the 120th day after the date the preferred provider affirmatively agrees to the adverse material change in writing.

(d) A proposed amendment by an insurer seeking an adverse material change to a preferred provider contract must include notice that clearly and conspicuously states that a preferred provider may choose to not agree to the amendment and that the decision to not agree to the amendment may not affect:

(1) the terms of the provider's existing contract with the insurer; or

(2) the provider's participation in other health plans or products.

(e) A preferred provider's failure to agree to an adverse material change to a preferred provider contract does not affect:

(1) the terms of the provider's existing contract with the insurer; or

(2) the provider's participation in other health care products or plans.

(f) An insurer's failure to include the notice described by Subsection (d) with the proposed amendment makes an otherwise agreed-to adverse material change void and unenforceable.

(g) This section does not apply to a preferred provider contract:

(1) with an unspecified and indefinite duration;

- (2) with no stated or automatic renewal period or event;
and
- (3) that may only be terminated by notice from one party to the other.

Added by Acts 2023, 88th Leg., R.S., Ch. 740 (H.B. 3359), Sec. 10, eff. September 1, 2023.

Sec. 1301.065. SHIFTING OF INSURER'S TORT LIABILITY PROHIBITED. A preferred provider contract may not require any physician, health care provider, or physicians' group to execute a hold harmless clause to shift the insurer's tort liability resulting from the insurer's acts or omissions to the preferred provider.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1301.066. RETALIATION AGAINST PREFERRED PROVIDER PROHIBITED. An insurer may not engage in any retaliatory action against a physician or health care provider, including terminating the physician's or provider's participation in the preferred provider benefit plan or refusing to renew the physician's or provider's contract, because the physician or provider has:

- (1) on behalf of an insured, reasonably filed a complaint against the insurer; or
- (2) appealed a decision of the insurer.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1301.067. INTERFERENCE WITH RELATIONSHIP BETWEEN PATIENT AND PHYSICIAN OR HEALTH CARE PROVIDER PROHIBITED. (a) An insurer may not, as a condition of a preferred provider contract with a physician or health care provider or in any other manner, prohibit, attempt to prohibit, or discourage a physician or provider from discussing with or communicating to a current, prospective, or former patient, or a person designated by a patient, information or an opinion:

- (1) regarding the patient's health care, including the patient's medical condition or treatment options; or

(2) in good faith regarding the provisions, terms, requirements, or services of the health insurance policy as they relate to the patient's medical needs.

(a-1) An insurer may not, as a condition of payment with a physician or health care provider or in any other manner, require a physician or health care provider to provide a notification form stating that the physician or health care provider is an out-of-network provider to a current, prospective, or former patient, or a person designated by the patient, if the form contains additional information that is intended, or is otherwise required to be presented in a manner that is intended, to intimidate the patient.

(b) An insurer may not in any way penalize, terminate the participation of, or refuse to compensate for covered services a physician or health care provider for discussing or communicating with a current, prospective, or former patient, or a person designated by a patient, pursuant to this section.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2015, 84th Leg., R.S., Ch. 275 (H.B. 574), Sec. 7, eff. September 1, 2015.

Sec. 1301.068. INDUCEMENT TO LIMIT MEDICALLY NECESSARY SERVICES PROHIBITED. (a) An insurer may not use any financial incentive or make payment to a physician or health care provider that acts directly or indirectly as an inducement to limit medically necessary services.

(b) This section does not prohibit the use of capitation as a method of payment.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1301.069. SERVICES PROVIDED BY CERTAIN PHYSICIANS AND HEALTH CARE PROVIDERS. The provisions of this chapter relating to prompt payment by an insurer of a physician or health care provider and to verification of medical care or health care services apply to a physician or provider who:

(1) is not a preferred provider included in the preferred provider network; and

(2) provides to an insured:

(A) care related to an emergency or its attendant episode of care as required by state or federal law; or

(B) specialty or other medical care or health care services at the request of the insurer or a preferred provider because the services are not reasonably available from a preferred provider who is included in the preferred delivery network.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.037(d), eff. September 1, 2005.

SUBCHAPTER C. PROMPT PAYMENT OF CLAIMS

Sec. 1301.101. DEFINITION. In this subchapter, "clean claim" means a claim that complies with Section 1301.131.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.037(a), eff. September 1, 2005.

Sec. 1301.102. SUBMISSION OF CLAIM. (a) A physician or health care provider must submit a claim to an insurer not later than the 95th day after the date the physician or provider provides the medical care or health care services for which the claim is made.

(b) Except as provided by Chapter 1213, a physician or health care provider may, as appropriate:

(1) mail a claim by United States mail, first class, or by overnight delivery service;

(2) submit the claim electronically;

(3) fax the claim; or

(4) hand deliver the claim.

(c) An insurer shall accept as proof of timely filing a claim filed in compliance with Subsection (b) or information from another insurer or health maintenance organization showing that the physician or health care provider submitted the claim to the insurer or health maintenance organization in compliance with Subsection (b).

(d) If a physician or health care provider fails to submit a claim in compliance with this section, the physician or provider forfeits the right to payment.

(e) The period for submitting a claim under this section may be extended by:

(1) contract;

(2) notice published by the commissioner allowing an extension of prompt payment deadlines to a later date chosen by the commissioner due to a catastrophic event; or

(3) the department's approval of a physician's or health care provider's request for an extension due to a catastrophic event that substantially interferes with the normal business operations of the physician or provider.

(e-1) The commissioner may adopt rules to implement Subsection (e), including rules establishing requirements for a request made under Subsection (e)(3).

(f) A physician or health care provider may not submit a duplicate claim for payment before the 46th day after the date the original claim was submitted. The commissioner shall adopt rules under which an insurer may determine whether a claim is a duplicate claim.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.037(a), eff. September 1, 2005.

Acts 2023, 88th Leg., R.S., Ch. 90 (S.B. 1286), Sec. 3, eff. September 1, 2023.

Sec. 1301.1021. RECEIPT OF CLAIM. (a) If a claim for medical care or health care services provided to a patient is mailed, the claim is presumed to have been received by the insurer on the fifth day after the date the claim is mailed or, if the claim is mailed using overnight service or return receipt requested, on the date the delivery receipt is signed.

(b) If the claim is submitted electronically, the claim is presumed to have been received on the date of the electronic verification of receipt by the insurer or the insurer's clearinghouse. If the insurer or the insurer's clearinghouse does not provide a confirmation within 24 hours of submission by the physician or health care provider, the physician's or provider's clearinghouse shall provide the confirmation. The physician's or

provider's clearinghouse must be able to verify that the filing contained the correct payor identification of the entity to receive the filing.

(c) If the claim is faxed, the claim is presumed to have been received on the date of the transmission acknowledgment.

(d) If the claim is hand delivered, the claim is presumed to have been received on the date the delivery receipt is signed.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.037(a), eff. September 1, 2005.

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

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

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

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

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.037(a), eff. September 1, 2005.

Acts 2011, 82nd Leg., R.S., Ch. 798 (H.B. 2292), Sec. 8, eff. September 1, 2011.

Sec. 1301.104. DEADLINE FOR ACTION ON PHARMACY CLAIMS; PAYMENT.

(a) 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 shall pay the total amount of the claim through electronic funds transfer not later than the 18th day after the date on which the claim was affirmatively adjudicated.

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

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.037(a), eff. September 1, 2005.

Acts 2011, 82nd Leg., R.S., Ch. 798 (H.B. 2292), Sec. 9, eff. September 1, 2011.

Sec. 1301.105. AUDITED CLAIMS. (a) Except as provided by Section 1301.1054, an insurer that intends to audit a claim submitted by a preferred provider shall pay the charges submitted at 100 percent of the contracted rate on the claim not later than:

(1) the 30th day after the date the insurer receives the clean claim from the preferred provider if the claim is submitted electronically; or

(2) the 45th day after the date the insurer receives the clean claim from the preferred provider if the claim is submitted nonelectronically.

(b) The insurer shall clearly indicate on the explanation of payment statement in the manner prescribed by the commissioner by rule that the clean claim is being paid at 100 percent of the contracted rate, subject to completion of the audit.

(c) If the insurer requests additional information to complete the audit, the request must describe with specificity the clinical information requested and relate only to information the insurer in good faith can demonstrate is specific to the claim or episode of care. The insurer may not request as a part of the audit information that is not contained in, or is not in the process of being

incorporated into, the patient's medical or billing record maintained by a preferred provider.

(d) If the preferred provider does not supply information reasonably requested by the insurer in connection with the audit, the insurer may:

(1) notify the provider in writing that the provider must provide the information not later than the 45th day after the date of the notice or forfeit the amount of the claim; and

(2) if the provider does not provide the information required by this section, recover the amount of the claim.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.037(a), eff. September 1, 2005.

Sec. 1301.1051. COMPLETION OF AUDIT. The insurer must complete an audit under Section 1301.105 on or before the 180th day after the date the clean claim is received by the insurer, and any additional payment due a preferred provider or any refund due the insurer shall be made not later than the 30th day after the completion of the audit.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.037(a), eff. September 1, 2005.

Sec. 1301.1052. PREFERRED PROVIDER APPEAL AFTER AUDIT. If a preferred provider disagrees with a refund request made by an insurer based on an audit under Section 1301.105, the insurer shall provide the provider with an opportunity to appeal, and the insurer may not attempt to recover the payment until all appeal rights are exhausted.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.037(a), eff. September 1, 2005.

Sec. 1301.1053. DEADLINES NOT EXTENDED. The investigation and

determination of payment, including any coordination of other payments, does not extend the period for determining whether a claim is payable under Section 1301.103 or 1301.104 or for auditing a claim under Section 1301.105.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.037(a), eff. September 1, 2005.

Sec. 1301.1054. REQUESTS FOR ADDITIONAL INFORMATION. (a) If an insurer needs additional information from a treating preferred provider to determine payment, the insurer, not later than the 30th calendar day after the date the insurer receives a clean claim, shall request in writing that the preferred provider provide an attachment to the claim that is relevant and necessary for clarification of the claim. The request must describe with specificity the clinical information requested and relate only to information the insurer can demonstrate is specific to the claim or the claim's related episode of care. The preferred provider is not required to provide an attachment that is not contained in, or is not in the process of being incorporated into, the patient's medical or billing record maintained by a preferred provider.

(b) An insurer that requests an attachment under Subsection (a) shall determine whether the claim is payable on or before the later of the 15th day after the date the insurer receives the requested attachment or the latest date for determining whether the claim is payable under Section 1301.103 or 1301.104.

(c) An insurer may not make more than one request under Subsection (a) in connection with a claim. Sections 1301.102(b) and 1301.1021 apply to a request for and submission of an attachment under Subsection (a).

(d) If an insurer requests an attachment or other information from a person other than the preferred provider who submitted the claim, the insurer shall provide notice containing the name of the physician or health care provider from whom the insurer is requesting information to the preferred provider who submitted the claim. The insurer may not withhold payment pending receipt of an attachment or information requested under this subsection. If on receiving an attachment or information requested under this subsection the insurer

determines that there was an error in payment of the claim, the insurer may recover any overpayment under Section 1301.132.

(e) The commissioner shall adopt rules under which an insurer can easily identify attachments or other information submitted by a physician or health care provider under this section.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.037(a), eff. September 1, 2005.

Sec. 1301.106. CLAIMS PROCESSING PROCEDURES AND CLAIMS PAYMENT PROCESSES. (a) An insurer shall provide a preferred provider with copies of all applicable utilization review policies and claim processing policies or procedures.

(b) An insurer's claims payment processes shall:

(1) use nationally recognized, generally accepted Current Procedural Terminology codes, notes, and guidelines, including all relevant modifiers; and

(2) be consistent with nationally recognized, generally accepted bundling edits and logic.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.037(a), eff. September 1, 2005.

Sec. 1301.107. CONTRACTUAL WAIVER AND OTHER ACTIONS PROHIBITED. Except as provided by Section 1301.102(e), the provisions of this subchapter may not be waived, voided, or nullified by contract.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.037(a), eff. September 1, 2005.

Sec. 1301.108. ATTORNEY'S FEES. A preferred provider may recover reasonable attorney's fees and court costs in an action to recover payment under this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.037(a), eff. September 1, 2005.

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

- (1) process or pay claims;
- (2) obtain the services of physicians and health care providers to provide health care services to insureds; or
- (3) issue verifications or preauthorizations.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.037(a), eff. September 1, 2005.

Acts 2011, 82nd Leg., R.S., Ch. 798 (H.B. 2292), Sec. 11, eff. September 1, 2011.

SUBCHAPTER C-1. OTHER PROVISIONS RELATING TO PAYMENT OF CLAIMS

Sec. 1301.131. ELEMENTS OF CLEAN CLAIM. (a) A nonelectronic claim by a physician or health care provider, other than an institutional provider, is a "clean claim" if the claim is submitted using the Centers for Medicare and Medicaid Services Form 1500 or, if adopted by the commissioner by rule, a successor to that form developed by the National Uniform Claim Committee or the committee's successor. An electronic claim by a physician or provider, other than an institutional provider, is a "clean claim" if the claim is submitted using the Professional 837 (ASC X12N 837) format or, if adopted by the commissioner by rule, a successor to that format adopted by the Centers for Medicare and Medicaid Services or the center's successor.

(b) A nonelectronic claim by an institutional provider is a "clean claim" if the claim is submitted using the Centers for Medicare and Medicaid Services Form UB-92 or, if adopted by the commissioner by rule, a successor to that form developed by the National Uniform Billing Committee or the committee's successor. An

electronic claim by an institutional provider is a "clean claim" if the claim is submitted using the Institutional 837 (ASC X12N 837) format or, if adopted by the commissioner by rule, a successor to that format adopted by the Centers for Medicare and Medicaid Services or the centers' successor.

(c) The commissioner may adopt rules that specify the information that must be entered into the appropriate fields on the applicable claim form for a claim to be a clean claim.

(d) The commissioner may not require any data element for an electronic claim that is not required in an electronic transaction set needed to comply with federal law.

(e) An insurer and a preferred provider may agree by contract to use fewer data elements than are required in an electronic transaction set needed to comply with federal law.

(f) An otherwise clean claim submitted by a physician or health care provider that includes additional fields, data elements, attachments, or other information not required under this section is considered to be a clean claim for the purposes of this chapter.

(g) Except as provided by Subsection (e), the provisions of this section may not be waived, voided, or nullified by contract.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.037(b), eff. September 1, 2005.

Sec. 1301.132. OVERPAYMENT. (a) An insurer may recover an overpayment to a physician or health care provider if:

(1) not later than the 180th day after the date the physician or provider receives the payment, the insurer provides written notice of the overpayment to the physician or provider that includes the basis and specific reasons for the request for recovery of funds; and

(2) the physician or provider does not make arrangements for repayment of the requested funds on or before the 45th day after the date the physician or provider receives the notice.

(b) If a physician or health care provider disagrees with a request for recovery of an overpayment, the insurer shall provide the physician or provider with an opportunity to appeal, and the insurer may not attempt to recover the overpayment until all appeal rights are exhausted.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.037(b), eff. September 1, 2005.

Sec. 1301.133. VERIFICATION. (a) In this section, "verification" includes preauthorization only when preauthorization is a condition for the verification.

(b) On the request of a preferred provider for verification of a particular medical care or health care service the preferred provider proposes to provide to a particular patient, the insurer shall inform the preferred provider without delay whether the service, if provided to that patient, will be paid by the insurer and shall specify any deductibles, copayments, or coinsurance for which the insured is responsible.

(c) An insurer shall have appropriate personnel reasonably available at a toll-free telephone number to provide a verification under this section between 6 a.m. and 6 p.m. central time Monday through Friday on each day that is not a legal holiday and between 9 a.m. and noon central time on Saturday, Sunday, and legal holidays. An insurer must have a telephone system capable of accepting or recording incoming phone calls for verifications after 6 p.m. central time Monday through Friday and after noon central time on Saturday, Sunday, and legal holidays and responding to each of those calls on or before the second calendar day after the date the call is received.

(d) An insurer may decline to determine eligibility for payment if the insurer notifies the physician or preferred provider who requested the verification of the specific reason the determination was not made.

(e) An insurer may establish a specific period during which the verification is valid of not less than 30 days.

(f) An insurer that declines to provide a verification shall notify the physician or provider who requested the verification of the specific reason the verification was not provided.

(g) If an insurer has provided a verification for proposed medical care or health care services, the insurer may not deny or reduce payment to the physician or provider for those medical care or health care services if provided to the insured on or before the 30th day after the date the verification was provided unless the physician or provider has materially misrepresented the proposed medical care

or health care services or has substantially failed to perform the proposed medical care or health care services.

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

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.037(b), eff. September 1, 2005.

Sec. 1301.134. COORDINATION OF PAYMENT. (a) An insurer may require a physician or health care provider to retain in the physician's or provider's records updated information concerning other health benefit plan coverage and to provide the information to the insurer on the applicable form described by Section 1301.131. Except as provided by this subsection, an insurer may not require a physician or provider to investigate coordination of other health benefit plan coverage.

(b) Coordination of payment under this section does not extend the period for determining whether a service is eligible for payment under Section 1301.103 or 1301.104 or for auditing a claim under Section 1301.105.

(c) A physician or health care provider who submits a claim for particular medical care or health care services to more than one health maintenance organization or insurer shall provide written notice on the claim submitted to each health maintenance organization or insurer of the identity of each other health maintenance organization or insurer with which the same claim is being filed.

(d) On receipt of notice under Subsection (c), an insurer shall coordinate and determine the appropriate payment for each health maintenance organization or insurer to make to the physician or health care provider.

(e) Except as provided by Subsection (f), if an insurer is a secondary payor and pays a portion of a claim that should have been paid by the insurer or health maintenance organization that is the primary payor, the overpayment may only be recovered from the health maintenance organization or insurer that is primarily responsible for that amount.

(f) If the portion of the claim overpaid by the secondary insurer was also paid by the primary health maintenance organization or insurer, the secondary insurer may recover the amount of

overpayment under Section 1301.132 from the physician or health care provider who received the payment. An insurer processing an electronic claim as a secondary payor shall rely on the primary payor information submitted on the claim by the physician or provider. Primary payor information may be submitted electronically by the primary payor to the secondary payor.

(g) An insurer may share information with a health maintenance organization or another insurer to the extent necessary to coordinate appropriate payment obligations on a specific claim.

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

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.037(b), eff. September 1, 2005.

Sec. 1301.135. PREAUTHORIZATION OF MEDICAL AND HEALTH CARE SERVICES. (a) An insurer that uses a preauthorization process for medical care or health care services shall provide to each preferred provider, not later than the fifth business day after the date a request is made, a list of medical care and health care services that require preauthorization and information concerning the preauthorization process.

(b) If proposed medical care or health care services require preauthorization as a condition of the insurer's payment to a preferred provider under a health insurance policy, the insurer shall determine whether the medical care or health care services proposed to be provided to the insured are medically necessary and appropriate.

(c) On receipt of a request from a preferred provider for preauthorization, the insurer shall review and issue a determination indicating whether the proposed medical care or health care services are preauthorized. The determination must be issued and transmitted not later than the third calendar day after the date the request is received by the insurer.

(d) If the proposed medical care or health care services involve inpatient care and the insurer requires preauthorization as a condition of payment, the insurer shall review the request and issue a length of stay for the admission into a health care facility based on the recommendation of the patient's physician or health care

provider and the insurer's written medically accepted screening criteria and review procedures. If the proposed medical or health care services are to be provided to a patient who is an inpatient in a health care facility at the time the services are proposed, the insurer shall review the request and issue a determination indicating whether proposed services are preauthorized within 24 hours of the request by the physician or provider.

(e) An insurer shall have appropriate personnel reasonably available at a toll-free telephone number to respond to requests for a preauthorization between 6 a.m. and 6 p.m. central time Monday through Friday on each day that is not a legal holiday and between 9 a.m. and noon central time on Saturday, Sunday, and legal holidays. An insurer must have a telephone system capable of accepting or recording incoming phone calls for preauthorizations after 6 p.m. central time Monday through Friday and after noon central time on Saturday, Sunday, and legal holidays and responding to each of those calls not later than 24 hours after the call is received.

(f) If an insurer has preauthorized medical care or health care services, the insurer may not deny or reduce payment to the physician or health care provider for those services based on medical necessity or appropriateness of care unless the physician or provider has materially misrepresented the proposed medical or health care services or has substantially failed to perform the proposed medical or health care services.

(g) This section applies to an agent or other person with whom an insurer contracts to perform, or to whom the insurer delegates the performance of, preauthorization of proposed medical or health care services.

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

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.037(b), eff. September 1, 2005.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 1218 (S.B. 1742), Sec. 2.03, eff. September 1, 2019.

Sec. 1301.1351. POSTING OF PREAUTHORIZATION REQUIREMENTS. (a) An insurer that uses a preauthorization process for medical care or

health care services shall make the requirements and information about the preauthorization process readily accessible to insureds, physicians, health care providers, and the general public by posting the requirements and information on the insurer's Internet website.

(b) The preauthorization requirements and information described by Subsection (a) must:

(1) be posted:

(A) except as provided by Subsection (c) or (d), conspicuously in a location on the Internet website that does not require the use of a log-in or other input of personal information to view the information; and

(B) in a format that is easily searchable and accessible;

(2) except for the screening criteria under Subdivision (4)(C), be written in plain language that is easily understandable by insureds, physicians, health care providers, and the general public;

(3) include a detailed description of the preauthorization process and procedure; and

(4) include an accurate and current list of medical care and health care services for which the insurer requires preauthorization that includes the following information specific to each service:

(A) the effective date of the preauthorization requirement;

(B) a list or description of any supporting documentation that the insurer requires from the physician or health care provider ordering or requesting the service to approve a request for the service;

(C) the applicable screening criteria, which may include Current Procedural Terminology codes and International Classification of Diseases codes; and

(D) statistics regarding the insurer's preauthorization approval and denial rates for the medical care or health care service in the preceding calendar year, including statistics in the following categories:

(i) physician or health care provider type and specialty, if any;

(ii) indication offered;

(iii) reasons for request denial;

(iv) denials overturned on internal appeal;

(v) denials overturned by an independent review organization; and

(vi) total annual preauthorization requests, approvals, and denials for the service.

(c) This section may not be construed to require an insurer to provide specific information that would violate any applicable copyright law or licensing agreement. To comply with a posting requirement described by Subsection (b), an insurer may, instead of making that information publicly available on the insurer's Internet website, supply a summary of the withheld information sufficient to allow a licensed physician or other health care provider, as applicable for the specific service, who has sufficient training and experience related to the service to understand the basis for the insurer's medical necessity or appropriateness determinations.

(d) If a requirement or information described by Subsection (a) is licensed, proprietary, or copyrighted material that the insurer has received from a third party with which the insurer has contracted, to comply with a posting requirement described by Subsection (b), the insurer may, instead of making that information publicly available on the insurer's Internet website, provide the material to a physician or health care provider who submits a preauthorization request using a nonpublic secured Internet website link or other protected, nonpublic electronic means.

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

Added by Acts 2019, 86th Leg., R.S., Ch. 1218 (S.B. [1742](#)), Sec. 2.04, eff. September 1, 2019.

Sec. 1301.1352. CHANGES TO PREAUTHORIZATION REQUIREMENTS. (a) Except as provided by Subsection (b), not later than the 60th day before the date a new or amended preauthorization requirement takes effect, an insurer that uses a preauthorization process for medical care or health care services shall provide notice of the new or amended preauthorization requirement and disclose the new or amended requirement in the insurer's newsletter or network bulletin, if any, and on the insurer's Internet website.

(b) For a change in a preauthorization requirement or process that removes a service from the list of medical care or health care

services requiring preauthorization or amends a preauthorization requirement in a way that is less burdensome to insureds, physicians, or health care providers, an insurer shall provide notice of the change in the preauthorization requirement and disclose the change in the insurer's newsletter or network bulletin, if any, and on the insurer's Internet website not later than the fifth day before the date the change takes effect.

(c) Not later than the fifth day before the date a new or amended preauthorization requirement takes effect, an insurer shall update its Internet website to disclose the change to the insurer's preauthorization requirements or process and the date and time the change is effective.

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

Added by Acts 2019, 86th Leg., R.S., Ch. 1218 (S.B. 1742), Sec. 2.04, eff. September 1, 2019.

Sec. 1301.1353. REMEDY FOR NONCOMPLIANCE. (a) In addition to any other penalty or remedy provided by law, an insurer that uses a preauthorization process for medical care or health care services that violates this subchapter with respect to a required publication, notice, or response regarding its preauthorization requirements, including by failing to comply with any applicable deadline for the publication, notice, or response, must provide an expedited appeal under Section 4201.357 for any medical care or health care service affected by the violation.

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

Added by Acts 2019, 86th Leg., R.S., Ch. 1218 (S.B. 1742), Sec. 2.04, eff. September 1, 2019.

Sec. 1301.136. AVAILABILITY OF CODING GUIDELINES. (a) A contract between an insurer and a preferred provider must provide that:

(1) the preferred 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 preferred provider will receive under the contract;

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

(3) the insurer or the insurer's agent will provide notice of changes to the coding guidelines and fee schedules that will result in a change of payment to the preferred 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) the contract may be terminated by the preferred provider on or before the 30th day after the date the preferred provider receives information requested under this subsection without penalty or discrimination in participation in other health care products or plans.

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

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

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

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

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

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.037(b), eff. September 1, 2005.

Sec. 1301.137. VIOLATION OF CLAIMS PAYMENT REQUIREMENTS; PENALTY. (a) Except as provided by this section, if a clean claim submitted to an insurer is payable and the insurer does not determine under Subchapter C that the claim is payable and pay the claim on or before the date the insurer is required to make a determination or adjudication of the claim, the insurer shall pay the preferred provider making the claim the contracted rate owed on the claim plus

a penalty in the amount of the lesser of:

(1) 50 percent of the difference between the billed charges, as submitted on the claim, and the contracted rate; or

(2) \$100,000.

(b) If the claim is paid on or after the 46th day and before the 91st day after the date the insurer is required to make a determination or adjudication of the claim, the insurer shall pay a penalty in the amount of the lesser of:

(1) 100 percent of the difference between the billed charges, as submitted on the claim, and the contracted rate; or

(2) \$200,000.

(c) If the claim is paid on or after the 91st day after the date the insurer is required to make a determination or adjudication of the claim, the insurer shall pay a penalty computed under Subsection (b) plus 18 percent annual interest on that amount. Interest under this subsection accrues beginning on the date the insurer was required to pay the claim and ending on the date the claim and the penalty are paid in full.

(d) Except as provided by this section, an insurer that determines under Subchapter C that a claim is payable, pays only a portion of the amount of the claim on or before the date the insurer is required to make a determination or adjudication of the claim, and pays the balance of the contracted rate owed for the claim after that date shall pay to the preferred provider, in addition to the contracted amount owed, a penalty on the amount not timely paid in the amount of the lesser of:

(1) 50 percent of the underpaid amount; or

(2) \$100,000.

(e) If the balance of the claim is paid on or after the 46th day and before the 91st day after the date the insurer is required to make a determination or adjudication of the claim, the insurer shall pay a penalty on the balance of the claim in the amount of the lesser of:

(1) 100 percent of the underpaid amount; or

(2) \$200,000.

(f) If the balance of the claim is paid on or after the 91st day after the date the insurer is required to make a determination or adjudication of the claim, the insurer shall pay a penalty on the balance of the claim computed under Subsection (e) plus 18 percent annual interest on that amount. Interest under this subsection

accrues beginning on the date the insurer was required to pay the claim and ending on the date the claim and the penalty are paid in full.

(g) For the purposes of Subsections (d) and (e), the underpaid amount is computed on the ratio of the amount underpaid on the contracted rate to the contracted rate as applied to an amount equal to the billed charges as submitted on the claim minus the contracted rate.

(h) An insurer is not liable for a penalty under this section:

(1) if the failure to pay the claim in accordance with Subchapter C is a result of a catastrophic event and:

(A) the commissioner published a notice allowing an extension of the applicable prompt payment deadlines due to the catastrophic event; or

(B) the department approved the insurer's request for an extension due to the substantial interference of the catastrophic event with the normal business operations of the insurer; or

(2) if the claim was paid in accordance with Subchapter C, but for less than the contracted rate, and:

(A) the preferred provider notifies the insurer of the underpayment after the 270th day after the date the underpayment was received; and

(B) the insurer pays the balance of the claim on or before the 30th day after the date the insurer receives the notice.

(i) Subsection (h) does not relieve the insurer of the obligation to pay the remaining unpaid contracted rate owed the preferred provider.

(j) An insurer that pays a penalty under this section shall clearly indicate on the explanation of payment statement in the manner prescribed by the commissioner by rule the amount of the contracted rate paid and the amount paid as a penalty.

(k) In addition to any other penalty or remedy authorized by this code, an insurer that violates Section 1301.103, 1301.104, or 1301.105 in processing more than two percent of clean claims submitted to the insurer is subject to an administrative penalty under Chapter 84. For each day an administrative penalty is imposed under this subsection, the penalty may not exceed \$1,000 for each claim that remains unpaid in violation of Section 1301.103, 1301.104, or 1301.105. In determining whether an insurer has processed preferred provider claims in compliance with Section 1301.103,

1301.104, or 1301.105, the commissioner shall consider paid claims, other than claims that have been paid under Section 1301.105, and shall compute a compliance percentage for physician and provider claims, other than institutional provider claims, and a compliance percentage for institutional provider claims.

(1) Notwithstanding any other provision of this section, this subsection governs the payment of a penalty under this section. For a penalty under this section relating to a clean claim submitted by a preferred provider other than an institutional provider, the insurer shall pay the entire penalty to the preferred provider, except for any interest computed under Subsection (c), which shall be paid to the Texas Health Insurance Risk Pool. For a penalty under this section relating to a clean claim submitted by an institutional provider, the insurer shall pay 50 percent of the penalty amount computed under this section, including interest, to the institutional provider and the remaining 50 percent of that amount to the Texas Health Insurance Risk Pool.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.037(b), eff. September 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 435 (S.B. 1884), Sec. 2, eff. September 1, 2007.

Acts 2009, 81st Leg., R.S., Ch. 265 (H.B. 2064), Sec. 2, eff. January 1, 2010.

Acts 2023, 88th Leg., R.S., Ch. 90 (S.B. 1286), Sec. 4, eff. September 1, 2023.

Sec. 1301.138. APPLICABILITY TO ENTITIES CONTRACTING WITH INSURER. This subchapter applies to a person described by Section 1301.109.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.037(b), eff. September 1, 2005.

Sec. 1301.139. LEGISLATIVE DECLARATION. It is the intent of the legislature that the requirements contained in this subchapter regarding payment of claims to preferred providers who are pharmacists or pharmacies apply to all insurers and pharmacy benefit

managers unless otherwise prohibited by federal law.

Added by Acts 2011, 82nd Leg., R.S., Ch. 798 (H.B. 2292), Sec. 12, eff. September 1, 2011.

Sec. 1301.140. OUT-OF-POCKET EXPENSE CREDIT. (a) An insurer shall credit toward an insured's deductible and annual maximum out-of-pocket expenses an amount the insured pays directly to any physician or health care provider for a medically necessary covered medical or health care service or supply if a claim for the service or supply is not submitted to the insurer and the amount paid by the insured to the physician or health care provider is less than the average discounted rate for the service or supply paid to an equivalently licensed or authorized preferred provider under the insured's preferred provider benefit plan.

(b) An insurer shall:

(1) establish a procedure by which an insured may claim a credit under Subsection (a); and

(2) identify documentation necessary to support a claim for a credit under Subsection (a).

(c) Information about the procedure and documentation described by Subsection (b) must be readily accessible to an insured on the insurer's Internet website.

Added by Acts 2023, 88th Leg., R.S., Ch. 437 (H.B. 2002), Sec. 1, eff. September 1, 2023.

SUBCHAPTER D. RELATIONS BETWEEN INSURED'S AND PREFERRED PROVIDERS

Sec. 1301.151. INSURED'S RIGHT TO TREATMENT. Each insured is entitled to treatment and diagnostic techniques that are prescribed by the physician or health care provider included in the preferred provider benefit plan.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1301.152. CONTINUING CARE IN GENERAL. (a) An insurer shall establish reasonable procedures for ensuring a transition of insureds to physicians or health care providers and for continuity of

treatment.

(b) An insurer shall:

(1) provide, subject to Section 1301.160, reasonable advance notice to an insured of the impending termination of the participation in the plan of a physician or health care provider who is currently treating the insured; and

(2) in the event of termination of a preferred provider's participation in the plan, make available to the insured a current listing of preferred providers.

(c) A contract between an insurer and a physician or health care provider must include a procedure for resolving disputes regarding the necessity for continued treatment by the physician or provider.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1301.153. CONTINUITY OF CARE. (a) In this section:

(1) "Life-threatening" means a disease or condition for which the likelihood of death is probable unless the course of the disease or condition is interrupted.

(2) "Special circumstances" means a condition regarding which the treating physician or health care provider reasonably believes that discontinuing care by the treating physician or provider could cause harm to the insured. Examples of an insured who has a special circumstance include an insured with a disability, acute condition, or life-threatening illness or an insured who is past the 24th week of pregnancy.

(b) Each contract between an insurer and a physician or health care provider must provide that the termination of the physician's or provider's participation in a preferred provider benefit plan, except for reason of medical competence or professional behavior, does not:

(1) release the physician or health care provider from the generally recognized obligation to:

(A) treat an insured whom the physician or provider is currently treating; and

(B) cooperate in arranging for appropriate referrals;

or

(2) release the insurer from the obligation to reimburse the physician or health care provider or, if applicable, the insured,

at the same preferred provider rate if, at the time a physician's or provider's participation is terminated, an insured whom the physician or provider is currently treating has special circumstances in accordance with the dictates of medical prudence.

(c) The treating physician or health care provider shall identify a special circumstance. The treating physician or health care provider shall:

(1) request that the insured be permitted to continue treatment under the physician's or provider's care; and

(2) agree not to seek payment from the insured of any amount for which the insured would not be responsible if the physician or provider were still a preferred provider.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1301.154. OBLIGATION FOR CONTINUITY OF CARE OF INSURER.

(a) Except as provided by Subsection (b), Sections 1301.152 and 1301.153 do not extend an insurer's obligation to reimburse the terminated physician or provider or, if applicable, the insured at the preferred provider level of coverage for ongoing treatment of an insured after:

(1) the 90th day after the effective date of the termination; or

(2) if the insured has been diagnosed as having a terminal illness at the time of the termination, the expiration of the nine-month period after the effective date of the termination.

(b) If an insured is past the 24th week of pregnancy at the time of termination, an insurer's obligation to reimburse, at the preferred provider level of coverage, the physician or provider or, if applicable, the insured, extends through delivery of the child, immediate postpartum care, and the follow-up checkup within the six-week period after delivery.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1301.155. EMERGENCY CARE. (a) In this section, "emergency care" means health care services provided in a hospital emergency facility, freestanding emergency medical care facility, or comparable emergency facility to evaluate and stabilize a medical

condition of a recent onset and severity, including severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the person's condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

- (1) placing the person's health in serious jeopardy;
- (2) serious impairment to bodily functions;
- (3) serious dysfunction of a bodily organ or part;
- (4) serious disfigurement; or
- (5) in the case of a pregnant woman, serious jeopardy to the health of the fetus.

(b) If an insured cannot reasonably reach a preferred provider, an insurer shall provide reimbursement for the following emergency care services at the usual and customary rate or at an agreed rate and at the preferred level of benefits until the insured can reasonably be expected to transfer to a preferred provider:

- (1) a medical screening examination or other evaluation required by state or federal law to be provided in the emergency facility of a hospital that is necessary to determine whether a medical emergency condition exists;
- (2) necessary emergency care services, including the treatment and stabilization of an emergency medical condition;
- (3) services originating in a hospital emergency facility or freestanding emergency medical care facility following treatment or stabilization of an emergency medical condition; and
- (4) supplies related to a service described by this subsection.

(c) For emergency care subject to this section or a supply related to that care, an insurer shall make a payment required by this section directly to the out-of-network provider not later than, as applicable:

- (1) the 30th day after the date the insurer receives an electronic clean claim as defined by Section 1301.101 for those services that includes all information necessary for the insurer to pay the claim; or
- (2) the 45th day after the date the insurer receives a nonelectronic clean claim as defined by Section 1301.101 for those services that includes all information necessary for the insurer to pay the claim.

(d) For emergency care subject to this section or a supply

related to that care, an out-of-network provider or a person asserting a claim as an agent or assignee of the provider may not bill an insured in, and the insured does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, and deductible under the insured's preferred provider benefit plan that:

(1) is based on:

(A) the amount initially determined payable by the insurer; or

(B) if applicable, a modified amount as determined under the insurer's internal appeal process; and

(2) is not based on any additional amount determined to be owed to the provider under Chapter 1467.

(e) This section may not be construed to require the imposition of a penalty under Section 1301.137.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1273 (H.B. 1357), Sec. 5, eff. March 1, 2010.

Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 1.08, eff. September 1, 2019.

Sec. 1301.156. PAYMENT OF CLAIMS TO INSURED. An insurer shall comply with Subchapter B, Chapter 542, with respect to prompt payment to insureds.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1301.157. PLAIN LANGUAGE REQUIREMENTS. Each health insurance policy, health benefit plan certificate, endorsement, amendment, application, or rider must:

(1) be written in plain language;

(2) be in a readable and understandable format; and

(3) comply with all applicable requirements relating to minimum readability requirements.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1301.158. INFORMATION CONCERNING PREFERRED PROVIDER BENEFIT PLANS. (a) In this section, "prospective insured" means:

(1) for group coverage, an individual or an individual's dependent who is eligible for coverage under a health insurance policy issued to the group; or

(2) for individual coverage, an individual or an individual's dependent who is eligible for coverage and who has expressed an interest in purchasing an individual health insurance policy.

(b) An insurer shall provide to a current or prospective group contract holder or current or prospective insured on request an accurate written description of the terms of the health insurance policy to allow the current or prospective group contract holder or current or prospective insured to make comparisons and an informed decision before selecting among health care plans. The description must be in a readable and understandable format as prescribed by the commissioner and must include a current list of preferred providers. The insurer may satisfy this requirement by providing its handbook if:

(1) the handbook's content is substantively similar to and achieves the same level of disclosure as the written description prescribed by the commissioner; and

(2) the current list of preferred providers is provided.

(c) An insurer or an agent or representative of an insurer may not use or distribute, or permit the use or distribution of, information for prospective insureds that is untrue or misleading.

(d) An insurer shall provide to an insured on request information on:

(1) whether a physician or other health care provider is a participating provider in the insurer's preferred provider network;

(2) whether proposed health care services are covered by the health insurance policy;

(3) what the insured's personal responsibility will be for payment of applicable copayment or deductible amounts; and

(4) coinsurance amounts owed based on the provider's contracted rate for in-network services or the insurer's usual and customary reimbursement rate for out-of-network services.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 997 (S.B. 1731), Sec. 14, eff. September 1, 2007.

Sec. 1301.1581. INFORMATION CONCERNING EXCLUSIVE PROVIDER BENEFIT PLANS. (a) In this section, "prospective insured" has the meaning assigned by Section 1301.158.

(b) In addition to the information required to be provided under Section 1301.158, an insurer that offers an exclusive provider benefit plan shall provide to a current or prospective group contract holder or current or prospective insured notice that the benefit plan includes limited coverage for services provided by a physician or health care provider that is not a preferred provider.

(c) An identification card or similar document issued by an insurer to an insured in an exclusive provider benefit plan must display:

(1) the first date on which the insured became insured under the plan;

(2) a toll-free number that a physician or health care provider may use to obtain the date on which the insured became insured under the plan; and

(3) the acronym "EPO" or the phrase "Exclusive Provider Organization" on the card in a location of the insurer's choice.

Added by Acts 2011, 82nd Leg., R.S., Ch. 288 (H.B. 1772), Sec. 10, eff. September 1, 2011.

Sec. 1301.159. ANNUAL LIST OF PREFERRED PROVIDERS. A current list of preferred providers shall be provided to each insured at least annually.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1301.1591. PREFERRED PROVIDER INFORMATION ON INTERNET.

(a) An insurer subject to this chapter that maintains an Internet site shall list on the Internet site the preferred providers, including, if appropriate, mental health providers and substance abuse treatment providers, that insureds may use in accordance with the terms of the insured's preferred provider benefit plan. The

listing must identify those preferred providers who continue to be available to provide services to new patients or clients.

(b) The insurer shall update at least quarterly an Internet site subject to this section.

(c) The commissioner may adopt rules as necessary to implement this section. The rules may govern the form and content of the information required to be provided under Subsection (a).

(d) Notwithstanding any other provision of this chapter, this section applies to an entity subject to Chapter 941 or 942 and to a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.036(a), eff. September 1, 2005.

Sec. 1301.160. NOTIFICATION OF TERMINATION OF PARTICIPATION OF PREFERRED PROVIDER. (a) If a practitioner's participation in a preferred provider benefit plan is terminated for a reason other than at the practitioner's request, an insurer may not notify insureds of the termination until the later of:

(1) the effective date of the termination; or

(2) the time at which a review panel makes a formal recommendation regarding the termination.

(b) A physician or health care provider that voluntarily terminates the physician's or provider's participation in a preferred provider benefit plan shall provide reasonable notice to each insured under the physician's or provider's care. The insurer shall provide assistance to the physician or provider in ensuring that the notice requirements of this subsection are met.

(c) If a practitioner's participation in a preferred provider benefit plan is terminated for reasons related to imminent harm, an insurer may notify insureds immediately.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1301.161. RETALIATION AGAINST INSURED PROHIBITED. An insurer may not engage in any retaliatory action against an insured, including canceling or refusing to renew a health insurance policy, because the insured or a person acting on the insured's behalf has:

- (1) filed a complaint against the insurer or against a preferred provider; or
- (2) appealed a decision of the insurer.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1301.162. IDENTIFICATION CARD. An identification card or other similar document issued by an insurer regulated by this code and subject to this chapter to an individual insured must display:

- (1) the first date on which the individual became insured under the plan; or
- (2) a toll-free number a physician or health care provider may use to obtain that date.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.037(e), eff. September 1, 2005.

Sec. 1301.163. APPLICABILITY OF SUBCHAPTER TO ENTITIES CONTRACTING WITH INSURER. This subchapter applies to a person to whom an insurer contracts to:

- (1) process or pay claims;
- (2) obtain the services of physicians or other providers to provide health care services to enrollees; or
- (3) issue verifications or preauthorizations.

Added by Acts 2007, 80th Leg., R.S., Ch. 997 (S.B. 1731), Sec. 15, eff. September 1, 2007.

Sec. 1301.164. OUT-OF-NETWORK FACILITY-BASED PROVIDERS. (a) In this section, "facility-based provider" means a physician or health care provider who provides medical care or health care services to patients of a health care facility.

(b) Except as provided by Subsection (d), an insurer shall pay for a covered medical care or health care service performed for or a covered supply related to that service provided to an insured by an out-of-network provider who is a facility-based provider at the usual and customary rate or at an agreed rate if the provider performed the service at a health care facility that is a preferred provider. The

insurer shall make a payment required by this subsection directly to the provider not later than, as applicable:

(1) the 30th day after the date the insurer receives an electronic clean claim as defined by Section 1301.101 for those services that includes all information necessary for the insurer to pay the claim; or

(2) the 45th day after the date the insurer receives a nonelectronic clean claim as defined by Section 1301.101 for those services that includes all information necessary for the insurer to pay the claim.

(c) Except as provided by Subsection (d), an out-of-network provider who is a facility-based provider or a person asserting a claim as an agent or assignee of the provider may not bill an insured receiving a medical care or health care service or supply described by Subsection (b) in, and the insured does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, and deductible under the insured's preferred provider benefit plan that:

(1) is based on:

(A) the amount initially determined payable by the insurer; or

(B) if applicable, a modified amount as determined under the insurer's internal appeal process; and

(2) is not based on any additional amount determined to be owed to the provider under Chapter 1467.

(d) This section does not apply to a nonemergency health care or medical service:

(1) that an insured elects to receive in writing in advance of the service with respect to each out-of-network provider providing the service; and

(2) for which an out-of-network provider, before providing the service, provides a complete written disclosure to the insured that:

(A) explains that the provider does not have a contract with the insured's preferred provider benefit plan;

(B) discloses projected amounts for which the insured may be responsible; and

(C) discloses the circumstances under which the insured would be responsible for those amounts.

(e) This section may not be construed to require the imposition

of a penalty under Section 1301.137.

Added by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. [1264](#)), Sec. 1.09, eff. September 1, 2019.

Sec. 1301.165. OUT-OF-NETWORK DIAGNOSTIC IMAGING PROVIDER OR LABORATORY SERVICE PROVIDER. (a) In this section, "diagnostic imaging provider" and "laboratory service provider" have the meanings assigned by Section 1467.001.

(b) Except as provided by Subsection (d), an insurer shall pay for a covered medical care or health care service performed by or a covered supply related to that service provided to an insured by an out-of-network provider who is a diagnostic imaging provider or laboratory service provider at the usual and customary rate or at an agreed rate if the provider performed the service in connection with a medical care or health care service performed by a preferred provider. The insurer shall make a payment required by this subsection directly to the provider not later than, as applicable:

(1) the 30th day after the date the insurer receives an electronic clean claim as defined by Section 1301.101 for those services that includes all information necessary for the insurer to pay the claim; or

(2) the 45th day after the date the insurer receives a nonelectronic clean claim as defined by Section 1301.101 for those services that includes all information necessary for the insurer to pay the claim.

(c) Except as provided by Subsection (d), an out-of-network provider who is a diagnostic imaging provider or laboratory service provider or a person asserting a claim as an agent or assignee of the provider may not bill an insured receiving a medical care or health care service or supply described by Subsection (b) in, and the insured does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, and deductible under the insured's preferred provider benefit plan that:

(1) is based on:

(A) the amount initially determined payable by the insurer; or

(B) if applicable, the modified amount as determined under the insurer's internal appeal process; and

(2) is not based on any additional amount determined to be owed to the provider under Chapter 1467.

(d) This section does not apply to a nonemergency health care or medical service:

(1) that an insured elects to receive in writing in advance of the service with respect to each out-of-network provider providing the service; and

(2) for which an out-of-network provider, before providing the service, provides a complete written disclosure to the insured that:

(A) explains that the provider does not have a contract with the insured's preferred provider benefit plan;

(B) discloses projected amounts for which the insured may be responsible; and

(C) discloses the circumstances under which the insured would be responsible for those amounts.

(e) This section may not be construed to require the imposition of a penalty under Section 1301.137.

Added by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. [1264](#)), Sec. 1.09, eff. September 1, 2019.

For expiration of this section, see Subsection (g).

Sec. 1301.166. OUT-OF-NETWORK EMERGENCY MEDICAL SERVICES PROVIDER. (a) In this section, "emergency medical services provider" has the meaning assigned by Section 773.003, Health and Safety Code, except that the term does not include an air ambulance.

(b) Except as provided by Subsection (c), an insurer shall pay for a covered medical care or health care service performed for, or a covered supply or covered transport related to that service provided to, an insured by an out-of-network provider who is an emergency medical services provider at:

(1) if the political subdivision has submitted the rate to the department under Section 38.006, the rate set, controlled, or regulated by the political subdivision in which:

(A) the service originated; or

(B) the transport originated if transport is provided;

or

(2) if the political subdivision has not submitted the rate

to the department, the lesser of:

(A) the provider's billed charge; or

(B) 325 percent of the current Medicare rate, including any applicable extenders and modifiers.

(c) An insurer shall adjust a payment required by Subsection (b)(1) each plan year by increasing the payment by the lesser of the Medicare Inflation Index or 10 percent of the provider's previous calendar year rates.

(d) The insurer shall make a payment required by this section directly to the provider not later than, as applicable:

(1) the 30th day after the date the insurer receives an electronic clean claim as defined by Section 1301.101 for those services that includes all information necessary for the insurer to pay the claim; or

(2) the 45th day after the date the insurer receives a nonelectronic clean claim as defined by Section 1301.101 for those services that includes all information necessary for the insurer to pay the claim.

(e) An out-of-network provider who is an emergency medical services provider or a person asserting a claim as an agent or assignee of the provider may not bill an insured receiving a medical care or health care service or supply or transport described by Subsection (b) in, and the insured does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, and deductible under the insured's preferred provider benefit plan that is based on:

(1) the amount initially determined payable by the insurer; or

(2) if applicable, the modified amount as determined under the insurer's internal appeal process.

(f) This section may not be construed to require the imposition of a penalty under Section 1301.137.

(g) This section expires September 1, 2025.

Added by Acts 2023, 88th Leg., R.S., Ch. 981 (S.B. [2476](#)), Sec. 8, eff. September 1, 2023.

SUBCHAPTER E. CERTAIN HEALTH CARE PROVIDERS

Sec. 1301.201. CONTRACTS WITH AND REIMBURSEMENT FOR NURSE FIRST

ASSISTANTS. A preferred provider may not refuse to:

(1) contract with a nurse first assistant, as defined by Section 301.1525, Occupations Code, to be included in the provider's network; or

(2) reimburse the nurse first assistant for a covered service that a physician has requested the nurse first assistant to perform.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1301.202. CONTRACTS WITH HOSPITALS. (a) An insurer that contracts with hospitals to provide services to insureds under a preferred provider benefit plan may not deny a hospital the opportunity to participate in providing health care services as a preferred provider solely because the hospital is not accredited by the Joint Commission on Accreditation of Healthcare Organizations or another specified national accrediting body. If a hospital is certified by the Medicare program, Title XVIII of the Social Security Act (42 U.S.C. Section 1395 et seq.), or accredited by the Joint Commission on Accreditation of Healthcare Organizations or another national accrediting body, an insurer shall accept that certification or accreditation.

(b) This section does not limit an insurer's authority to establish other reasonable terms under which a hospital may provide health care services to individuals covered by a preferred provider benefit plan.

(c) On the request of a hospital, the commissioner shall conduct an investigation, review, hearing, or other proceeding to determine whether an insurer is complying with this section.

(d) The commissioner shall take reasonable action to ensure compliance with this section, including issuing orders and imposing sanctions.

Added by Acts 2005, 79th Leg., Ch. 1305 (H.B. [2999](#)), Sec. 1, eff. June 18, 2005.

CHAPTER 1305. WORKERS' COMPENSATION HEALTH CARE NETWORKS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1305.001. SHORT TITLE. This chapter may be cited as the

Workers' Compensation Health Care Network Act.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

Sec. 1305.002. PURPOSE. The purpose of this chapter is to:

(1) authorize the establishment of workers' compensation health care networks for the provision of workers' compensation medical benefits; and

(2) provide standards for the certification, administration, evaluation, and enforcement of the delivery of health care services to injured employees by networks contracting with or established by:

(A) workers' compensation insurance carriers;

(B) employers certified to self-insure under Chapter 407, Labor Code;

(C) groups of employers certified to self-insure under Chapter 407A, Labor Code; and

(D) governmental entities that self-insure, either individually or collectively.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

Sec. 1305.003. LIMITATIONS ON APPLICABILITY. (a) This chapter does not affect the authority of the division of workers' compensation of the department to exercise the powers granted to the division under Title 5, Labor Code, that do not conflict with this chapter.

(b) In the event of a conflict between Title 5, Labor Code, and this chapter as to the provision of medical benefits for injured employees, the establishment and regulation of fees for medical treatments and services, the time frames for payment of medical bills, the operation and regulation of workers' compensation health care networks, the regulation of health care providers who contract with those networks, or the resolution of disputes regarding medical benefits provided through those networks, this chapter prevails.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff.

September 1, 2005.

Sec. 1305.004. DEFINITIONS. (a) In this chapter, unless the context clearly indicates otherwise:

(1) "Adverse determination" has the meaning assigned by Chapter 4201.

(1-a) "Administrator" has the meaning assigned by Section 4151.001.

(2) "Affiliate" means a person that directly, or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, the person specified.

(3) "Capitation" means a method of compensation for arranging for or providing health care services to employees for a specified period that is based on a predetermined payment for each employee for the specified period, without regard to the quantity of services provided for the compensable injury.

(4) "Complainant" means a person who files a complaint under this chapter. The term includes:

(A) an employee;

(B) an employer;

(C) a health care provider; and

(D) another person designated to act on behalf of an employee.

(5) "Complaint" means any dissatisfaction expressed orally or in writing by a complainant to a network regarding any aspect of the network's operation. The term includes dissatisfaction relating to medical fee disputes and the network's administration and the manner in which a service is provided. The term does not include:

(A) a misunderstanding or a problem of misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information to the satisfaction of the complainant; or

(B) an oral or written expression of dissatisfaction or disagreement with an adverse determination.

(6) "Credentialing" means the review, under nationally recognized standards to the extent that those standards do not conflict with other laws of this state, of qualifications and other relevant information relating to a health care provider who seeks a contract with a network.

(7) "Emergency" means either a medical or mental health emergency.

(8) "Employee" has the meaning assigned by Section 401.012, Labor Code.

(9) "Fee dispute" means a dispute over the amount of payment due for health care services determined to be medically necessary and appropriate for treatment of a compensable injury.

(10) "Independent review" means a system for final administrative review by an independent review organization of the medical necessity and appropriateness, or the experimental or investigational nature, of health care services being provided, proposed to be provided, or that have been provided to an employee.

(11) "Independent review organization" means an entity that is certified by the commissioner to conduct independent review under Chapter 4202 and rules adopted by the commissioner.

(12) "Life-threatening" has the meaning assigned by Chapter 4201.

(13) "Medical emergency" means the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in:

(A) placing the patient's health or bodily functions in serious jeopardy; or

(B) serious dysfunction of any body organ or part.

(14) "Medical records" means the history of diagnosis and treatment for an injury, including medical, dental, and other health care records from each health care practitioner who provides care to an injured employee.

(15) "Mental health emergency" means a condition that could reasonably be expected to present danger to the person experiencing the mental health condition or another person.

(16) "Network" or "workers' compensation health care network" means an organization that is:

(A) formed as a health care provider network to provide health care services to injured employees;

(B) certified in accordance with this chapter and commissioner rules; and

(C) established by, or operates under contract with, an insurance carrier.

(17) "Nurse" has the meaning assigned by Chapter 4201.

(18) "Person" means any natural or artificial person, including an individual, partnership, association, corporation, organization, trust, hospital district, community mental health center, intellectual disability center, mental health center, limited liability company, or limited liability partnership.

(19) "Preauthorization" means the process required to request approval from the insurance carrier or the network to provide a specific treatment or service before the treatment or service is provided.

(20) "Quality improvement program" means a system designed to continuously examine, monitor, and revise processes and systems that support and improve administrative and clinical functions.

(21) Repealed by Acts 2009, 81st Leg., R.S., Ch. 1330, Sec. 19(1), eff. September 1, 2009.

(22) "Rural area" means:

(A) a county with a population of 50,000 or less;

(B) an area that is not designated as an urbanized area by the United States Census Bureau; or

(C) any other area designated as rural under rules adopted by the commissioner.

(23) "Screening criteria" means the written policies, medical protocols, and treatment guidelines used by an insurance carrier or a network as part of utilization review.

(24) "Service area" means a geographic area within which health care services from network providers are available and accessible to employees who live within that geographic area.

(25) "Texas Workers' Compensation Act" means Subtitle A, Title 5, Labor Code.

(26) "Transfer of risk" means, for purposes of this chapter only, an insurance carrier's transfer of financial risk for the provision of health care services to a network through capitation or other means.

(27) "Utilization review" has the meaning assigned by Chapter 4201.

(28) "Utilization review agent" has the meaning assigned by Chapter 4201.

(29) "Utilization review plan" means the screening criteria and utilization review procedures of an insurance carrier, a workers' compensation health care network, or a utilization review agent.

(b) In this chapter, the following terms have the meanings

assigned by Section 401.011, Labor Code:

- (1) "compensable injury";
- (2) "doctor";
- (3) "employer";
- (4) "health care";
- (5) "health care facility";
- (6) "health care practitioner";
- (7) "health care provider";
- (8) "injury";
- (9) "insurance carrier";
- (10) "orthotic device";
- (11) "prosthetic device"; and
- (12) "treating doctor."

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 134 (H.B. 1006), Sec. 4, eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 147 (S.B. 458), Sec. 2, eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2G.007, eff. April 1, 2009.

Acts 2007, 80th Leg., R.S., Ch. 1176 (H.B. 472), Sec. 2.01, eff. September 1, 2007.

Acts 2009, 81st Leg., R.S., Ch. 1330 (H.B. 4290), Sec. 1, eff. September 1, 2009.

Acts 2009, 81st Leg., R.S., Ch. 1330 (H.B. 4290), Sec. 19(1), eff. September 1, 2009.

Acts 2023, 88th Leg., R.S., Ch. 30 (H.B. 446), Sec. 8.03, eff. September 1, 2023.

Sec. 1305.005. PARTICIPATION IN NETWORK; NOTICE OF NETWORK REQUIREMENTS. (a) An employer that elects to provide workers' compensation insurance coverage under the Texas Workers' Compensation Act may receive workers' compensation health care services for the employer's injured employees through a workers' compensation health care network.

(b) An insurance carrier may establish or contract with

networks certified under this chapter to provide health care services under the Texas Workers' Compensation Act. If an employer elects to contract with an insurance company for the provision of health care services through a network, or if a self-insured employer under Chapter 407, Labor Code, a group of employers certified to self-insure under Chapter 407A, Labor Code, or a public employer under Subtitle C, Title 5, Labor Code, elects to establish or contract with a network, the employer's employees who live within the network's service area are required to obtain medical treatment for a compensable injury within the network, except as provided by Sections 1305.006(1) and (3).

(c) Notwithstanding Subsection (b), the State Office of Risk Management shall have exclusive authority to establish or contract with networks certified under this chapter to provide health care services under Chapter 501, Labor Code.

(d) The insurance carrier shall provide to the employer, and the employer shall provide to the employer's employees, notice of network requirements, including all information required by Section 1305.451. The employer shall:

(1) obtain a signed acknowledgment from each employee, written in English, Spanish, and any other language common to the employer's employees, that the employee has received information concerning the network and the network's requirements; and

(2) post notice of the network requirements at each place of employment.

(e) The employer shall provide to each employee hired after the notice is given under Subsection (d) the notice and information required under that subsection not later than the third day after the date of hire.

(f) An injured employee who has received notice of network requirements but refuses to sign the acknowledgment form required under Subsection (d) remains subject to the network requirements established under this chapter.

(g) The employer shall notify an injured employee of the network requirements at the time the employer receives actual or constructive notice of an injury.

(h) An injured employee is not required to comply with the network requirements until the employee receives the notice under Subsection (d), (e), or (g). An insurance carrier that establishes or contracts with a network is liable for the payment of medical care

under the requirements of Title 5, Labor Code, for an injured employee who does not receive notice until the employee receives notice of network requirements under this section.

(i) The commissioner may adopt rules as necessary to implement this section.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

Sec. 1305.006. INSURANCE CARRIER LIABILITY FOR OUT-OF-NETWORK HEALTH CARE. An insurance carrier that establishes or contracts with a network is liable for the following out-of-network health care that is provided to an injured employee:

(1) emergency care;

(2) health care provided to an injured employee who does not live within the service area of any network established by the insurance carrier or with which the insurance carrier has a contract; and

(3) health care provided by an out-of-network provider pursuant to a referral from the injured employee's treating doctor that has been approved by the network pursuant to Section 1305.103.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

Sec. 1305.007. RULES. The commissioner may adopt rules as necessary to implement this chapter.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

Sec. 1305.008. ADMINISTRATOR CERTIFICATE OF AUTHORITY REQUIRED. A person that performs the functions of an administrator under Chapter 4151 must hold a certificate of authority issued under that chapter to provide those functions under this chapter for an insurance carrier.

Added by Acts 2007, 80th Leg., R.S., Ch. 1176 (H.B. 472), Sec. 2.02,

eff. September 1, 2007.

SUBCHAPTER B. CERTIFICATION

Sec. 1305.051. CERTIFICATION REQUIRED. (a) A person may not operate a workers' compensation health care network in this state unless the person holds a certificate issued under this chapter and rules adopted by the commissioner.

(b) A person may not perform any act of a workers' compensation health care network except in accordance with the specific authorization of this chapter or rules adopted by the commissioner.

(c) A health maintenance organization regulated under Chapter 843 or an organization of physicians and providers that operates as a preferred provider benefit plan, as defined by Chapter 1301, may obtain a certification as a workers' compensation health care network in the same manner as any other person if that entity meets the requirements of this chapter and rules adopted by the commissioner under this chapter.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

Sec. 1305.052. CERTIFICATE APPLICATION. (a) A person who seeks to operate as a workers' compensation health care network shall apply to the department for a certificate to organize and operate as a network.

(b) A certificate application must be:

(1) filed with the department in the form prescribed by the commissioner;

(2) verified by the applicant or an officer or other authorized representative of the applicant; and

(3) accompanied by a nonrefundable fee set by commissioner rule.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

Sec. 1305.053. CONTENTS OF APPLICATION. Each certificate application must include:

(1) a description or a copy of the applicant's basic organizational structure documents and other related documents, including organizational charts or lists that show:

(A) the relationships and contracts between the applicant and any affiliates of the applicant; and

(B) the internal organizational structure of the applicant's management and administrative staff;

(2) biographical information regarding each person who governs or manages the affairs of the applicant, accompanied by information sufficient to allow the commissioner to determine the competence, fitness, and reputation of each officer or director of the applicant or other person having control of the applicant;

(3) a copy of the form of any contract between the applicant and any provider or group of providers, and with any third party performing services on behalf of the applicant under Subchapter D;

(4) a copy of the form of each contract with an insurance carrier, as described by Section 1305.154;

(5) a financial statement, current as of the date of the application, that is prepared using generally accepted accounting practices and includes:

(A) a balance sheet that reflects a solvent financial position;

(B) an income statement;

(C) a cash flow statement; and

(D) the sources and uses of all funds;

(6) a statement acknowledging that lawful process in a legal action or proceeding against the network on a cause of action arising in this state is valid if served in the manner provided by Chapter 804 for a domestic company;

(7) a description and a map of the applicant's service area or areas, with key and scale, that identifies each county or part of a county to be served;

(8) a description of programs and procedures to be utilized, including:

(A) a complaint system, as required under Subchapter I;

(B) a quality improvement program, as required under Subchapter G; and

(C) the utilization review program described in Subchapter H;

(9) a list of all contracted network providers that demonstrates the adequacy of the network to provide comprehensive health care services sufficient to serve the population of injured employees within the service area and maps that demonstrate that the access and availability standards under Subchapter G are met; and

(10) any other information that the commissioner requires by rule to implement this chapter.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1330 (H.B. 4290), Sec. 2, eff. September 1, 2009.

Sec. 1305.054. ACTION ON APPLICATION; RENEWAL OF CERTIFICATION.

(a) The commissioner shall approve or disapprove an application for certification as a network not later than the 60th day after the date the completed application is received by the department. An application is considered complete on receipt of all information required by this chapter and any commissioner rules, including receipt of any additional information requested by the commissioner as needed to make the determination.

(b) Additional information requested by the commissioner under Subsection (a) may include information derived from an on-site quality-of-care examination.

(c) The department shall notify the applicant of any deficiencies in the application and may allow the applicant to request additional time to revise the application, in which case the 60-day period for approval or disapproval is tolled. The commissioner may grant or deny requests for additional time at the commissioner's discretion.

(d) An order issued by the commissioner disapproving an application must specify in what respects the application does not comply with applicable statutes and rules. An applicant whose application is disapproved may request a hearing not later than the 30th day after the date of the commissioner's disapproval order. The hearing is a contested case hearing under Chapter 2001, Government Code.

(e) A certificate issued under this subchapter is valid until

revoked or suspended.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

Sec. 1305.055. USE OF CERTAIN INSURANCE TERMS BY NETWORK PROHIBITED. A network is not an insurer and may not use in the network's name or informational literature the word "insurance," "casualty," "surety," or "mutual" or any other word that is:

- (1) descriptive of the insurance, casualty, or surety business; or
- (2) deceptively similar to the name or description of an insurer or surety corporation engaging in the business of insurance in this state.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

Sec. 1305.056. RESTRAINT OF TRADE; APPLICATION OF CERTAIN LAWS.

(a) A network that contracts with a provider or providers practicing individually or as a group is not, because of the contract or arrangement, considered to have entered into a conspiracy in restraint of trade in violation of Chapter 15, Business & Commerce Code.

(b) Notwithstanding any other law, a person who contracts under this chapter with one or more providers in the process of conducting activities that are permitted by law but that do not require a certificate of authority or other authorization under this code is not, because of the contract, considered to have entered into a conspiracy in restraint of trade in violation of Chapter 15, Business & Commerce Code.

(c) A network is subject to Chapters 441 and 443 and is considered an insurer or insurance company, as applicable, for purposes of those laws.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2G.008,

eff. April 1, 2009.

**SUBCHAPTER C. GENERAL POWERS AND DUTIES OF WORKERS' COMPENSATION
HEALTH CARE NETWORKS**

Sec. 1305.101. PROVIDING OR ARRANGING FOR HEALTH CARE. (a) Except for emergencies and out-of-network referrals, a network shall provide or arrange for health care services only through providers or provider groups that are under contract with or are employed by the network.

(b) A network doctor may not serve as a designated doctor or perform a required medical examination, as those terms are used under the Texas Workers' Compensation Act, for an employee receiving medical care through a network with which the doctor contracts or is employed.

(c) Notwithstanding any other provision of this chapter, prescription medication or services, as defined by Section 401.011(19)(E), Labor Code, may not, directly or through a contract, be delivered through a workers' compensation health care network. Prescription medication and services shall be reimbursed as provided by Section 408.0281, Labor Code, other provisions of the Texas Workers' Compensation Act, and applicable rules of the commissioner of workers' compensation.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 705 (H.B. 528), Sec. 4, eff. June 17, 2011.

Sec. 1305.102. MANAGEMENT CONTRACTS. (a) A network may not enter into a contract with another entity for management services unless the proposed contract is first filed with the department and approved by the commissioner.

(b) The commissioner shall approve or disapprove the contract not later than the 30th day after the date the contract is filed, or within a reasonable extended period that the commissioner specifies by notice given within the 30-day period.

(c) The contract must state that:

(1) the contract may not be canceled without cause without at least 90 days' prior written notice;

(2) notice of any cancellation must be sent simultaneously to the commissioner by certified mail; and

(3) the network is responsible for ensuring that all functions delegated by the contract are performed in accordance with applicable statutes and rules, subject to the carrier's oversight and monitoring of the network's performance.

(d) The management contractor proposing to contract shall provide to the commissioner information sufficient to allow the commissioner to determine the competence, fitness, or reputation of each of the contractor's officers and directors or other person having control of the contractor, including criminal history information demonstrating that none of those individuals has been convicted of a felony involving moral turpitude or breach of fiduciary duty.

(e) The commissioner shall disapprove the proposed contract if the commissioner determines that the contract authorizes a person who is not sufficiently trustworthy, competent, experienced, and free from conflict of interest to manage the network with due regard for the interests of employers, employees, creditors, or the public.

(f) The commissioner may not approve a proposed management contract unless the management contractor has in force in the management contractor's own name a fidelity bond on the contractor's officers and employees in the amount of \$250,000 or a greater amount prescribed by the commissioner.

(g) The fidelity bond must be issued by an insurer authorized to engage in business in this state and must be filed with the department. If the commissioner determines that a fidelity bond is not available from an insurer authorized to engage in business in this state, the management contractor may obtain a fidelity bond procured by a surplus lines agent under Chapter 981.

(h) The fidelity bond must obligate the surety to pay any loss of money or other property or damage that the network sustains because of an act of fraud or dishonesty by an employee or officer of the management contractor during the period that the management contract is in effect.

(i) In lieu of a fidelity bond, and at the commissioner's discretion, the management contractor may deposit with the comptroller cash or readily marketable liquid securities acceptable

to the commissioner. The deposit must be maintained in the amount of, and is subject to the same conditions required for, a fidelity bond under this section.

(j) A management contract approved by the commissioner under this section may not be assigned to any other entity.

(k) A management contract filed with the department under this section is confidential and is not subject to disclosure as public information under Chapter 552, Government Code.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

Sec. 1305.103. TREATING DOCTOR; REFERRALS. (a) A network shall determine the specialty or specialties of doctors who may serve as treating doctors.

(b) For each injury, an injured employee shall select a treating doctor from the list of all treating doctors under contract with the network in that service area.

(c) An employee who lives within the service area of a network and who is being treated by a non-network provider for an injury that occurred before the employer's insurance carrier established or contracted with the network, shall select a network treating doctor on notification by the carrier that health care services are being provided through the network. The carrier shall provide to the employee all information required by Section 1305.451. If the employee fails to select a treating doctor on or before the 14th day after the date of receipt of the information required by Section 1305.451, the network may assign the employee a network treating doctor. An issue regarding whether a carrier properly provided an employee the information required by this subsection may be resolved using the process for adjudication of disputes under Chapter 410, Labor Code, as used by the department's division of workers' compensation.

(d) Each network shall, by contract, require treating doctors to provide, at a minimum, the functions and services for injured employees described by this section.

(e) A treating doctor shall provide health care to the employee for the employee's compensable injury and shall make referrals to other network providers, or request referrals to out-of-network

providers if medically necessary services are not available within the network. Referrals to out-of-network providers must be approved by the network. The network shall approve a referral to an out-of-network provider not later than the seventh day after the date on which the referral is requested, or sooner if circumstances and the condition of the employee require expedited approval. If the network denies the referral request, the employee may appeal the decision through the network's complaint process under Subchapter I.

(f) The treating doctor shall participate in the medical case management process as required by the network, including participation in return-to-work planning.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 1066 (S.B. 809), Sec. 4, eff. September 1, 2011.

Sec. 1305.104. SELECTION OF TREATING DOCTOR. (a) An injured employee is entitled to the employee's initial choice of a treating doctor from the list provided by the network of all treating doctors under contract with the network who provide services within the service area in which the injured employee lives. The following does not constitute an initial choice of treating doctor:

- (1) a doctor salaried by the employer;
- (2) a doctor providing emergency care; or
- (3) any doctor who provides care before the employee is enrolled in the network, except for a doctor selected under Section 1305.105.

(b) An employee who is dissatisfied with the initial choice of a treating doctor is entitled to select an alternate treating doctor from the network's list of treating doctors who provide services within the service area in which the injured employee lives by notifying the network in the manner prescribed by the network. The network may not deny a selection of an alternate treating doctor.

(c) An employee who is dissatisfied with an alternate treating doctor must obtain authorization from the network to select any subsequent treating doctor. The network shall establish procedures and criteria to be used in authorizing an employee to select

subsequent treating doctors. The criteria must include, at a minimum, whether:

(1) treatment by the current treating doctor is medically inappropriate;

(2) the employee is receiving appropriate medical care to reach maximum medical improvement or medical care in compliance with the network's treatment guidelines; and

(3) a conflict exists between the employee and the current treating doctor to the extent that the doctor-patient relationship is jeopardized or impaired.

(d) Denial of a request for any subsequent treating doctor is subject to the appeal process for a complaint filed under Subchapter I.

(e) For purposes of this section, the following do not constitute the selection of an alternate or any subsequent treating doctor:

(1) a referral made by the treating doctor, including a referral for a second or subsequent opinion;

(2) the selection of a treating doctor because the original treating doctor:

(A) dies;

(B) retires; or

(C) leaves the network; or

(3) a change of treating doctor required because of a change of address by the employee to a location outside the service area distance requirements, as described by Section 1305.302(g).

(f) A network shall provide that an injured employee with a chronic, life-threatening injury or chronic pain related to a compensable injury may apply to the network's medical director to use a nonprimary care physician specialist that is in the network as the injured employee's treating doctor.

(g) An application under Subsection (f) must:

(1) include information specified by the network, including certification of the medical need provided by the nonprimary care physician specialist; and

(2) be signed by the injured employee and the nonprimary care physician specialist interested in serving as the injured employee's treating doctor.

(h) To be eligible to serve as the injured employee's treating doctor, a physician specialist must agree to accept the

responsibility to coordinate all of the injured employee's health care needs.

(i) If a network denies a request under Subsection (f), the injured employee may appeal the decision through the network's established complaint resolution process under Subchapter I.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

Sec. 1305.105. TREATMENT BY A PRIMARY CARE PHYSICIAN OR PROVIDER UNDER CHAPTER 843; RECOMMENDATIONS REGARDING USE OF PREFERRED PROVIDER PLAN. (a) Notwithstanding any other provision of this chapter, an injured employee required to receive health care services within a network may select as the employee's treating doctor a doctor who the employee selected, prior to injury, as the employee's primary care physician or provider under Chapter 843, as the terms "physician" and "provider" are defined in that chapter.

(b) A doctor serving as an employee's treating doctor under Subsection (a) must agree to abide by the terms of the network's contract and comply with the provisions of this subchapter and Subchapters D and G. Services provided by such a doctor are considered to be network services and are subject to Subchapters H and I.

(c) Any change of doctor requested by an employee being treated by a doctor under Subsection (a) must be to a network doctor and is subject to the requirements of this chapter.

(d) In studying the adequacy of networks under this chapter, the department shall offer recommendations to the 80th Legislature regarding whether to make statutory changes to allow treatment by non-network providers through a preferred provider benefit plan, as defined by Chapter 1301.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

Sec. 1305.106. PAYMENT OF HEALTH CARE PROVIDER. Notwithstanding any other provision of this chapter, an insurance carrier shall pay, reduce, deny, or determine to audit, a claim for services provided through a workers' compensation health care network

only in accordance with Section 408.027, Labor Code.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

Sec. 1305.107. TELEPHONE ACCESS. (a) Each network shall have appropriate personnel reasonably available through a toll-free telephone service at least 40 hours per week during normal business hours, in both time zones in this state if applicable, to discuss an employee's care and to allow response to requests for information, including information regarding adverse determinations.

(b) A network must have a telephone system capable of accepting or recording or providing instructions to incoming calls during other than normal business hours. The network shall respond to those calls not later than two business days after the date:

(1) the call was received by the network; or

(2) the details necessary to respond were received by the network from the caller.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

SUBCHAPTER D. CONTRACTING PROVISIONS

Sec. 1305.151. TRANSFER OF RISK. A contract under this subchapter may not involve a transfer of risk.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

Sec. 1305.152. NETWORK CONTRACTS WITH PROVIDERS. (a) A network shall enter into a written contract with each provider or group of providers that participates in the network. A provider contract under this section is confidential and is not subject to disclosure as public information under Chapter 552, Government Code.

(b) A network is not required to accept an application for participation in the network from a health care provider who otherwise meets the requirements specified in this chapter for participation if the network determines that the network has

contracted with a sufficient number of qualified health care providers.

(c) Provider contracts and subcontracts must include, at a minimum, the following provisions:

(1) a hold-harmless clause stating that the network and the network's contracted providers are prohibited from billing or attempting to collect any amounts from employees for health care services under any circumstances, including the insolvency of the insurance carrier or the network, except as provided by Section 1305.451(b)(6);

(2) a statement that the provider agrees to follow treatment guidelines adopted by the network under Section 1305.304, as applicable to an employee's injury;

(3) a continuity of treatment clause that states that if a provider leaves the network, the insurance carrier or network is obligated to continue to reimburse the provider for a period not to exceed 90 days at the contracted rate for care of an employee with a life-threatening condition or an acute condition for which disruption of care would harm the employee;

(4) a clause regarding appeal by the provider of termination of provider status and applicable written notification to employees regarding such a termination, including provisions determined by the commissioner; and

(5) any other provisions required by the commissioner by rule.

(d) Continued care as described by Subsection (c)(3) must be requested by a provider. A dispute involving continuity of care is subject to the dispute resolution process under Subchapter I.

(e) An insurance carrier and a network may not use any financial incentive or make a payment to a health care provider that acts directly or indirectly as an inducement to limit medically necessary services.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

Sec. 1305.153. PROVIDER REIMBURSEMENT. (a) The amount of reimbursement for services provided by a network provider is determined by the contract between the network and the provider or

group of providers.

(b) If an insurance carrier or network has preauthorized a health care service, the insurance carrier or network or the network's agent or other representative may not deny payment to a provider except for reasons other than medical necessity.

(c) Out-of-network providers who provide care as described by Section 1305.006 shall be reimbursed as provided by the Texas Workers' Compensation Act and applicable rules of the commissioner of workers' compensation.

(d) Subject to Subsection (a), billing by, and reimbursement to, contracted and out-of-network providers is subject to the requirements of the Texas Workers' Compensation Act and applicable rules of the commissioner of workers' compensation, as consistent with this chapter. This subsection may not be construed to require application of rules of the commissioner of workers' compensation regarding reimbursement if application of those rules would negate reimbursement amounts negotiated by the network.

(e) An insurance carrier shall notify in writing a network provider if the carrier contests the compensability of the injury for which the provider provides health care services. A carrier may not deny payment for health care services provided by a network provider before that notification on the grounds that the injury was not compensable. Payment for medically necessary health care services provided prior to written notification of a compensability denial is not subject to denial, recoupment, or refund from a network provider based on compensability. If the insurance carrier successfully contests compensability, the carrier is liable for health care provided before issuance of the notification required by this subsection, up to a maximum of \$7,000.

(f) If, for the purposes of credentialing and contracting with health care providers on behalf of the certified network, a person is serving as both a management contractor under Section 1305.102 or a third party to which the network delegates a function and as an agent of the health care provider, the contract between the management contractor or third party and the health care provider must specify:

(1) the certified network's contract rate for health care services; and

(2) the amount of reimbursement the health care provider will be paid after the health care provider agent's fee for providing administrative services is applied.

(g) If a management contractor or third party to which the network delegates a function is serving as an agent for health care providers in the certified network, the management contractor or third party must disclose that relationship in its contract with the certified network.

(h) A contract described by Subsection (f), or a contract between a management contractor or third party to which the network delegates a function and a certified network, must comply with the requirements of this chapter.

(i) If a contract described by Subsection (f) complies with the requirements of this chapter, the health care provider shall be reimbursed in accordance with the terms of the contract. If a contract described by Subsection (f) does not comply with the requirements of this chapter, the health care provider shall be reimbursed in accordance with the certified network's contracted rate.

(j) A certified network, management contractor, or third party to which the network delegates a function may not require a health care provider, as a condition for contracting with the certified network, to utilize as a health care provider agent the management contractor or the third party.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 374 (H.B. 3152), Sec. 1, eff. September 1, 2013.

Sec. 1305.154. NETWORK-CARRIER CONTRACTS. (a) Except for emergencies and out-of-network referrals, a network may provide health care services to employees only through a written contract with an insurance carrier. A network-carrier contract under this section is confidential and is not subject to disclosure as public information under Chapter 552, Government Code.

(b) A carrier and a network may negotiate the functions to be provided by the network, except that the network shall contract with providers for the provision of health care, and shall perform functions related to the operation of a quality improvement program and credentialing in accordance with the requirements of this

chapter.

(c) A network's contract with a carrier must include:

(1) a description of the functions that the carrier delegates to the network, consistent with the requirements of Subsection (b), and the reporting requirements for each function;

(2) a statement that the network and any management contractor or third party to which the network delegates a function will perform all delegated functions in full compliance with all requirements of this chapter, the Texas Workers' Compensation Act, and rules of the commissioner or the commissioner of workers' compensation;

(3) a provision that the contract:

(A) may not be terminated without cause by either party without 90 days' prior written notice; and

(B) must be terminated immediately if cause exists;

(4) a hold-harmless provision stating that the network, a management contractor, a third party to which the network delegates a function, and the network's contracted providers are prohibited from billing or attempting to collect any amounts from employees for health care services under any circumstances, including the insolvency of the carrier or the network, except as provided by Section 1305.451(b)(6);

(5) a statement that the carrier retains ultimate responsibility for ensuring that all delegated functions and all management contractor functions are performed in accordance with applicable statutes and rules and that the contract may not be construed to limit in any way the carrier's responsibility, including financial responsibility, to comply with all statutory and regulatory requirements;

(6) a statement that the network's role is to provide the services described under Subsection (b) as well as any other services or functions delegated by the carrier, including functions delegated to a management contractor, subject to the carrier's oversight and monitoring of the network's performance;

(7) a requirement that the network provide the carrier, at least monthly and in a form usable for audit purposes, the data necessary for the carrier to comply with reporting requirements of the department and the division of workers' compensation with respect to any services provided under the contract, as determined by commissioner rules;

(8) a requirement that the carrier, the network, any management contractor, and any third party to which the network delegates a function comply with the data reporting requirements of the Texas Workers' Compensation Act and rules of the commissioner of workers' compensation;

(9) a contingency plan under which the carrier would, in the event of termination of the contract or a failure to perform, reassume one or more functions of the network under the contract, including functions related to:

(A) payments to providers and notification to employees;

(B) quality of care;

(C) utilization review; and

(D) continuity of care, including a plan for identifying and transitioning employees to new providers;

(10) a provision that requires that any agreement by which the network delegates any function to a management contractor or any third party be in writing, and that such an agreement require the delegated third party or management contractor to be subject to all the requirements of this subchapter;

(11) a provision that requires the network to provide to the department the license number of a management contractor or any delegated third party who performs a function that requires a license as a utilization review agent under Chapter 4201 or any other license under this code or another insurance law of this state;

(12) an acknowledgment that:

(A) any management contractor or third party to whom the network delegates a function must perform in compliance with this chapter and other applicable statutes and rules, and that the management contractor or third party is subject to the carrier's and the network's oversight and monitoring of its performance; and

(B) if the management contractor or the third party fails to meet monitoring standards established to ensure that functions delegated to the management contractor or the third party under the delegation contract are in full compliance with all statutory and regulatory requirements, the carrier or the network may cancel the delegation of one or more delegated functions;

(13) a requirement that the network and any management contractor or third party to which the network delegates a function provide all necessary information to allow the carrier to provide

information to employees as required by Section 1305.451; and

(14) a provision that requires the network, in contracting with a third party directly or through another third party, to require the third party to permit the commissioner to examine at any time any information the commissioner believes is relevant to the third party's financial condition or the ability of the network to meet the network's responsibilities in connection with any function the third party performs or has been delegated.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 134 (H.B. 1006), Sec. 5, eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2G.009, eff. April 1, 2009.

Acts 2009, 81st Leg., R.S., Ch. 1330 (H.B. 4290), Sec. 3, eff. September 1, 2009.

Sec. 1305.1545. RESTRICTIONS ON PAYMENT AND REIMBURSEMENT. (a) An insurance carrier or administrator may not reimburse a doctor or other health care provider, an institutional provider, or an organization of doctors and health care providers on a discounted fee basis for services that are provided to an injured employee unless:

(1) the carrier or administrator has contracted with either:

(A) the doctor or other health care provider, institutional provider, or organization of doctors and health care providers; or

(B) a network that has contracted with the doctor or other health care provider, institutional provider, or organization of doctors and health care providers; and

(2) the doctor or other health care provider, institutional provider, or organization of doctors and health care providers has agreed to the contract and has agreed to provide health care services under the terms of the contract.

(b) A party to a carrier-network contract may not sell, lease, or otherwise transfer information regarding the payment or reimbursement terms of the contract without the express authority of

and prior adequate notification to the other contracting parties. This subsection does not affect the authority of the commissioner under this code to request and obtain information.

(c) An insurance carrier or administrator who violates this section:

- (1) commits an unfair claim settlement practice in violation of Subchapter A, Chapter 542, Insurance Code; and
- (2) is subject to administrative penalties under Chapters 82 and 84, Insurance Code.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 1176 (H.B. 472), Sec. 2.03, eff. September 1, 2007.

Sec. 1305.155. COMPLIANCE REQUIREMENTS. (a) An insurance carrier that becomes aware of any information that indicates that the network, any management contractor, or any third party to which the network delegates a function is not operating in accordance with the contract or is operating in a condition that renders the continuance of the network's business hazardous to employees shall:

- (1) notify the network in writing of those findings;
 - (2) request in writing a written explanation, with documentation supporting the explanation, of:
 - (A) the network's apparent noncompliance with the contract; or
 - (B) the existence of the condition that apparently renders the continuance of the network's business hazardous to employees; and
 - (3) notify the commissioner and provide the department with copies of all notices and requests submitted to the network and the responses and other documentation the carrier generates or receives in response to the notices and requests.
- (b) A network shall respond to a request from a carrier under Subsection (a) in writing not later than the 30th day after the date the request is received.
- (c) The carrier shall cooperate with the network to correct any failure by the network to comply with any regulatory requirement of

the department.

(d) On receipt of a notice under Subsection (a), or if a complaint is filed with the department, on receipt of that complaint, the commissioner or the commissioner's designated representative shall examine the matters contained in the notice or complaint as well as any other matter relating to the financial solvency of the network or the network's ability to meet its responsibilities in connection with any function performed by the network or delegated to the network by the carrier.

(e) Except as provided by this subsection, on completion of the examination, the department shall report to the network and the carrier the results of the examination and any action the department determines is necessary to ensure that the carrier meets its responsibilities under this chapter, this code, and rules adopted by the commissioner, and that the network can meet the network's responsibilities in connection with any function delegated by the carrier or performed by the network, any management contractor, or any third party to which the network delegates a function. The department may not report to the carrier any information regarding fee schedules, prices, cost of care, or other information not relevant to the monitoring plan.

(f) The network and the carrier shall respond to the department's report and submit a corrective plan to the department not later than the 30th day after the date of receipt of the report.

(g) The commissioner may order a carrier to take any action the commissioner determines is necessary to ensure that the carrier can provide all health care services under the Texas Workers' Compensation Act, including:

(1) reassuming the functions performed by or delegated to the network, including claims payments for services previously provided to injured employees;

(2) temporarily or permanently ceasing coverage of employees through the network;

(3) complying with the contingency plan required by Section 1305.154(c)(9), including permitting an injured employee to select a treating doctor in the manner provided by Section 408.022, Labor Code; or

(4) terminating the carrier's contract with the network.

(h) The carrier retains ultimate responsibility for ensuring that all delegated functions and all management contractor functions

are performed in accordance with applicable statutes and rules and nothing in this section may be construed to limit in any way the carrier's responsibility, including financial responsibility, to comply with all statutory and regulatory requirements.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

SUBCHAPTER E. FINANCIAL REQUIREMENTS

Sec. 1305.201. NETWORK FINANCIAL REQUIREMENTS. (a) Each network shall prepare financial statements in accordance with generally accepted accounting standards, which must include adequate provisions for liabilities, including incurred but not reported obligations relating to providing benefits or services.

(b) Each network shall file the financial statement under Subsection (a) with the department in the manner prescribed by commissioner rule.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

SUBCHAPTER F. EXAMINATIONS

Sec. 1305.251. EXAMINATION OF NETWORK. (a) As often as the commissioner considers necessary, the commissioner or the commissioner's designated representative may review the operations of a network to determine compliance with this chapter. The review may include on-site visits to the network's premises.

(b) During on-site visits, the network must make available to the department all records relating to the network's operations.

(c) A network shall pay a fee to the department, in an amount set by the commissioner and in accordance with rules adopted by the commissioner, for the expenses of an examination conducted under this section or Section 1305.252 that:

(1) are incurred by the commissioner or under the commissioner's authority; and

(2) are directly attributable to that examination, including the actual salaries and expenses of the examiners directly attributable to that examination, as determined under rules adopted by the commissioner.

(d) Fees collected under this section shall be deposited to the credit of the Texas Department of Insurance operating account.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 188 (S.B. 1253), Sec. 2, eff. September 1, 2007.

Sec. 1305.252. EXAMINATION OF PROVIDER OR THIRD PARTY. If requested by the commissioner or the commissioner's representative, each provider, provider group, or third party with which the network has contracted to provide health care services or any other services delegated to the network by an insurance carrier shall make available for examination by the department that portion of the books and records of the provider, provider group, or third party that is relevant to the relationship with the network of the provider, provider group, or third party.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

SUBCHAPTER G. PROVISION OF SERVICES BY NETWORK; QUALITY IMPROVEMENT PROGRAM

Sec. 1305.301. NETWORK ORGANIZATION; SERVICE AREAS. (a) The chief executive officer, operations officer, or governing body of a network is responsible for:

- (1) the development, approval, implementation, and enforcement of:
 - (A) administrative, operational, personnel, and patient care policies; and
 - (B) network procedures; and
 - (2) the development of any documents necessary for the operation of the network.
- (b) Each network shall have a chief executive officer or operations officer who:
- (1) is accountable for the day-to-day administration of the network; and
 - (2) shall ensure compliance with all applicable statutes

and rules pertaining to the operation of the network.

(c) Each network shall have a medical director, who must be an occupational medicine specialist or employ or contract with an occupational medicine specialist, and who must be licensed to practice medicine in the United States. The medical director shall:

(1) be available at all times to address complaints, clinical issues, and any quality improvement issues on behalf of the network;

(2) be actively involved in all quality improvement activities; and

(3) comply with the network's credentialing requirements.

(d) The network shall establish one or more service areas within this state. For each defined service area, the network must:

(1) demonstrate to the satisfaction of the department the ability to provide continuity, accessibility, availability, and quality of services;

(2) specify the counties and zip code areas, or any parts of a county or zip code area, included in the service area; and

(3) provide a complete provider directory to all policyholders who have selected a network in the service area.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

Sec. 1305.302. ACCESSIBILITY AND AVAILABILITY REQUIREMENTS.

(a) All services specified by this section must be provided by a provider who holds an appropriate license, unless the provider is exempt from license requirements.

(b) The network shall ensure that the network's provider panel includes an adequate number of treating doctors and specialists, who must be available and accessible to employees 24 hours a day, seven days a week, within the network's service area. A network must include sufficient numbers and types of health care providers to ensure choice, access, and quality of care to injured employees. An adequate number of the treating doctors and specialists must have admitting privileges at one or more network hospitals located within the network's service area to ensure that any necessary hospital admissions are made.

(c) Hospital services must be available and accessible 24 hours

a day, seven days a week, within the network's service area. The network shall provide for the necessary hospital services by contracting with general, special, and psychiatric hospitals.

(d) Physical and occupational therapy services and chiropractic services must be available and accessible within the network's service area.

(e) Emergency care must be available and accessible 24 hours a day, seven days a week, without restrictions as to where the services are rendered.

(f) Except for emergencies, a network shall arrange for services, including referrals to specialists, to be accessible to employees on a timely basis on request, but not later than the last day of the third week after the date of the request.

(g) Each network shall provide that network services are sufficiently accessible and available as necessary to ensure that the distance from any point in the network's service area to a point of service by a treating doctor or general hospital is not greater than 30 miles in nonrural areas and 60 miles in rural areas and that the distance from any point in the network's service area to a point of service by a specialist or specialty hospital is not greater than 75 miles in nonrural areas and 75 miles in rural areas. For portions of the service area in which the network identifies noncompliance with this subsection, the network must file an access plan with the department in accordance with Subsection (h).

(h) The network shall submit an access plan, as required by commissioner rules, to the department for approval at least 30 days before implementation of the plan if any health care service or a network provider is not available to an employee within the distance specified by Subsection (g) because:

- (1) providers are not located within that distance;
- (2) the network is unable to obtain provider contracts after good faith attempts; or
- (3) providers meeting the network's minimum quality of care and credentialing requirements are not located within that distance.

(i) The network may make arrangements with providers outside the service area to enable employees to receive a skill or specialty not available within the network service area.

(j) The network may not be required to expand services outside the network's service area to accommodate employees who live outside the service area.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

Sec. 1305.303. QUALITY OF CARE REQUIREMENTS. (a) A network shall develop and maintain an ongoing quality improvement program designed to objectively and systematically monitor and evaluate the quality and appropriateness of care and services and to pursue opportunities for improvement. The quality improvement program must include return-to-work and medical case management programs.

(b) The network's governing body is ultimately responsible for the quality improvement program. The governing body shall:

- (1) appoint a quality improvement committee that includes network providers;
- (2) approve the quality improvement program;
- (3) approve an annual quality improvement plan;
- (4) meet at least annually to receive and review reports of the quality improvement committee or group of committees, and take action as appropriate; and
- (5) review the annual written report on the quality improvement program.

(c) The quality improvement committee or committees shall evaluate the overall effectiveness of the quality improvement program as determined by commissioner rules.

(d) The quality improvement program must be continuous and comprehensive and must address both the quality of clinical care and the quality of services. The network shall dedicate adequate resources, including adequate personnel and information systems, to the quality improvement program.

(e) The network shall develop a written description of the quality improvement program that outlines the organizational structure of the program, the functional responsibilities of the program, and the frequency of committee meetings.

(f) The network shall develop an annual quality improvement work plan designed to reflect the type of services and the populations served by the network in terms of age groups, disease or injury categories, and special risk status, such as type of industry.

(g) The network shall prepare an annual written report to the department on the quality improvement program. The report must include:

- (1) completed activities;
- (2) the trending of clinical and service goals;
- (3) an analysis of program performance; and
- (4) conclusions regarding the effectiveness of the program.

(h) Each network shall implement a documented process for the selection and retention of contracted providers, in accordance with rules adopted by the commissioner.

(i) The quality improvement program must provide for a peer review action procedure for providers, as described by Section 151.002, Occupations Code.

(j) The network shall have a medical case management program with certified case managers. Case managers shall work with treating doctors, referral providers, and employers to facilitate cost-effective care and employee return-to-work.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

Sec. 1305.304. GUIDELINES AND PROTOCOLS. Each network shall adopt treatment guidelines, return-to-work guidelines, and individual treatment protocols. The treatment guidelines and individual treatment protocols must be evidence-based, scientifically valid, and outcome-focused and be designed to reduce inappropriate or unnecessary health care while safeguarding necessary care. Treatment may not be denied solely on the basis that the treatment for the compensable injury in question is not specifically addressed by the treatment guidelines used by the insurance carrier or network.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

SUBCHAPTER H. UTILIZATION REVIEW

Sec. 1305.351. UTILIZATION REVIEW IN NETWORK. (a) The requirements of Chapter 4201 apply to utilization review conducted in relation to claims in a workers' compensation health care network. In the event of a conflict between Chapter 4201 and this chapter, this chapter controls.

(b) Any screening criteria used for utilization review related to a workers' compensation health care network must be consistent

with the network's treatment guidelines.

(c) The preauthorization requirements of Section 413.014, Labor Code, and commissioner of workers' compensation rules adopted under that section, do not apply to health care provided through a workers' compensation network. If a network or carrier uses a preauthorization process within a network, the requirements of this subchapter and commissioner rules apply. A network or an insurance carrier may not require preauthorization of treatments and services for a medical emergency.

(d) A utilization review agent or an insurance carrier that uses doctors to perform reviews of health care services provided under this chapter, including utilization review, or peer reviews under Section 408.0231(g), Labor Code, may only use doctors licensed to practice in this state.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 134 (H.B. 1006), Sec. 6, eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2G.010, eff. April 1, 2009.

Acts 2009, 81st Leg., R.S., Ch. 1330 (H.B. 4290), Sec. 5, eff. September 1, 2009.

Acts 2019, 86th Leg., R.S., Ch. 1218 (S.B. 1742), Sec. 3.11, eff. September 1, 2019.

Sec. 1305.353. NOTICE OF CERTAIN UTILIZATION REVIEW DETERMINATIONS; PREAUTHORIZATION REQUIREMENTS. (a) The entity performing utilization review shall notify the employee or the employee's representative, if any, and the requesting provider of a determination made in a utilization review.

(b) Notification of an adverse determination must include:

- (1) the principal reasons for the adverse determination;
- (2) the clinical basis for the adverse determination;
- (3) a description of or the source of the screening criteria that were used as guidelines in making the determination;
- (4) a description of the procedure for the reconsideration process; and

(5) notification of the availability of independent review in the form prescribed by the commissioner.

(c) On receipt of a preauthorization request from a provider for proposed services that require preauthorization, the utilization review agent shall issue and transmit a determination indicating whether the proposed health care services are preauthorized. The utilization review agent shall respond to requests for preauthorization within the periods prescribed by this section.

(d) For services not described under Subsection (e) or (f), the determination under Subsection (c) must be issued and transmitted not later than the third working day after the date the request is received. For the purposes of this subsection, "working day" has the meaning assigned by Section 4201.002.

(e) If the proposed services are for concurrent hospitalization care, the utilization review agent shall, within 24 hours of receipt of the request, transmit a determination indicating whether the proposed services are preauthorized.

(f) If the proposed health care services involve poststabilization treatment or a life-threatening condition, the utilization review agent shall transmit to the requesting provider a determination indicating whether the proposed services are preauthorized within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, not to exceed one hour from receipt of the request. If the utilization review agent issues an adverse determination in response to a request for poststabilization treatment or a request for treatment involving a life-threatening condition, the utilization review agent shall provide to the employee or the employee's representative, if any, and the employee's treating provider the notification required under Subsection (a).

(g) For life-threatening conditions, the notification of adverse determination must include notification of the availability of independent review in the form prescribed by the commissioner.

(h) Treatments and services for an emergency do not require preauthorization.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 972 (H.B. 3625), Sec. 1, eff.

September 1, 2009.

Acts 2009, 81st Leg., R.S., Ch. 1330 (H.B. 4290), Sec. 6, eff. September 1, 2009.

Sec. 1305.354. RECONSIDERATION OF ADVERSE DETERMINATION. (a) A utilization review agent shall maintain and make available a written description of the reconsideration procedures involving an adverse determination. The reconsideration procedures must be reasonable and must include:

(1) a provision stating that reconsideration must be performed by a provider other than the provider who made the original adverse determination;

(2) a provision that an employee, a person acting on behalf of the employee, or the employee's requesting provider may, not later than the 30th day after the date of issuance of written notification of an adverse determination, request reconsideration of the adverse determination either orally or in writing;

(3) a provision that, not later than the fifth calendar day after the date of receipt of the request, the network shall send to the requesting party a letter acknowledging the date of the receipt of the request that includes a reasonable list of documents the requesting party is required to submit;

(4) a provision that, after completion of the review of the request for reconsideration of the adverse determination, the utilization review agent shall issue a response letter to the employee or person acting on behalf of the employee, and the employee's requesting provider, that:

(A) explains the resolution of the reconsideration; and

(B) includes:

(i) a statement of the specific medical or clinical reasons for the resolution;

(ii) the medical or clinical basis for the decision;

(iii) the professional specialty of any provider consulted; and

(iv) notice of the requesting party's right to seek review of the denial by an independent review organization and the procedures for obtaining that review; and

(5) written notification to the requesting party of the

determination of the request for reconsideration as soon as practicable, but not later than the 30th day after the date the utilization review agent received the request.

(b) In addition to the written request for reconsideration, the reconsideration procedures must include a method for expedited reconsideration procedures for denials of proposed health care services involving poststabilization treatment or life-threatening conditions, and for denials of continued stays for hospitalized employees. The procedures must include a review by a provider who has not previously reviewed the case and who is of the same or a similar specialty as a provider who typically manages the condition, procedure, or treatment under review. The period during which that reconsideration must be completed shall be based on the medical or clinical immediacy of the condition, procedure, or treatment, but may not exceed one calendar day from the date of receipt of all information necessary to complete the reconsideration.

(c) Notwithstanding Subsection (a) or (b), an employee with a life-threatening condition is entitled to an immediate review by an independent review organization and is not required to comply with the procedures for a reconsideration of an adverse determination.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

Sec. 1305.355. INDEPENDENT REVIEW OF ADVERSE DETERMINATION.

(a) The utilization review agent shall:

(1) permit the employee or person acting on behalf of the employee and the employee's requesting provider whose reconsideration of an adverse determination is denied to seek review of that determination within the period prescribed by Subsection (b) by an independent review organization assigned in accordance with Chapter 4202 and commissioner rules; and

(2) provide to the appropriate independent review organization, not later than the third business day after the date the utilization review agent receives notification of the assignment of the request to an independent review organization:

(A) any medical records of the employee that are relevant to the review;

(B) any documents used by the utilization review agent

in making the determination;

(C) the response letter described by Section 1305.354(a)(4);

(D) any documentation and written information submitted in support of the request for reconsideration; and

(E) a list of the providers who provided care to the employee and who may have medical records relevant to the review.

(b) A request for independent review under Subsection (a) must be timely filed by the requestor as follows:

(1) for a request for preauthorization or concurrent review by an independent review organization, not later than the 45th day after the date of denial of a reconsideration for health care requiring preauthorization or concurrent review; or

(2) for a request for retrospective medical necessity review, not later than the 45th day after the denial of reconsideration.

(c) The insurance carrier shall pay for the independent review provided under this subchapter.

(d) The department shall assign the review request to an independent review organization. An independent review organization that uses doctors to perform reviews of health care services under this chapter may only use doctors licensed to practice in this state.

(e) A party to a medical dispute that remains unresolved after a review under this section is entitled to a hearing and judicial review of the decision in accordance with Section 1305.356. The division of workers' compensation and the department are not considered to be parties to the medical dispute.

(f) A determination of an independent review organization related to a request for preauthorization or concurrent review is binding during the pendency of a dispute and the carrier and network shall comply with the determination.

(g) If a contested case hearing or judicial review is not sought under Section 1305.356, the carrier and network shall comply with the independent review organization's determination.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 133 (H.B. 1003), Sec. 3, eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2G.011, eff. April 1, 2009.

Acts 2011, 82nd Leg., R.S., Ch. 1162 (H.B. 2605), Sec. 2, eff. September 1, 2011.

Acts 2019, 86th Leg., R.S., Ch. 1218 (S.B. 1742), Sec. 3.12, eff. September 1, 2019.

Sec. 1305.356. CONTESTED CASE HEARING ON AND JUDICIAL REVIEW OF INDEPENDENT REVIEW. (a) A party to a medical dispute that remains unresolved after a review under Section 1305.355 is entitled to a contested case hearing. A hearing under this subsection shall be conducted by the department's division of workers' compensation in the same manner as a hearing conducted under Section 413.0311, Labor Code.

(b) At a contested case hearing held under Subsection (a), the administrative law judge conducting the hearing shall consider evidence-based treatment guidelines adopted by the network under Section 1305.304.

(c) A party that has exhausted all administrative remedies under Subsection (a) and is aggrieved by a final decision of the department's division of workers' compensation may seek judicial review of the decision.

(d) Judicial review under Subsection (c) shall be conducted in the manner provided for judicial review of a contested case under Subchapter G, Chapter 2001, Government Code, and is governed by the substantial evidence rule.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1162 (H.B. 2605), Sec. 3, eff. September 1, 2011.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 839 (H.B. 2111), Sec. 1, eff. September 1, 2017.

SUBCHAPTER I. COMPLAINT RESOLUTION

Sec. 1305.401. COMPLAINT SYSTEM REQUIRED. (a) Each network shall implement and maintain a complaint system that provides reasonable procedures to resolve an oral or written complaint.

(b) The network may require a complainant to file the complaint

not later than the 90th day after the date of the event or occurrence that is the basis for the complaint.

(c) The complaint system must include a process for the notice and appeal of a complaint.

(d) The commissioner may adopt rules as necessary to implement this section.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

Sec. 1305.402. COMPLAINT INITIATION AND INITIAL RESPONSE; DEADLINES FOR RESPONSE AND RESOLUTION. (a) If a complainant notifies a network of a complaint, the network, not later than the seventh calendar day after the date the network receives the complaint, shall respond to the complainant, acknowledging the date of receipt of the complaint and providing a description of the network's complaint procedures and deadlines.

(b) The network shall investigate and resolve a complaint not later than the 30th calendar day after the date the network receives the complaint.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

Sec. 1305.403. RECORD OF COMPLAINTS. (a) Each network shall maintain a complaint and appeal log regarding each complaint. The commissioner shall adopt rules designating the classification of network complaints under this section.

(b) Each network shall maintain a record of and documentation on each complaint, complaint proceeding, and action taken on the complaint until the third anniversary of the date the complaint was received.

(c) A complainant is entitled to a copy of the network's record regarding the complaint and any proceeding relating to that complaint.

(d) The department, during any investigation or examination of a network, may review documentation maintained under this subchapter, including original documentation, regarding a complaint and action taken on the complaint.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

Sec. 1305.404. RETALIATORY ACTION PROHIBITED. A network may not engage in any retaliatory action against an employer or employee because the employer or employee or a person acting on behalf of the employer or employee has filed a complaint against the network.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

Sec. 1305.405. POSTING OF INFORMATION ON COMPLAINT PROCESS REQUIRED. (a) A contract between a network and a provider must require the provider to post, in the provider's office, a notice to injured employees on the process for resolving complaints with the network.

(b) The notice required under Subsection (a) must include the department's toll-free telephone number for filing a complaint.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

SUBCHAPTER J. EMPLOYEE INFORMATION AND RESPONSIBILITIES

Sec. 1305.451. EMPLOYEE INFORMATION; RESPONSIBILITIES OF EMPLOYEE. (a) An insurance carrier that establishes or contracts with a network shall provide to employers, and the employer shall provide to its employees, an accurate written description of the terms and conditions for obtaining health care within the network's service area.

(b) The written description required under Subsection (a) must be in English, Spanish, and any additional language common to an employer's employees, must be in plain language and in a readable and understandable format, and must include, in a clear, complete, and accurate format:

(1) a statement that the entity providing health care to employees is a workers' compensation health care network;

(2) the network's toll-free number and address for obtaining additional information about the network, including

information about network providers;

(3) a statement that in the event of an injury, the employee must select a treating doctor:

(A) from a list of all the network's treating doctors who have contracts with the network in that service area; or

(B) as described by Section 1305.105;

(4) a statement that, except for emergency services, the employee shall obtain all health care and specialist referrals through the employee's treating doctor;

(5) an explanation that network providers have agreed to look only to the network or insurance carrier and not to employees for payment of providing health care, except as provided by Subdivision (6);

(6) a statement that if the employee obtains health care from non-network providers without network approval, except as provided by Section 1305.006, the insurance carrier may not be liable, and the employee may be liable, for payment for that health care;

(7) information about how to obtain emergency care services, including emergency care outside the service area, and after-hours care;

(8) a list of the health care services for which the insurance carrier or network requires preauthorization or concurrent review;

(9) an explanation regarding continuity of treatment in the event of the termination from the network of a treating doctor;

(10) a description of the network's complaint system, including a statement that the network is prohibited from retaliating against:

(A) an employee if the employee files a complaint against the network or appeals a decision of the network; or

(B) a provider if the provider, on behalf of an employee, reasonably files a complaint against the network or appeals a decision of the network;

(11) a summary of the insurance carrier's or network's procedures relating to adverse determinations and the availability of the independent review process;

(12) a list of network providers updated at least quarterly, including:

(A) the names and addresses of the providers;

(B) a statement of limitations of accessibility and referrals to specialists; and

(C) a disclosure of which providers are accepting new patients; and

(13) a description of the network's service area.

(c) The network and the network's representatives and agents may not cause or knowingly permit the use or distribution to employees of information that is untrue or misleading.

(d) A network that contracts with an insurance carrier shall provide all the information necessary to allow the carrier to comply with this section.

(e) An issue regarding whether an employer properly provided an employee with the information required by this section may be resolved using the process for adjudication of disputes under Chapter 410, Labor Code, as used by the department's division of workers' compensation.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 1066 (S.B. 809), Sec. 5, eff. September 1, 2011.

SUBCHAPTER K. EVALUATION OF NETWORKS; CONSUMER REPORT CARD

Sec. 1305.502. CONSUMER REPORT CARDS. (a) Not later than December 1 of each even-numbered year, the group shall develop and issue an informational report card that identifies and compares, on an objective basis, the quality, costs, health care provider availability, and other analogous factors of workers' compensation health care networks operating under the workers' compensation system of this state with each other and with medical care provided outside of networks.

(b) The group may procure services as necessary to produce the report card. The report card must include a risk-adjusted evaluation of:

- (1) employee access to care;
- (2) return-to-work outcomes;
- (3) health-related outcomes;
- (4) employee satisfaction with care; and

(5) health care costs and utilization of health care.

(c) The report cards may be based on information or data from any person, agency, organization, or governmental entity that the group considers reliable. The group may not endorse or recommend a specific workers' compensation health care network or plan, or subjectively rate or rank networks or plans, other than through comparison and evaluation of objective criteria.

(d) The commissioner shall ensure that consumer report cards issued by the group under this section are accessible to the public on the department's Internet website and available to any person on request. The commissioner by rule may set a reasonable fee for obtaining a paper copy of report cards.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

Amended by:

Acts 2021, 87th Leg., R.S., Ch. 670 (H.B. 1753), Sec. 1, eff. June 15, 2021.

Acts 2021, 87th Leg., R.S., Ch. 856 (S.B. 800), Sec. 21, eff. September 1, 2021.

Sec. 1305.503. CONFIDENTIALITY REQUIREMENTS. (a) As necessary to implement this subchapter, the department may access information from an executive agency that is otherwise confidential under any law of this state, including the Texas Workers' Compensation Act.

(b) Confidential information provided to or obtained by the department under this section remains confidential and is not subject to disclosure under Chapter 552, Government Code. The department may not release, and a person may not gain access to, any information that:

(1) could reasonably be expected to reveal the identity of an injured employee; or

(2) discloses provider discounts or differentials between payments and billed charges for individual providers or networks.

(c) Information that is in the possession of the department and that relates to an individual injured employee, and any compilation, report, or analysis produced from the information that identifies an individual injured employee, are not:

(1) subject to discovery, subpoena, or other means of legal

compulsion for release to any person; or

(2) admissible in any civil, administrative, or criminal proceeding.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

SUBCHAPTER L. DISCIPLINARY ACTIONS

Sec. 1305.551. DETERMINATION OF VIOLATION; NOTICE. (a) If the commissioner determines that a network, insurance carrier, or any other person or third party operating under this chapter, including a third party to which a network delegates a function, or any third party with which a network contracts for management services, is in violation of this chapter, rules adopted by the commissioner under this chapter, or applicable provisions of the Labor Code or rules adopted under that code, the commissioner or a designated representative may notify the network, insurance carrier, person, or third party of the alleged violation and may compel the production of any documents or other information as necessary to determine whether the violation occurred.

(b) The commissioner's designated representative may initiate the proceedings under this section.

(c) A proceeding under this section is a contested case under Chapter 2001, Government Code.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

Sec. 1305.552. DISCIPLINARY ACTIONS. If under Section 1305.551 the commissioner determines that a network, insurance carrier, or other person or third party described under Section 1305.551 has violated or is violating this chapter, rules adopted by the commissioner under this chapter, or the Labor Code or rules adopted under that code, the commissioner may:

- (1) suspend or revoke a certificate issued under this code;
- (2) impose sanctions under Chapter 82;
- (3) issue a cease and desist order under Chapter 83;
- (4) impose administrative penalties under Chapter 84; or
- (5) take any combination of these actions.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

SUBTITLE E. BENEFITS PAYABLE UNDER HEALTH COVERAGES

CHAPTER 1351. HOME HEALTH SERVICES

Sec. 1351.001. DEFINITIONS. In this chapter:

(1) "Health services" includes:

(A) skilled nursing by a registered nurse or a licensed vocational nurse under the supervision of at least one registered nurse and at least one physician;

(B) physical, occupational, speech, or respiratory therapy;

(C) the services of a home health aide under the supervision of a registered nurse; and

(D) the furnishing of medical equipment and supplies other than drugs or medicines.

(2) "Home health agency" means a business that:

(A) provides home health services; and

(B) is licensed by the Texas Department of Human Services under Chapter 142, Health and Safety Code.

(3) "Home health services" means the provision of health services for payment or other consideration in a patient's residence under a plan of care that is:

(A) established, approved in writing, and reviewed at least every two months by the attending physician; and

(B) certified by the attending physician as necessary for medical purposes.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1351.002. APPLICABILITY OF CHAPTER. (a) This chapter applies to a group health benefit plan that is delivered or issued for delivery in this state and that is a group policy of accident and health insurance, including a policy issued by a group hospital service corporation operating under Chapter 842.

(b) This chapter applies to an accident and health insurance policy issued by a stipulated premium company subject to Chapter 884.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1351.003. APPLICABILITY OF GENERAL PROVISIONS OF OTHER LAW. The provisions of Chapter 1201, including provisions relating to the applicability, purpose, and enforcement of that chapter, the construction of policies under that chapter, rulemaking under that chapter, and definitions of terms applicable in that chapter, apply to this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1351.004. EXCEPTION. This chapter does not apply to:

(1) a group policy of accident and health insurance that provides coverage only for:

- (A) a specified disease or diseases;
- (B) vision care;
- (C) dental care;
- (D) hospital indemnity;
- (E) prescription drugs; or
- (F) other limited benefits;

(2) a blanket insurance policy, as described by Chapter 1251;

(3) a short-term travel insurance policy;

(4) an accident-only insurance policy;

(5) a hospital indemnity insurance policy;

(6) a limited or specified disease insurance policy;

(7) an insurance policy or contract issued under a right of conversion; or

(8) an insurance policy or contract designed for issuance to a person eligible for Medicare coverage.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1351.005. COVERAGE REQUIRED. Except as provided by Section 1351.008, a group health benefit plan must provide coverage for home health services provided by a home health agency.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1351.006. REIMBURSEMENT FOR HOME HEALTH SERVICES: PHYSICIAN CERTIFICATION REQUIRED. A group health benefit plan issuer may not provide reimbursement for home health services provided under the plan unless the attending physician certifies that hospitalization or confinement in a skilled facility would be required if a treatment plan for home health care were not provided.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1351.007. LIMITATIONS AND EXCLUSIONS ON COVERAGE PERMITTED. (a) A group health benefit plan may include:

- (1) a limitation on the number of visits for home health services for which benefits are payable, subject to Subsection (b);
- (2) an exclusion for home health services coverage for:
 - (A) custodial care;
 - (B) services provided by an individual who:
 - (i) resides in the covered individual's home; or
 - (ii) is a member of the covered individual's family; or
 - (C) services provided to a covered individual who is eligible for Medicare coverage;
- (3) annual deductible and coinsurance provisions for home health services coverage that are not less favorable than the deductible or coinsurance provisions applicable to hospital services coverage under the plan; and
- (4) other coverage limitations or exclusions consistent with the remaining provisions of the plan.

(b) A limitation under Subsection (a)(1) may not limit each individual covered under the plan to fewer than 60 visits in any calendar year or continuous 12-month period.

(c) For purposes of this section, each of the following is considered to be one visit for home health services:

- (1) a visit by a representative of a home health agency;
- (2) four hours of home health aide service; and
- (3) if home health aide service extends beyond four hours, each additional four hours or portion of that four-hour period.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1351.008. REJECTION OF COVERAGE BY PLAN HOLDER; NEGOTIATION OF ALTERNATIVE COVERAGE. (a) If the holder of a group health benefit plan rejects in writing the coverage required under this chapter, the plan issuer:

- (1) may not include the coverage in the plan; and
- (2) is not required to:
 - (A) offer the coverage to the plan holder; or
 - (B) provide the coverage under the plan.

(b) If a plan holder rejects in writing the coverage required under this chapter, the plan holder and the plan issuer may negotiate coverage for home health services other than the coverage required under this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1351.009. ADDITIONAL COVERAGE NOT PRECLUDED. This chapter does not preclude a group health benefit plan issuer from providing coverage for home health services that exceeds the coverage required under this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

CHAPTER 1352. BRAIN INJURY

Sec. 1352.001. APPLICABILITY OF CHAPTER. (a) This chapter applies only to a health benefit plan, including, subject to this chapter, a small employer health benefit plan written under Chapter 1501, that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is offered by:

- (1) an insurance company;
- (2) a group hospital service corporation operating under Chapter 842;
- (3) a fraternal benefit society operating under Chapter 885;
- (4) a stipulated premium company operating under Chapter 884;

- (5) a reciprocal exchange operating under Chapter 942;
 - (6) a Lloyd's plan operating under Chapter 941;
 - (7) a health maintenance organization operating under Chapter 843;
 - (8) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; or
 - (9) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844.
- (b) Notwithstanding any provision in Chapter 1551, 1575, 1579, or 1601 or any other law, this chapter applies to:
- (1) a basic coverage plan under Chapter 1551;
 - (2) a basic plan under Chapter 1575;
 - (3) a primary care coverage plan under Chapter 1579; and
 - (4) basic coverage under Chapter 1601.
- (c) This chapter applies to group health coverage made available by a school district in accordance with Section 22.004, Education Code.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 877 (H.B. 1919), Sec. 1, eff. September 1, 2007.

Acts 2013, 83rd Leg., R.S., Ch. 370 (H.B. 2929), Sec. 1, eff. September 1, 2013.

Sec. 1352.002. EXCEPTION; APPLICATION TO QUALIFIED HEALTH PLAN.

- (a) This chapter does not apply to:
- (1) a 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; or

(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 as described by Section 1352.001.

(b) This chapter does not apply to a standard health benefit plan issued under Chapter 1507.

(c) To the extent that a change in law made to this chapter after January 1, 2013, would otherwise require this state to make a payment under 42 U.S.C. Section 18031(d)(3)(B)(ii), a qualified health plan, as defined by 45 C.F.R. Section 155.20, is not required to provide a benefit under this section that exceeds the specified essential health benefits required under 42 U.S.C. Section 18022(b).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 370 (H.B. 2929), Sec. 2, eff. September 1, 2013.

Sec. 1352.003. REQUIRED COVERAGES--HEALTH BENEFIT PLANS OTHER THAN SMALL EMPLOYER HEALTH BENEFIT PLANS. (a) A health benefit plan must include coverage for cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation, neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing and treatment, neurofeedback therapy, and remediation required for and related to treatment of an acquired brain injury.

(b) A health benefit plan must include coverage for post-acute transition services, community reintegration services, including outpatient day treatment services, or other post-acute care treatment services necessary as a result of and related to an acquired brain injury.

(c) A health benefit plan may not include, in any annual or lifetime limitation on the number of days of acute care treatment

covered under the plan, any post-acute care treatment covered under the plan.

(c-1) A health benefit plan may not limit the number of days of covered post-acute care, including any therapy or treatment or rehabilitation, testing, remediation, or other service described by Subsections (a) and (b), or the number of days of covered inpatient care to the extent that the treatment or care is determined to be medically necessary as a result of and related to an acquired brain injury. The insured's or enrollee's treating physician shall determine whether treatment or care is medically necessary for purposes of this subsection in consultation with the treatment or care provider, the insured or enrollee, and, if appropriate, members of the insured's or enrollee's family. The determination is subject to review under Section 1352.006.

(d) Except as provided by Subsection (c) or (c-1), a health benefit plan must include the same amount limitations, deductibles, copayments, and coinsurance factors for coverage required under this chapter as applicable to other medical conditions for which coverage is provided under the health benefit plan.

(e) To ensure that appropriate post-acute care treatment is provided, a health benefit plan must include coverage for reasonable expenses related to periodic reevaluation of the care of an individual covered under the plan who:

- (1) has incurred an acquired brain injury;
- (2) has been unresponsive to treatment; and
- (3) becomes responsive to treatment at a later date.

(f) A determination of whether expenses, as described by Subsection (e), are reasonable may include consideration of factors including:

- (1) cost;
- (2) the time that has expired since the previous evaluation;
- (3) any difference in the expertise of the physician or practitioner performing the evaluation;
- (4) changes in technology; and
- (5) advances in medicine.

(g) The commissioner shall adopt rules as necessary to implement this chapter.

(h) This section does not apply to a small employer health benefit plan.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 877 (H.B. 1919), Sec. 2, eff. September 1, 2007.

Acts 2013, 83rd Leg., R.S., Ch. 370 (H.B. 2929), Sec. 3, eff. September 1, 2013.

Sec. 1352.0035. REQUIRED COVERAGES--SMALL EMPLOYER HEALTH BENEFIT PLANS. (a) A small employer health benefit plan may not exclude coverage for cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation, neurobehavioral, neurophysiological, neuropsychological, or psychophysiological testing or treatment, neurofeedback therapy, remediation, post-acute transition services, or community reintegration services necessary as a result of and related to an acquired brain injury.

(b) Coverage required under this section may be subject to deductibles, copayments, coinsurance, or annual or maximum amount limits that are consistent with the deductibles, copayments, coinsurance, or annual or maximum amount limits applicable to other medical conditions for which coverage is provided under the small employer health benefit plan.

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

Added by Acts 2007, 80th Leg., R.S., Ch. 877 (H.B. 1919), Sec. 3, eff. September 1, 2007.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 370 (H.B. 2929), Sec. 4, eff. September 1, 2013.

Sec. 1352.004. TRAINING FOR CERTAIN PERSONNEL REQUIRED. (a) In this section, "preauthorization" means the provision of a reliable representation to a physician or health care provider of whether a health benefit plan issuer will pay the physician or provider for proposed medical or health care services if the physician or provider provides those services to the patient for whom the services are proposed. The term includes precertification, certification,

recertification, or any other activity that involves providing a reliable representation by the issuer to a physician or health care provider.

(b) The commissioner by rule shall require a health benefit plan issuer to provide adequate training to personnel responsible for preauthorization of coverage or utilization review under the plan. The purpose of the training is to prevent denial of coverage in violation of Section 1352.003 and to avoid confusion of medical benefits with mental health benefits. The commissioner shall prescribe by rule the basic requirements for the training described by this subsection.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 877 (H.B. 1919), Sec. 4, eff. September 1, 2007.

Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 3.38, eff. January 1, 2016.

Acts 2015, 84th Leg., R.S., Ch. 946 (S.B. 277), Sec. 2.35, eff. January 1, 2016.

Sec. 1352.005. NOTICE TO INSUREDS AND ENROLLEES. (a) A health benefit plan issuer subject to this chapter, other than a small employer health benefit plan issuer, must annually notify each insured or enrollee under the plan in writing about the coverages described by Section 1352.003.

(b) The commissioner shall prescribe by rule the specific contents and wording of the notice required under this section.

(c) The notice required under this section must include:

(1) a description of the benefits listed under Section 1352.003;

(2) a statement that the fact that an acquired brain injury does not result in hospitalization or receipt of a specific treatment or service described by Section 1352.003 for acute care treatment does not affect the right of the insured or enrollee to receive benefits described by Section 1352.003 commensurate with the condition of the insured or enrollee; and

(3) a statement of the fact that benefits described by Section 1352.003 may be provided in a facility listed in Section

1352.007.

Added by Acts 2007, 80th Leg., R.S., Ch. 877 (H.B. 1919), Sec. 5, eff. September 1, 2007.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 3.39, eff. January 1, 2016.

Acts 2015, 84th Leg., R.S., Ch. 946 (S.B. 277), Sec. 2.36, eff. January 1, 2016.

Sec. 1352.006. DETERMINATION OF MEDICAL NECESSITY; EXTENSION OF COVERAGE. (a) In this section, "utilization review" has the meaning assigned by Section 4201.002.

(b) Notwithstanding Chapter 4201 or any other law relating to the determination of medical necessity under this code, a health benefit plan shall respond to a person requesting utilization review or appealing for an extension of coverage based on an allegation of medical necessity not later than three business days after the date on which the person makes the request or submits the appeal. The person must make the request or submit the appeal in the manner prescribed by the terms of the plan's health insurance policy or agreement, contract, evidence of coverage, or similar coverage document. To comply with the requirements of this section, the health benefit plan issuer must respond through a direct telephone contact made by a representative of the issuer. This subsection does not apply to a small employer health benefit plan.

Added by Acts 2007, 80th Leg., R.S., Ch. 877 (H.B. 1919), Sec. 5, eff. September 1, 2007.

Sec. 1352.007. TREATMENT FACILITIES. (a) A health benefit plan may not deny coverage under this chapter based solely on the fact that the treatment or services are provided at a facility other than a hospital. Treatment for an acquired brain injury may be provided under the coverage required by this chapter, as appropriate, at a facility at which appropriate services may be provided, including:

(1) a hospital regulated under Chapter 241, Health and Safety Code, including an acute or post-acute rehabilitation

hospital; and

(2) an assisted living facility regulated under Chapter 247, Health and Safety Code.

(b) This section does not apply to a small employer health benefit plan.

(c) The issuer of a health benefit plan, including a preferred provider benefit plan or health maintenance organization plan, that contracts with or approves admission to a service provider under this chapter may not, solely because a facility is licensed by this state as an assisted living facility, refuse to contract with or approve admission to that facility to provide services that are:

(1) required under this chapter;

(2) within the scope of the license of an assisted living facility; and

(3) within the scope of the services provided under a CARF-accredited rehabilitation program for brain injury or another nationally recognized accredited rehabilitation program for brain injury.

(d) The issuer of a health benefit plan that requires or encourages insureds or enrollees to use health care providers designated by the plan shall ensure that the services required by this chapter that are within the scope of the license of an assisted living facility and that may be provided under a program described by Subsection (c)(3) are made available and accessible to the insureds or enrollees at an adequate number of assisted living facilities.

(e) A health benefit plan may not treat care provided in accordance with this chapter as custodial care solely because it is provided by an assisted living facility if the facility holds a CARF accreditation or other nationally recognized accreditation for a rehabilitation program for brain injury.

(f) To ensure the health and safety of insureds and enrollees, the commissioner may require that a licensed assisted living facility that provides covered post-acute care other than custodial care under this chapter to an insured or enrollee with acquired brain injury hold a CARF accreditation or other nationally recognized accreditation for a rehabilitation program for brain injury.

Added by Acts 2007, 80th Leg., R.S., Ch. 877 (H.B. [1919](#)), Sec. 5, eff. September 1, 2007.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 370 (H.B. 2929), Sec. 5, eff. September 1, 2013.

Sec. 1352.008. CONSUMER INFORMATION. The commissioner shall prepare information for use by consumers, purchasers of health benefit plan coverage, and self-insurers regarding coverages recommended for acquired brain injuries. The department shall publish information prepared under this section on the department's Internet website.

Added by Acts 2007, 80th Leg., R.S., Ch. 877 (H.B. 1919), Sec. 5, eff. September 1, 2007.

CHAPTER 1353. IMMUNIZATION OR VACCINATION PROTOCOLS UNDER MANAGED CARE PLANS

Sec. 1353.001. PROHIBITED CONDUCT. A managed care entity may not:

(1) require a physician participating in a managed care plan to issue an immunization or vaccination protocol for an immunization or vaccination to be administered to an enrollee in the plan;

(2) limit an enrollee's benefits for immunizations or vaccinations to circumstances in which an immunization or vaccination protocol is issued;

(3) provide a financial incentive to a physician to issue an immunization or vaccination protocol; or

(4) impose a financial or other penalty on a physician who refuses to issue an immunization or vaccination protocol.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1353.002. RULES. The commissioner may adopt rules to implement this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

CHAPTER 1354. ELIGIBILITY FOR BENEFITS FOR ALZHEIMER'S DISEASE

Sec. 1354.001. APPLICABILITY OF CHAPTER. This chapter applies only to a health benefit plan that:

- (1) provides coverage for Alzheimer's disease; and
- (2) is an individual or group policy, contract, certificate, or evidence of coverage that is delivered or issued for delivery in this state by an insurer or a group hospital service corporation operating under Chapter 842.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1354.002. PROOF OF ORGANIC DISEASE. If a health benefit plan requires demonstrable proof of organic disease or other proof before the health benefit plan issuer will authorize payment of benefits for Alzheimer's disease, that proof requirement is satisfied by a clinical diagnosis of Alzheimer's disease made by a physician licensed in this state, including a history and physical, neurological, and psychological or psychiatric evaluations, and laboratory studies.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

CHAPTER 1355. BENEFITS FOR CERTAIN MENTAL DISORDERS

SUBCHAPTER A. GROUP HEALTH BENEFIT PLAN COVERAGE

FOR CERTAIN SERIOUS MENTAL ILLNESSES AND OTHER DISORDERS

Sec. 1355.001. DEFINITIONS. In this subchapter:

- (1) "Serious mental illness" means the following psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM):
 - (A) bipolar disorders (hypomanic, manic, depressive, and mixed);
 - (B) depression in childhood and adolescence;
 - (C) major depressive disorders (single episode or recurrent);
 - (D) obsessive-compulsive disorders;
 - (E) paranoid and other psychotic disorders;
 - (F) schizo-affective disorders (bipolar or depressive); and
 - (G) schizophrenia.
- (2) "Small employer" has the meaning assigned by Section

1501.002.

(3) "Autism spectrum disorder" means a neurobiological disorder that includes autism, Asperger's syndrome, or Pervasive Developmental Disorder--Not Otherwise Specified.

(4) "Neurobiological disorder" means an illness of the nervous system caused by genetic, metabolic, or other biological factors.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 877 (H.B. 1919), Sec. 7, eff. September 1, 2007.

Sec. 1355.002. APPLICABILITY OF SUBCHAPTER. (a) This subchapter applies only to a group health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(1) a group insurance policy, group insurance agreement, group hospital service contract, or group evidence of coverage that is offered by:

(A) an insurance company;

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

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

(D) a stipulated premium company operating under Chapter 884; or

(E) a health maintenance organization operating under Chapter 843; and

(2) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a plan offered under:

(A) a multiple employer welfare arrangement as defined by Section 3 of that Act; or

(B) another analogous benefit arrangement.

(b) Notwithstanding any provision in Chapter 1575 or 1579 or any other law, Section 1355.015 applies to:

(1) a basic plan under Chapter 1575; and

(2) a primary care coverage plan under Chapter 1579.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1107 (H.B. 451), Sec. 1, eff.
September 1, 2009.

Sec. 1355.003. EXCEPTION. (a) This subchapter does not apply to coverage under:

- (1) a blanket accident and health insurance policy, as described by Chapter 1251;
- (2) a short-term travel policy;
- (3) an accident-only policy;
- (4) a limited or specified-disease policy that does not provide benefits for mental health care or similar services;
- (5) except as provided by Subsection (b), a plan offered under Chapter 1551 or Chapter 1601;
- (6) a plan offered in accordance with Section 1355.151; or
- (7) a Medicare supplement benefit plan, as defined by Section 1652.002.

(b) For the purposes of a plan described by Subsection (a)(5), "serious mental illness" has the meaning assigned by Section 1355.001.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1355.004. REQUIRED COVERAGE FOR SERIOUS MENTAL ILLNESS.

(a) A group health benefit plan:

- (1) must provide coverage, based on medical necessity, for not less than the following treatments of serious mental illness in each calendar year:
 - (A) 45 days of inpatient treatment; and
 - (B) 60 visits for outpatient treatment, including group and individual outpatient treatment;
- (2) may not include a lifetime limitation on the number of days of inpatient treatment or the number of visits for outpatient treatment covered under the plan; and
- (3) must include the same amount limitations, deductibles, copayments, and coinsurance factors for serious mental illness as the plan includes for physical illness.

(b) A group health benefit plan issuer:

(1) may not count an outpatient visit for medication management against the number of outpatient visits required to be covered under Subsection (a)(1)(B); and

(2) must provide coverage for an outpatient visit described by Subsection (a)(1)(B) under the same terms as the coverage the issuer provides for an outpatient visit for the treatment of physical illness.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1355.005. MANAGED CARE PLAN AUTHORIZED. A group health benefit plan issuer may provide or offer coverage required by Section 1355.004 through a managed care plan.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1355.006. COVERAGE FOR CERTAIN CONDITIONS RELATED TO CONTROLLED SUBSTANCE OR MARIHUANA NOT REQUIRED. (a) In this section, "controlled substance" and "marihuana" have the meanings assigned by Section 481.002, Health and Safety Code.

(b) This subchapter does not require a group health benefit plan to provide coverage for the treatment of:

(1) addiction to a controlled substance or marihuana that is used in violation of law; or

(2) mental illness that results from the use of a controlled substance or marihuana in violation of law.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1355.007. SMALL EMPLOYER COVERAGE. An issuer of a group health benefit plan to a small employer must offer the coverage described by Section 1355.004 to the employer but is not required to provide the coverage if the employer rejects the coverage.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1355.015. REQUIRED COVERAGE FOR CERTAIN ENROLLEES. (a) At a minimum, a health benefit plan must provide coverage for screening a child for autism spectrum disorder at the ages of 18 and 24 months.

(a-1) At a minimum, a health benefit plan must provide coverage for treatment of autism spectrum disorder as provided by this section to an enrollee who is diagnosed with autism spectrum disorder from the date of diagnosis, only if the diagnosis was in place prior to the child's 10th birthday.

(b) The health benefit plan must provide coverage under this section to the enrollee for all generally recognized services prescribed in relation to autism spectrum disorder by the enrollee's primary care physician in the treatment plan recommended by that physician. An individual providing treatment prescribed under this subsection must be:

(1) a health care practitioner:

(A) who is licensed, certified, or registered by an appropriate agency of this state;

(B) whose professional credential is recognized and accepted by an appropriate agency of the United States; or

(C) who is certified as a provider under the TRICARE military health system; or

(2) an individual acting under the supervision of a health care practitioner described by Subdivision (1).

(c) For purposes of Subsection (b), "generally recognized services" may include services such as:

(1) evaluation and assessment services;

(2) applied behavior analysis;

(3) behavior training and behavior management;

(4) speech therapy;

(5) occupational therapy;

(6) physical therapy; or

(7) medications or nutritional supplements used to address symptoms of autism spectrum disorder.

(c-1) The health benefit plan is not required to provide coverage under Subsection (b) for benefits for an enrollee 10 years of age or older for applied behavior analysis in an amount that exceeds \$36,000 per year.

(d) Coverage under Subsection (b) may be subject to annual deductibles, copayments, and coinsurance that are consistent with

annual deductibles, copayments, and coinsurance required for other coverage under the health benefit plan.

(e) Notwithstanding any other law, this section does not apply to a standard health benefit plan provided under Chapter 1507.

(f) Subsection (a) does not apply to a qualified health plan defined by 45 C.F.R. Section 155.20 if a determination is made under 45 C.F.R. Section 155.170 that:

(1) this subchapter requires the qualified health plan to offer benefits in addition to the essential health benefits required under 42 U.S.C. Section 18022(b); and

(2) this state must make payments to defray the cost of the additional benefits mandated by this subchapter.

(g) To the extent that this section would otherwise require this state to make a payment under 42 U.S.C. Section 18031(d)(3)(B)(ii), a qualified health plan, as defined by 45 C.F.R. Section 155.20, is not required to provide a benefit under this section that exceeds the specified essential health benefits required under 42 U.S.C. Section 18022(b).

Added by Acts 2007, 80th Leg., R.S., Ch. 877 (H.B. [1919](#)), Sec. 8, eff. September 1, 2007.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1107 (H.B. [451](#)), Sec. 2, eff. September 1, 2009.

Acts 2013, 83rd Leg., R.S., Ch. 1070 (H.B. [3276](#)), Sec. 1, eff. September 1, 2013.

Acts 2013, 83rd Leg., R.S., Ch. 1359 (S.B. [1484](#)), Sec. 1, eff. September 1, 2013.

Acts 2013, 83rd Leg., R.S., Ch. 1359 (S.B. [1484](#)), Sec. 2, eff. September 1, 2013.

Acts 2015, 84th Leg., R.S., Ch. 1236 (S.B. [1296](#)), Sec. 11.003(a), eff. September 1, 2015.

Acts 2015, 84th Leg., R.S., Ch. 1236 (S.B. [1296](#)), Sec. 11.003(b), eff. September 1, 2015.

Acts 2015, 84th Leg., R.S., Ch. 1236 (S.B. [1296](#)), Sec. 21.001(37), eff. September 1, 2015.

SUBCHAPTER B. ALTERNATIVE MENTAL HEALTH TREATMENT BENEFITS

Sec. 1355.051. DEFINITIONS. In this subchapter:

(1) "Crisis stabilization unit" means a 24-hour residential program that provides, usually for a short term, intensive supervision and highly structured activities to individuals who demonstrate a moderate to severe acute psychiatric crisis.

(2) "Individual treatment plan" means a treatment plan with specific attainable goals and objectives that are appropriate to:

- (A) the patient; and
- (B) the program's treatment modality.

(3) "Residential treatment center for children and adolescents" means a child-care institution that:

- (A) is accredited as a residential treatment center by:
 - (i) the Council on Accreditation;
 - (ii) the Joint Commission on Accreditation of Healthcare Organizations; or
 - (iii) the American Association of Psychiatric Services for Children; and
- (B) provides residential care and treatment for emotionally disturbed children and adolescents.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1355.052. APPLICABILITY OF SUBCHAPTER. This subchapter applies to a group health benefit plan that is delivered or issued for delivery in this state and that is:

- (1) an accident and health insurance group policy;
- (2) a group policy issued by a group hospital service corporation operating under Chapter 842; or
- (3) a group health care plan provided by a health maintenance organization operating under Chapter 843.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1355.053. REQUIRED COVERAGE FOR CERTAIN ILLNESSES AND DISORDERS. A group health benefit plan that provides coverage for treatment of mental or emotional illness or disorder for a covered individual when the individual is confined in a hospital must also provide coverage for treatment in a residential treatment center for children and adolescents or a crisis stabilization unit that is at least as favorable as the coverage the plan provides for treatment of

mental or emotional illness or disorder in a hospital.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1355.054. CONDITIONS FOR COVERAGE. (a) Benefits of coverage provided under this subchapter may be used only in a situation in which:

(1) the covered individual has a serious mental illness that requires confinement of the individual in a hospital unless treatment is available through a residential treatment center for children and adolescents or a crisis stabilization unit; and

(2) the covered individual's mental illness:

(A) substantially impairs the individual's thought, perception of reality, emotional process, or judgment; or

(B) as manifested by the individual's recent disturbed behavior, grossly impairs the individual's behavior.

(b) The service for which benefits are to be paid from coverage provided under this subchapter must be:

(1) based on an individual treatment plan for the covered individual; and

(2) provided by a service provider licensed or operated by the appropriate state agency to provide those services.

(c) Benefits under coverage provided under this subchapter are subject to the same benefit maximums, durational limitations, deductibles, and coinsurance factors that apply to inpatient psychiatric treatment under the coverage.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1355.055. DETERMINATIONS FOR TREATMENT IN A RESIDENTIAL TREATMENT CENTER FOR CHILDREN AND ADOLESCENTS. (a) Treatment in a residential treatment center for children and adolescents must be determined as if necessary care and treatment were inpatient care and treatment in a hospital.

(b) For the purposes of determining policy benefits and benefit maximums, each two days of treatment in a residential treatment center for children and adolescents is the equivalent of one day of treatment of mental or emotional illness or disorder in a hospital or inpatient program.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1355.056. DETERMINATIONS FOR TREATMENT BY A CRISIS STABILIZATION UNIT. (a) Treatment by a crisis stabilization unit must be determined as if necessary care and treatment were inpatient care and treatment in a hospital.

(b) For the purposes of determining plan benefits and benefit maximums, each two days of treatment in a crisis stabilization unit is the equivalent of one day of treatment of mental or emotional illness or disorder in a hospital or inpatient program.

(c) Treatment provided to an individual by a crisis stabilization unit licensed or certified by the Health and Human Services Commission shall be reimbursed.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2023, 88th Leg., R.S., Ch. 30 (H.B. 446), Sec. 8.04, eff. September 1, 2023.

Sec. 1355.057. REVIEW AND ADJUSTMENT OF MINIMUM RATIOS OF REIMBURSEMENT. (a) The commissioner shall monitor and review the minimum ratios of reimbursement for alternative treatments required by Sections 1355.055 and 1355.056.

(b) If the commissioner finds that the limits provided by this subchapter are creating an artificial increase in the costs of services, the commissioner by rule may adjust the ratios to the extent necessary to prevent the artificial increase.

(c) Before the commissioner adjusts a ratio under Subsection (b), the commissioner must give notice and hold a hearing to:

(1) consider information related to the adjustment; and
(2) determine whether the information justifies the adjustment.

(d) The department shall review the reimbursement ratios at least every two years.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1355.058. HEALTH AND HUMAN SERVICES COMMISSION ASSISTANCE.

(a) The Health and Human Services Commission shall assist the department in carrying out the department's responsibilities under this subchapter.

(b) The department and the Health and Human Services Commission by rule may adopt a memorandum of understanding to carry out this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2023, 88th Leg., R.S., Ch. 30 (H.B. 446), Sec. 8.05, eff. September 1, 2023.

SUBCHAPTER C. PSYCHIATRIC DAY TREATMENT FACILITIES

Sec. 1355.101. DEFINITION. In this subchapter, "psychiatric day treatment facility" means a mental health facility that:

(1) provides treatment for individuals suffering from acute mental and nervous disorders in a structured psychiatric program using individualized treatment plans with specific attainable goals and objectives that are appropriate to the patient and the program's treatment modality; and

(2) is clinically supervised by a doctor of medicine who is certified in psychiatry by the American Board of Psychiatry and Neurology.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1355.102. APPLICABILITY OF SUBCHAPTER. This subchapter applies to a group policy of accident and health insurance delivered or issued for delivery in this state, including a group policy issued by a group hospital service corporation operating under Chapter 842.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1355.103. APPLICABILITY OF GENERAL PROVISIONS OF OTHER LAW. The provisions of Chapter 1201, including provisions relating to the applicability, purpose, and enforcement of that chapter, construction of policies under that chapter, rulemaking under that chapter, and definitions of terms applicable in that chapter, apply

to this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1355.104. REQUIRED COVERAGE FOR TREATMENT IN PSYCHIATRIC DAY TREATMENT FACILITY. (a) A group insurance policy that provides coverage for treatment of mental or emotional illness or disorder when an individual is confined in a hospital must also provide coverage for treatment obtained under the direction and continued medical supervision of a doctor of medicine or doctor of osteopathy in a psychiatric day treatment facility that provides organizational structure and individualized treatment plans separate from an inpatient program.

(b) The psychiatric day treatment facility coverage required by this section may not be less favorable than the hospital coverage and must be subject to the same durational limits, deductibles, and coinsurance factors.

(c) A group insurance policy subject to this section may require that:

(1) the treatment obtained in a psychiatric day treatment facility be provided by a facility that treats a patient for not more than 8 hours in any 24-hour period;

(2) the attending physician certify that the treatment is in lieu of hospitalization; and

(3) the psychiatric day treatment facility be accredited by the Program for Psychiatric Facilities, or its successor, of the Joint Commission on Accreditation of Healthcare Organizations.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1355.105. DETERMINATIONS FOR TREATMENT IN PSYCHIATRIC DAY TREATMENT FACILITY. (a) Benefits provided under this subchapter shall be determined as if necessary care and treatment in a psychiatric day treatment facility were inpatient care and treatment in a hospital.

(b) For the purpose of determining policy benefits and benefit maximums, each full day of treatment in a psychiatric day treatment facility is the equivalent of one-half of one day of treatment of mental or emotional illness or disorder in a hospital or inpatient

program.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1355.106. OFFER OF COVERAGE REQUIRED; ALTERNATIVE BENEFITS. (a) An insurer shall offer, and a policyholder is entitled to reject, coverage under a group insurance policy for treatment of mental or emotional illness or disorder when confined in a hospital or in a psychiatric day treatment facility.

(b) A policyholder may select an alternative level of benefits under the group insurance policy if the alternative level is offered by or negotiated with the insurer.

(c) The alternative level of benefits must provide policy benefits and benefit maximums for treatment in a psychiatric day treatment facility equal to at least one-half of that provided for treatment in a hospital, except that benefits for treatment in a psychiatric day treatment facility may not exceed the usual and customary charges of the facility.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

SUBCHAPTER D. CERTAIN COVERAGES PROVIDED BY LOCAL GOVERNMENTS

Sec. 1355.151. PROHIBITION ON EXCLUSION OR LIMITATION OF CERTAIN COVERAGES. (a) In this section, "serious mental illness" has the meaning assigned by Section 1355.001.

(b) A political subdivision that provides group health insurance coverage, health maintenance organization coverage, or self-insured health care coverage to the political subdivision's officers or employees may not contract for or provide coverage that is less extensive for serious mental illness than the coverage provided for any other physical illness.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

SUBCHAPTER E. BENEFITS FOR TREATMENT BY TAX-SUPPORTED INSTITUTION

Sec. 1355.201. APPLICABILITY OF GENERAL PROVISIONS OF OTHER LAW. The provisions of Chapter 1201, including provisions relating to the applicability, purpose, and enforcement of that chapter,

construction of policies under that chapter, rulemaking under that chapter, and definitions of terms applicable in that chapter, apply to this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1355.202. PROHIBITION OF EXCLUSION OF MENTAL HEALTH OR INTELLECTUAL DISABILITY BENEFITS FOR TREATMENT BY TAX-SUPPORTED INSTITUTION. (a) An individual or group accident and health insurance policy delivered or issued for delivery to a person in this state that provides coverage for mental illness or intellectual disability may not exclude benefits under that coverage for support, maintenance, and treatment provided by a tax-supported institution of this state, or by a community center for mental health services or intellectual disability services, that regularly and customarily charges patients who are not indigent for those services.

(b) In determining whether a patient is not indigent, as provided by Subchapter B, Chapter 552, Health and Safety Code, a tax-supported institution of this state or a community center for mental health services or intellectual disability services shall consider any insurance policy or policies that provide coverage to the patient for mental illness or intellectual disability.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 30 (H.B. 446), Sec. 8.06, eff. September 1, 2023.

SUBCHAPTER F. COVERAGE FOR MENTAL HEALTH CONDITIONS AND SUBSTANCE USE DISORDERS

Sec. 1355.251. DEFINITIONS. In this subchapter:

(1) "Mental health benefit" means a benefit relating to an item or service for a mental health condition, as defined under the terms of a health benefit plan and in accordance with applicable federal and state law.

(2) "Nonquantitative treatment limitation" means a limit on the scope or duration of treatment that is not expressed numerically. The term includes:

(A) a medical management standard limiting or excluding

benefits based on medical necessity or medical appropriateness or based on whether a treatment is experimental or investigational;

(B) formulary design for prescription drugs;

(C) network tier design;

(D) a standard for provider participation in a network, including reimbursement rates;

(E) a method used by a health benefit plan to determine usual, customary, and reasonable charges;

(F) a step therapy protocol;

(G) an exclusion based on failure to complete a course of treatment; and

(H) a restriction based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of a benefit.

(3) "Quantitative treatment limitation" means a treatment limitation that determines whether, or to what extent, benefits are provided based on an accumulated amount such as an annual or lifetime limit on days of coverage or number of visits. The term includes a deductible, a copayment, coinsurance, or another out-of-pocket expense or annual or lifetime limit, or another financial requirement.

(4) "Substance use disorder benefit" means a benefit relating to an item or service for a substance use disorder, as defined under the terms of a health benefit plan and in accordance with applicable federal and state law.

Added by Acts 2017, 85th Leg., R.S., Ch. 769 (H.B. 10), Sec. 2, eff. September 1, 2017.

Sec. 1355.252. APPLICABILITY OF SUBCHAPTER. (a) This subchapter applies only to a health benefit plan that provides benefits or coverage for medical or surgical expenses incurred as a result of a health condition, accident, or sickness and for treatment expenses incurred as a result of a mental health condition or substance use disorder, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, an individual or group evidence of coverage, or a similar coverage document, that is offered by:

(1) an insurance company;

- (2) a group hospital service corporation operating under Chapter 842;
- (3) a fraternal benefit society operating under Chapter 885;
- (4) a stipulated premium company operating under Chapter 884;
- (5) a health maintenance organization operating under Chapter 843;
- (6) a reciprocal exchange operating under Chapter 942;
- (7) a Lloyd's plan operating under Chapter 941;
- (8) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844; or
- (9) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846.

(b) Notwithstanding Section 1501.251 or any other law, this subchapter applies to coverage under a small employer health benefit plan subject to Chapter 1501.

(c) This subchapter applies to a standard health benefit plan issued under Chapter 1507.

Added by Acts 2017, 85th Leg., R.S., Ch. 769 (H.B. 10), Sec. 2, eff. September 1, 2017.

Sec. 1355.253. EXCEPTIONS. (a) This subchapter does not apply to:

- (1) a plan that provides coverage:
 - (A) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;
 - (B) as a supplement to a liability insurance policy;
 - (C) for credit insurance;
 - (D) only for dental or vision care;
 - (E) only for hospital expenses;
 - (F) only for indemnity for hospital confinement; or
 - (G) only for accidents;
- (2) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss(g)(1));
- (3) a workers' compensation insurance policy;
- (4) medical payment insurance coverage provided under a

motor vehicle insurance policy; or

(5) a long-term care 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 as described by Section 1355.252.

(b) To the extent that this section would otherwise require this state to make a payment under 42 U.S.C. Section 18031(d)(3)(B)(ii), a qualified health plan, as defined by 45 C.F.R. Section 155.20, is not required to provide a benefit under this subchapter that exceeds the specified essential health benefits required under 42 U.S.C. Section 18022(b).

Added by Acts 2017, 85th Leg., R.S., Ch. 769 (H.B. 10), Sec. 2, eff. September 1, 2017.

Sec. 1355.254. COVERAGE FOR MENTAL HEALTH CONDITIONS AND SUBSTANCE USE DISORDERS. (a) A health benefit plan must provide benefits and coverage for mental health conditions and substance use disorders under the same terms and conditions applicable to the plan's medical and surgical benefits and coverage.

(b) Coverage under Subsection (a) may not impose quantitative or nonquantitative treatment limitations on benefits for a mental health condition or substance use disorder that are generally more restrictive than quantitative or nonquantitative treatment limitations imposed on coverage of benefits for medical or surgical expenses.

Added by Acts 2017, 85th Leg., R.S., Ch. 769 (H.B. 10), Sec. 2, eff. September 1, 2017.

Sec. 1355.255. COMPLIANCE. The commissioner shall enforce compliance with Section 1355.254 by evaluating the benefits and coverage offered by a health benefit plan for quantitative and nonquantitative treatment limitations in the following categories:

- (1) in-network and out-of-network inpatient care;
- (2) in-network and out-of-network outpatient care;
- (3) emergency care; and
- (4) prescription drugs.

Added by Acts 2017, 85th Leg., R.S., Ch. 769 (H.B. 10), Sec. 2, eff. September 1, 2017.

Sec. 1355.256. DEFINITIONS UNDER PLAN. (a) A health benefit plan must define a condition to be a mental health condition or not a mental health condition in a manner consistent with generally recognized independent standards of medical practice.

(b) A health benefit plan must define a condition to be a substance use disorder or not a substance use disorder in a manner consistent with generally recognized independent standards of medical practice.

Added by Acts 2017, 85th Leg., R.S., Ch. 769 (H.B. 10), Sec. 2, eff. September 1, 2017.

Sec. 1355.257. COORDINATION WITH OTHER LAW; INTENT OF LEGISLATURE. This subchapter supplements Subchapters A and B of this chapter and Chapter 1368 and the department rules adopted under those statutes. It is the intent of the legislature that Subchapter A or B of this chapter or Chapter 1368 or a department rule adopted under those statutes controls in any circumstance in which that other law requires:

- (1) a benefit that is not required by this subchapter; or
- (2) a more extensive benefit than is required by this subchapter.

Added by Acts 2017, 85th Leg., R.S., Ch. 769 (H.B. 10), Sec. 2, eff. September 1, 2017.

Sec. 1355.2571. PARITY COMPLAINT PORTAL. (a) The commissioner shall develop and maintain a parity complaint portal that is an integrated system that allows for the enrollee of a health benefit plan to submit complaints of suspected violations of the provisions of this subchapter. The parity complaint portal must:

- (1) allow for an enrollee to submit a complaint through multiple ways;
- (2) provide updates on the status of an enrollee's complaint;

- (3) ensure timely, effective, and equitable resolution for submitted complaints;
- (4) include educational materials regarding:
 - (A) benefits for mental health conditions and substance use disorders required under this subchapter;
 - (B) an enrollee's rights and responsibilities under a health benefit plan concerning coverage under this subchapter;
 - (C) circumstances under which a claim may be denied;
 and
 - (D) the processes for reviewing a complaint submitted through the portal;
- (5) adhere to national best practices as determined by the commissioner; and
- (6) include the findings of the report required by Section 1355.2572(b).

(b) In developing the parity complaint portal under Subsection (a), the commissioner:

- (1) shall conduct an assessment of complaint portals and similar systems used by other relevant public or private entities;
- (2) shall develop best practice standards for complaint submissions and tracking consistent with the findings of the assessment conducted under Subdivision (1); and
- (3) may develop a new complaint portal or modify an existing complaint portal.

(c) The Health and Human Services Commission shall appoint a liaison to the department to receive reports of concerns, complaints, and potential violations submitted through the parity complaint portal established under Subsection (a).

Added by Acts 2021, 87th Leg., R.S., Ch. 703 (H.B. [2595](#)), Sec. 2, eff. September 1, 2021.

Sec. 1355.2572. EDUCATIONAL MATERIALS AND PARITY LAW TRAINING; REPORT. (a) The commissioner, in collaboration with the Health and Human Services Commission's ombudsman for behavioral health, shall develop educational materials and parity law training sessions regarding the coverage for mental health conditions and substance use disorders required under this subchapter. The commissioner shall ensure that the materials and training sessions:

- (1) are available to health benefit plan issuers and enrollees;
 - (2) include online, print, and in-person formats;
 - (3) are made available through the parity complaint portal established under Section 1355.2571 and at relevant locations and settings, including:
 - (A) any relevant agency offices;
 - (B) health benefit plan provider service locations; and
 - (C) relevant professional conferences and trade association meetings; and
 - (4) include a list of relevant third-party organization educational and parity law awareness materials that provide additional information regarding mental health conditions and substance use disorder parity and, if provided in an online format, provide the links needed to access those materials online.
- (b) Not later than September 1 of each year, the commissioner, in collaboration with the Health and Human Services Commission's ombudsman for behavioral health, shall:
- (1) prepare and submit a report to the appropriate committees of the legislature and the appropriate state agencies on the status of:
 - (A) rights and responsibilities for mental health condition and substance use disorder benefits; and
 - (B) resolved and unresolved complaints submitted through the parity complaint portal established under Section 1355.2571(a); and
 - (2) publish the findings of the report under Subdivision (1) to the parity complaint portal established under Section 1355.2571(a).

Added by Acts 2021, 87th Leg., R.S., Ch. 703 (H.B. [2595](#)), Sec. 2, eff. September 1, 2021.

Sec. 1355.258. RULES. The commissioner shall adopt rules necessary to implement this subchapter.

Added by Acts 2017, 85th Leg., R.S., Ch. 769 (H.B. [10](#)), Sec. 2, eff. September 1, 2017.

CHAPTER 1356. MAMMOGRAPHY AND OTHER BREAST IMAGING

Sec. 1356.001. DEFINITIONS. In this chapter:

(1) "Breast tomosynthesis" means a radiologic mammography procedure that involves the acquisition of projection images over a stationary breast to produce cross-sectional digital three-dimensional images of the breast from which applicable breast cancer screening diagnoses may be determined.

(1-a) "Diagnostic imaging" means an imaging examination using mammography, ultrasound imaging, or magnetic resonance imaging that is designed to evaluate:

(A) a subjective or objective abnormality detected by a physician or patient in a breast;

(B) an abnormality seen by a physician on a screening mammogram;

(C) an abnormality previously identified by a physician as probably benign in a breast for which follow-up imaging is recommended by a physician; or

(D) an individual with a personal history of breast cancer or dense breast tissue.

(2) "Low-dose mammography" means:

(A) the x-ray examination of the breast using equipment dedicated specifically for mammography, including an x-ray tube, filter, compression device, and screens, with an average radiation exposure delivery of less than one rad mid-breast and with two views for each breast;

(B) digital mammography; or

(C) breast tomosynthesis.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 816 (H.B. 1036), Sec. 2, eff. September 1, 2017.

Acts 2019, 86th Leg., R.S., Ch. 1356 (H.B. 170), Sec. 1, eff. September 1, 2019.

Acts 2021, 87th Leg., R.S., Ch. 867 (S.B. 1065), Sec. 2, eff. September 1, 2021.

Sec. 1356.002. APPLICABILITY OF CHAPTER. (a) This chapter applies to a health benefit plan, including a small employer health

benefit plan written under Chapter 1501 or coverage that is provided by a health group cooperative under Subchapter B of that chapter, 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 offered by:

- (1) an insurance company;
- (2) a group hospital service corporation operating under Chapter 842;
- (3) a health maintenance organization operating under Chapter 843;
- (4) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844;
- (5) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846;
- (6) a stipulated premium company operating under Chapter 884;
- (7) a fraternal benefit society operating under Chapter 885;
- (8) a Lloyd's plan operating under Chapter 941; or
- (9) an exchange operating under Chapter 942.

(b) This chapter applies to coverage under a group health benefit plan described by Subsection (a) provided to a resident of this state, regardless of whether the group policy or contract is delivered, issued for delivery, or renewed within or outside this state.

(c) This chapter applies to group health coverage made available by a school district in accordance with Section 22.004(b), Education Code.

(d) This chapter applies to a self-funded health benefit plan sponsored by a professional employer organization under Chapter 91, Labor Code.

(e) Notwithstanding Section 22.409, Business Organizations Code, or any other law, this chapter applies to a church benefits board established under Chapter 22, Business Organizations Code.

(f) Notwithstanding Section 75.104, Health and Safety Code, or any other law, this chapter applies to a regional or local health care program established under Chapter 75, Health and Safety Code.

(g) Notwithstanding any provision in Chapter 1551, 1575, 1579, or 1601 or any other law, this chapter applies to:

- (1) a basic coverage plan under Chapter 1551;
- (2) a basic plan under Chapter 1575;
- (3) a primary care coverage plan under Chapter 1579; and
- (4) basic coverage under Chapter 1601.

(h) Notwithstanding any other law, a standard health benefit plan provided under Chapter 1507 must provide the coverage required by this chapter.

Text of subsection effective until April 1, 2025

(i) To the extent allowed by federal law, this chapter applies to:

- (1) the state Medicaid program operated under Chapter 32, Human Resources Code; and
- (2) a Medicaid managed care program operated under Chapter 533, Government Code.

Text of subsection effective on April 1, 2025

(i) To the extent allowed by federal law, this chapter applies to:

- (1) the state Medicaid program operated under Chapter 32, Human Resources Code; and
- (2) a Medicaid managed care program operated under Chapter 540 or 540A, Government Code, as applicable.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2017, 85th Leg., R.S., Ch. 816 (H.B. 1036), Sec. 2, eff. September 1, 2017.

Acts 2019, 86th Leg., R.S., Ch. 1356 (H.B. 170), Sec. 2, eff. September 1, 2019.

Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 2.123, eff. April 1, 2025.

Sec. 1356.003. APPLICABILITY OF GENERAL PROVISIONS OF OTHER LAW. The provisions of Chapter 1201, including provisions relating to the applicability, purpose, and enforcement of that chapter, construction of policies under that chapter, rulemaking under that chapter, and definitions of terms applicable in that chapter, apply to this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1356.004. EXCEPTION. This chapter does not apply to a plan that provides coverage only for a specified disease or for another limited benefit.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1356.005. COVERAGE REQUIRED. (a) A health benefit plan that provides coverage to a female who is 35 years of age or older must include coverage for an annual screening by all forms of low-dose mammography for the presence of occult breast cancer.

(a-1) A health benefit plan that provides coverage for a screening mammogram must provide coverage for diagnostic imaging that is no less favorable than the coverage for a screening mammogram.

(b) Coverage required by this section:

(1) may not be less favorable than coverage for other radiological examinations under the plan; and

(2) must be subject to the same dollar limits, deductibles, and coinsurance factors as coverage for other radiological examinations under the plan.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 816 (H.B. 1036), Sec. 4, eff. September 1, 2017.

Acts 2019, 86th Leg., R.S., Ch. 1356 (H.B. 170), Sec. 3, eff. September 1, 2019.

Acts 2021, 87th Leg., R.S., Ch. 867 (S.B. 1065), Sec. 3, eff. September 1, 2021.

CHAPTER 1357. MASTECTOMY

SUBCHAPTER A. RECONSTRUCTIVE SURGERY FOLLOWING MASTECTOMY

Sec. 1357.001. DEFINITIONS. In this subchapter:

(1) "Breast reconstruction" means reconstruction of a breast incident to mastectomy to restore or achieve breast symmetry. The term includes surgical reconstruction of a breast on which mastectomy has been performed and surgical reconstruction of a breast

on which mastectomy has not been performed.

(2) "Enrollee" means an individual entitled to coverage under a health benefit plan.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1357.002. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is offered by:

- (1) an insurance company;
- (2) a group hospital service corporation operating under Chapter 842;
- (3) a fraternal benefit society operating under Chapter 885;
- (4) a stipulated premium company operating under Chapter 884;
- (5) a reciprocal exchange operating under Chapter 942;
- (6) a health maintenance organization operating under Chapter 843;
- (7) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; or
- (8) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1357.003. EXCEPTION. This subchapter does not apply to:

- (1) a plan that provides coverage:
 - (A) only for a specified disease or another limited benefit, other than benefits for cancer;
 - (B) only for accidental death or dismemberment;
 - (C) only 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) only for credit insurance;

- (E) only for dental or vision care;
- (F) only for indemnity for hospital confinement; or
- (G) as a supplement to a liability insurance policy;
- (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; or
- (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 as described by Section 1357.002.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1357.004. COVERAGE REQUIRED. (a) A health benefit plan that provides coverage for mastectomy must provide coverage for:

- (1) reconstruction of the breast on which the mastectomy has been performed;
- (2) surgery and reconstruction of the other breast to achieve a symmetrical appearance; and
- (3) prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy.

(b) Coverage required under this section:

- (1) shall be provided in a manner determined to be appropriate in consultation with the attending physician and the enrollee;
- (2) may be subject to annual deductibles, copayments, and coinsurance that are consistent with annual deductibles, copayments, and coinsurance required for other coverage under the health benefit plan; and
- (3) may not be subject to dollar limits other than the lifetime maximum benefits under the plan.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1357.005. PROHIBITED CONDUCT. (a) An issuer of a health benefit plan may not:

(1) offer a financial incentive for an enrollee to not receive breast reconstruction or to waive the coverage required under this subchapter;

(2) condition, limit, or deny the eligibility of a person to enroll in the plan or to renew coverage under the terms of the plan solely to avoid the requirements of this subchapter; or

(3) reduce or limit the reimbursement or amount paid to, or otherwise penalize, an attending physician or provider or provide a financial incentive or other benefit to an attending physician or provider to induce the physician or provider to provide care to an enrollee in a manner that is inconsistent with this subchapter.

(b) This section does not prevent an issuer of a health benefit plan from negotiating with a physician or provider the level and type of reimbursement that the physician or provider will receive for care provided in accordance with this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1357.006. NOTICE OF COVERAGE. (a) An issuer of a health benefit plan that provides coverage under this subchapter shall provide to each enrollee notice of the availability of the coverage.

(b) The notice must be provided in accordance with rules adopted by the commissioner.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1357.007. RULES. The commissioner may adopt rules to implement this subchapter and to meet the minimum requirements of federal law.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

SUBCHAPTER B. HOSPITAL STAY FOLLOWING MASTECTOMY AND CERTAIN RELATED PROCEDURES

Sec. 1357.051. DEFINITION. In this subchapter, "enrollee" means an individual entitled to coverage under a health benefit plan.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1357.052. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

- (i) an insurance company;
- (ii) a group hospital service corporation operating under Chapter 842;
- (iii) a fraternal benefit society operating under Chapter 885;
- (iv) a stipulated premium company operating under Chapter 884; or
- (v) a health maintenance organization operating under Chapter 843; and

(B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:

- (i) a multiple employer welfare arrangement as defined by Section 3 of that Act; or
- (ii) another analogous benefit arrangement;

(2) is offered by an approved nonprofit health corporation that holds a certificate of authority under Chapter 844; or

(3) provides coverage only for a specific disease or condition or for hospitalization.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1357.053. EXCEPTION. This subchapter does not apply to:

- (1) a plan that provides coverage:
 - (A) only for accidental death or dismemberment;
 - (B) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury; or

- (C) as a supplement to a liability insurance policy;
- (2) a small employer health benefit plan written under Chapter 1501;
- (3) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);
- (4) a workers' compensation insurance policy;
- (5) medical payment insurance coverage provided under a motor vehicle insurance policy; or
- (6) 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 as described by Section 1357.052.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1357.054. COVERAGE REQUIRED. (a) A health benefit plan that provides coverage for the treatment of breast cancer must provide to each enrollee coverage for inpatient care for a minimum of:

- (1) 48 hours following a mastectomy; and
- (2) 24 hours following a lymph node dissection for the treatment of breast cancer.

(b) A health benefit plan is not required to provide the minimum hours of coverage of inpatient care required under Subsection (a) if the enrollee and the enrollee's attending physician determine that a shorter period of inpatient care is appropriate.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1357.055. PROHIBITED CONDUCT. An issuer of a health benefit plan may not:

- (1) deny the eligibility or continued eligibility of an individual to enroll in the plan or renew coverage under the plan solely to avoid the requirements of this subchapter;
- (2) provide money payments or rebates to an enrollee to encourage the enrollee to accept less than the minimum coverage required under this subchapter;
- (3) reduce or limit the amount paid to an attending physician, or otherwise penalize the physician, because the physician

provided care to an enrollee in accordance with this subchapter; or
 (4) provide financial or other incentives to an attending physician to encourage the physician to provide care to an enrollee in a manner inconsistent with this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1357.056. NOTICE OF COVERAGE. (a) An issuer of a health benefit plan shall provide to each enrollee written notice of the coverage required under this subchapter.

(b) The notice must be provided in accordance with rules adopted by the commissioner.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1357.057. RULES. The commissioner shall adopt rules necessary to administer this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

CHAPTER 1358. DIABETES

SUBCHAPTER A. GUIDELINES FOR DIABETES CARE; MINIMUM COVERAGE REQUIRED

Sec. 1358.001. DEFINITION. In this subchapter, "enrollee" means an individual entitled to coverage under a health benefit plan.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1358.002. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(1) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(A) an insurance company;

(B) a group hospital service corporation operating

under Chapter 842;

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

(D) a stipulated premium company operating under Chapter 884; or

(E) a health maintenance organization operating under Chapter 843;

(2) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:

(A) a multiple employer welfare arrangement as defined by Section 3 of that Act; or

(B) another analogous benefit arrangement; and

(3) health and accident coverage provided by a risk pool created under Chapter 172, Local Government Code, notwithstanding Section 172.014, Local Government Code, or any other law.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1358.003. EXCEPTION. This subchapter does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease;

(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) only for dental or vision care; or

(F) only for indemnity for hospital confinement;

(2) a small employer health benefit plan written under Chapter 1501;

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

(4) a workers' compensation insurance policy;

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

(6) 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 as described by Section 1358.002.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1358.004. ADOPTION OF MINIMUM STANDARDS. The commissioner, in consultation with the Texas Diabetes Council, by rule shall adopt minimum standards for coverage provided to an enrollee with diabetes.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1358.005. COVERAGE REQUIRED. (a) A health benefit plan must provide coverage in accordance with the standards adopted under Section 1358.004.

(b) Coverage required under this section may not be subject to a deductible, coinsurance, or copayment requirement that exceeds the deductible, coinsurance, or copayment requirement applicable to other similar coverage provided under the health benefit plan.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

**SUBCHAPTER B. SUPPLIES AND SERVICES ASSOCIATED WITH DIABETES
TREATMENT**

Sec. 1358.051. DEFINITIONS. In this subchapter:

(1) "Diabetes equipment" means:

(A) blood glucose monitors, including noninvasive glucose monitors and glucose monitors designed to be used by blind individuals;

(B) insulin pumps and associated appurtenances;

(C) insulin infusion devices; and

(D) podiatric appliances for the prevention of complications associated with diabetes.

(2) "Diabetes supplies" means:

(A) test strips for blood glucose monitors;

(B) visual reading and urine test strips;

(C) lancets and lancet devices;

(D) insulin and insulin analogs;

(E) injection aids;

(F) syringes;

(G) prescriptive and nonprescriptive oral agents for controlling blood sugar levels; and

(H) glucagon emergency kits.

(3) "Nutrition counseling" has the meaning assigned by Section 701.002, Occupations Code.

(4) "Qualified enrollee" means an individual eligible for coverage under a health benefit plan who has been diagnosed with:

(A) insulin dependent or noninsulin dependent diabetes;

(B) elevated blood glucose levels induced by pregnancy;

or

(C) another medical condition associated with elevated blood glucose levels.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.038(a), eff. September 1, 2005.

Sec. 1358.052. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(i) an insurance company;

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

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

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

(v) a reciprocal exchange operating under Chapter 942; or

(vi) a health maintenance organization operating under Chapter 843; and

(B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by a multiple employer welfare arrangement as defined by Section 3 of that Act; or

(2) is offered by an approved nonprofit health corporation that holds a certificate of authority under Chapter 844.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1358.053. EXCEPTION. This subchapter does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease or another limited benefit;

(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; or

(G) only for indemnity for hospital confinement;

(2) a small employer health benefit plan written under Chapter 1501;

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

(4) a workers' compensation insurance policy;

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

(6) 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 as described by Section 1358.052.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1358.054. COVERAGE REQUIRED. (a) A health benefit plan that provides coverage for the treatment of diabetes and conditions associated with diabetes must provide to each qualified enrollee coverage for:

(1) diabetes equipment;
 (2) diabetes supplies; and
 (3) diabetes self-management training in accordance with the requirements of Section 1358.055.

(a-1) A health benefit plan described by Subsection (a) must provide to each qualified enrollee coverage for emergency refills of diabetes equipment or diabetes supplies dispensed to the enrollee in accordance with Section 562.0541, Occupations Code, in the same manner as for a nonemergency refill of diabetes equipment or diabetes supplies.

(b) A health benefit plan may require a deductible, copayment, or coinsurance for coverage provided under this section. The amount of the deductible, copayment, or coinsurance may not exceed the amount of the deductible, copayment, or coinsurance required for treatment of other analogous chronic medical conditions.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
 Amended by:

Acts 2021, 87th Leg., R.S., Ch. 679 (H.B. 1935), Sec. 2, eff. September 1, 2021.

Sec. 1358.055. DIABETES SELF-MANAGEMENT TRAINING. (a) Diabetes self-management training must be provided by a health care practitioner or provider who is:

(1) licensed, registered, or certified in this state to provide appropriate health care services; and
 (2) acting within the scope of practice authorized by the license, registration, or certification.

(b) For purposes of this subchapter, "self-management training" includes:

(1) training provided to a qualified enrollee, after the initial diagnosis of diabetes, in the care and management of that condition, including nutrition counseling and counseling on the proper use of diabetes equipment and supplies;

(2) additional training authorized on the diagnosis of a physician or other health care practitioner of a significant change in the qualified enrollee's symptoms or condition that requires changes in the qualified enrollee's self-management regime; and

(3) periodic or episodic continuing education training

prescribed by an appropriate health care practitioner as warranted by the development of new techniques or treatments for diabetes.

(c) If the diabetes self-management training is provided on the written order of a physician or other health care practitioner, including a health care practitioner practicing under protocols jointly developed with a physician, the training must also include:

(1) a diabetes self-management training program recognized by the American Diabetes Association;

(2) diabetes self-management training provided by a multidisciplinary team:

(A) the nonphysician members of which are coordinated by:

(i) a diabetes educator who is certified by the National Certification Board for Diabetes Educators; or

(ii) an individual who has completed at least 24 hours of continuing education that meets guidelines established by the Texas Board of Health and that includes a combination of diabetes-related educational principles and behavioral strategies;

(B) that consists of at least a licensed dietitian and a registered nurse and may include a pharmacist and a social worker; and

(C) each member of which, other than a social worker, has recent didactic and experiential preparation in diabetes clinical and educational issues as determined by the member's licensing agency, in consultation with the commissioner of public health, unless the member's licensing agency, in consultation with the commissioner of public health, determines that the core educational preparation for the member's license includes the skills the member needs to provide diabetes self-management training;

(3) diabetes self-management training provided by a diabetes educator certified by the National Certification Board for Diabetes Educators; or

(4) diabetes self-management training that provides one or more of the following components:

(A) a nutrition counseling component provided by a licensed dietitian, for which the licensed dietitian shall be paid;

(B) a pharmaceutical component provided by a pharmacist, for which the pharmacist shall be paid;

(C) a component provided by a physician assistant or registered nurse, for which the physician assistant or registered

nurse shall be paid, except that the physician assistant or registered nurse may not be paid for providing a nutrition counseling or pharmaceutical component unless a licensed dietitian or pharmacist is unavailable to provide that component; or

(D) a component provided by a physician.

(d) An individual may not provide a component of diabetes self-management training under Subsection (c)(4) unless:

(1) the subject matter of the component is within the scope of the individual's practice; and

(2) the individual meets the education requirements, as determined by the individual's licensing agency in consultation with the commissioner of public health.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1358.056. COVERAGE FOR NEW OR IMPROVED EQUIPMENT AND SUPPLIES. A health benefit plan must provide coverage for new or improved diabetes equipment or supplies, including improved insulin or another prescription drug, approved by the United States Food and Drug Administration if the equipment or supplies are determined by a physician or other health care practitioner to be medically necessary and appropriate.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1358.057. RULES. (a) The commissioner shall adopt rules necessary to implement this subchapter.

(b) In adopting rules under this section, the commissioner may consult with the commissioner of public health and other appropriate entities.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

SUBCHAPTER C. COST-SHARING LIMIT

Sec. 1358.101. APPLICABILITY OF SUBCHAPTER. (a) This subchapter applies only to a health benefit plan 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 a small or large employer group contract or similar coverage document that is offered by:

- (1) an insurance company;
- (2) a group hospital service corporation operating under Chapter 842;
- (3) a fraternal benefit society operating under Chapter 885;
- (4) a stipulated premium company operating under Chapter 884;
- (5) a reciprocal exchange operating under Chapter 942;
- (6) a health maintenance organization operating under Chapter 843;
- (7) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; or
- (8) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844.

(b) This subchapter applies to group health coverage made available by a school district in accordance with Section 22.004, Education Code.

(c) Notwithstanding any provision in Chapter 1551, 1575, 1579, or 1601 or any other law, this subchapter applies to:

- (1) a basic coverage plan under Chapter 1551;
- (2) a basic plan under Chapter 1575;
- (3) a primary care coverage plan under Chapter 1579; and
- (4) basic coverage under Chapter 1601.

(d) Notwithstanding any other law, this subchapter applies to coverage under:

- (1) the child health plan program under Chapter 62, Health and Safety Code, or the health benefits plan for children under Chapter 63, Health and Safety Code; and
- (2) the medical assistance program under Chapter 32, Human Resources Code.

Added by Acts 2021, 87th Leg., R.S., Ch. 589 (S.B. [827](#)), Sec. 1, eff. September 1, 2021.

Sec. 1358.102. EXCEPTION. This subchapter does not apply to:

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

- (A) only for a specified disease or for another single benefit;
 - (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);
 - (3) medical payment insurance coverage provided under a motor vehicle insurance policy;
 - (4) 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 as described by Section 1358.101;
 - (5) health and accident coverage provided by a risk pool created under Chapter 172, Local Government Code; or
 - (6) a workers' compensation insurance policy.

Added by Acts 2021, 87th Leg., R.S., Ch. 589 (S.B. [827](#)), Sec. 1, eff. September 1, 2021.

Sec. 1358.103. LIMIT ON COST-SHARING REQUIREMENT. (a) In this section, "insulin" means a prescription drug that contains insulin and is used to treat diabetes. The term does not include an insulin drug that is administered to a patient intravenously.

(b) A health benefit plan may not impose a cost-sharing provision for insulin that is included in the health benefit plan's formulary if the total amount the enrollee is required to pay exceeds \$25 per prescription for a 30-day supply, regardless of the amount or type of insulin needed to fill the enrollee's prescription.

Added by Acts 2021, 87th Leg., R.S., Ch. 589 (S.B. [827](#)), Sec. 1, eff. September 1, 2021.

Sec. 1358.104. FORMULARY REQUIREMENT. A health benefit plan must include at least one insulin from each therapeutic class in the plan's formulary.

Added by Acts 2021, 87th Leg., R.S., Ch. 589 (S.B. 827), Sec. 1, eff. September 1, 2021.

CHAPTER 1359. FORMULAS FOR INDIVIDUALS WITH PHENYLKETONURIA OR OTHER HERITABLE DISEASES

Sec. 1359.001. DEFINITIONS. In this chapter:

(1) "Heritable disease" means an inherited disease that may result in a physical or intellectual disability or death.

(2) "Phenylketonuria" means an inherited condition that, if not treated, may cause a severe intellectual disability.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2023, 88th Leg., R.S., Ch. 30 (H.B. 446), Sec. 8.07, eff. September 1, 2023.

Sec. 1359.002. APPLICABILITY OF CHAPTER. This chapter applies only to a group health benefit plan that is a group policy, contract, or certificate of health insurance or an evidence of coverage delivered, issued for delivery, or renewed in this state by:

- (1) an insurance company;
- (2) a group hospital service corporation operating under Chapter 842; or
- (3) a health maintenance organization operating under Chapter 843.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1359.003. COVERAGE REQUIRED. (a) A group health benefit plan must provide coverage for formulas necessary to treat phenylketonuria or a heritable disease.

(b) The group health benefit plan must provide the coverage to the same extent that the plan provides coverage for drugs that are available only on the orders of a physician.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

**CHAPTER 1360. DIAGNOSIS AND TREATMENT AFFECTING TEMPOROMANDIBULAR
JOINT**

Sec. 1360.001. DEFINITION. In this chapter, "temporomandibular joint" includes the jaw and the craniomandibular joint.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1360.002. APPLICABILITY OF CHAPTER. This chapter applies only to a group health benefit plan delivered or issued for delivery in this state that:

(1) provides benefits for dental, medical, or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) a group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or a group evidence of coverage that is offered by:

(i) an insurance company;

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

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

(iv) a stipulated premium company operating under Chapter 884; or

(v) a health maintenance organization operating under Chapter 843; and

(B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:

(i) a multiple employer welfare arrangement as defined by Section 3 of that Act;

(ii) an entity not authorized under this code or another insurance law of this state that contracts directly for health care services on a risk-sharing basis, including a capitation basis; or

(iii) another analogous benefit arrangement; or

(2) is offered by an approved nonprofit health corporation

that holds a certificate of authority under Chapter 844.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1360.003. EXCEPTION. This chapter does not apply to:

- (1) a plan that provides coverage:
 - (A) only for a specified disease or another limited benefit;
 - (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 vision care; or
 - (G) only for indemnity for hospital confinement;
- (2) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);
- (3) a workers' compensation insurance policy;
- (4) a small employer health benefit plan written under Chapter 1501;
- (5) medical payment insurance coverage provided under a motor vehicle insurance policy; or
- (6) 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 as described by Section 1360.002.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1360.004. COVERAGE REQUIRED. (a) A health benefit plan that provides coverage for medically necessary diagnostic or surgical treatment of conditions affecting skeletal joints must provide comparable coverage for diagnostic or surgical treatment of conditions affecting the temporomandibular joint if the treatment is medically necessary as a result of:

- (1) an accident;
- (2) a trauma;
- (3) a congenital defect;

- (4) a developmental defect; or
- (5) a pathology.

(b) Coverage required under this section may be subject to any provision in the health benefit plan that is generally applicable to surgical treatment, including a requirement for precertification of coverage.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1360.005. DENTAL SERVICES COVERAGE NOT REQUIRED. (a) This chapter does not require a health benefit plan to provide coverage for dental services if dental services are not otherwise scheduled or provided as part of the coverage provided under the plan.

(b) A health benefit plan may not exclude from coverage under the plan an individual who is unable to undergo dental treatment in an office setting or under local anesthesia due to a documented physical, mental, or medical reason as determined by the individual's physician or by the dentist providing the dental care.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

CHAPTER 1361. DETECTION AND PREVENTION OF OSTEOPOROSIS

Sec. 1361.001. DEFINITION. In this chapter, "qualified enrollee" means an individual entitled to coverage under a group health benefit plan who is:

- (1) a postmenopausal woman who is not receiving estrogen replacement therapy;
- (2) an individual with:
 - (A) vertebral abnormalities;
 - (B) primary hyperparathyroidism; or
 - (C) a history of bone fractures; or
- (3) an individual who is:
 - (A) receiving long-term glucocorticoid therapy; or
 - (B) being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1361.002. APPLICABILITY OF CHAPTER. This chapter applies only to a group health benefit plan delivered, issued for delivery, or renewed in this state that provides coverage for medical or surgical expenses incurred as a result of accident or sickness, including:

- (1) a group insurance policy;
- (2) a group contract issued by a group hospital service corporation operating under Chapter 842; and
- (3) a group contract issued by a health maintenance organization operating under Chapter 843.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1361.003. COVERAGE REQUIRED. A group health benefit plan must provide to a qualified enrollee coverage for medically accepted bone mass measurement to detect low bone mass and to determine the enrollee's risk of osteoporosis and fractures associated with osteoporosis.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

CHAPTER 1362. CERTAIN TESTS FOR DETECTION OF PROSTATE CANCER

Sec. 1362.001. APPLICABILITY OF CHAPTER. This chapter applies only to a health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

- (i) an insurance company;
- (ii) a group hospital service corporation operating under Chapter 842;
- (iii) a fraternal benefit society operating under Chapter 885;
- (iv) a stipulated premium company operating under Chapter 884; or
- (v) a health maintenance organization operating

under Chapter 843; and

(B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:

(i) a multiple employer welfare arrangement as defined by Section 3 of that Act; or

(ii) another analogous benefit arrangement;

(2) is offered by:

(A) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844; or

(B) an entity not authorized under this code or another insurance law of this state that contracts directly for health care services on a risk-sharing basis, including a capitation basis; or

(3) provides health and accident coverage through a risk pool created under Chapter 172, Local Government Code, notwithstanding Section 172.014, Local Government Code, or any other law.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1362.002. EXCEPTION. This chapter does not apply to:

(1) a health benefit plan that provides coverage:

(A) only for a specified disease or for another limited benefit;

(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;

or

(E) only for indemnity for hospital confinement;

(2) a small employer health benefit plan written under Chapter 1501;

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

(4) a workers' compensation insurance policy;

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

(6) 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 as described by Section 1362.001.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1362.003. COVERAGE REQUIRED. (a) A health benefit plan that provides coverage for diagnostic medical procedures must provide to each male enrolled in the plan coverage for expenses for an annual medically recognized diagnostic examination for the detection of prostate cancer.

(b) Coverage required under this section includes at a minimum:

(1) a physical examination for the detection of prostate cancer; and

(2) a prostate-specific antigen test used for the detection of prostate cancer for each male who:

(A) is at least 50 years of age and is asymptomatic;
or

(B) is at least 40 years of age and has a family history of prostate cancer or another prostate cancer risk factor.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1362.004. NOTICE OF COVERAGE. (a) A health benefit plan issuer shall provide to each individual enrolled in the plan written notice of the coverage required under this chapter.

(b) The notice must be provided in accordance with rules adopted by the commissioner.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1362.005. RULES. The commissioner shall adopt rules necessary to administer this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

CHAPTER 1363. CERTAIN TESTS FOR DETECTION OF COLORECTAL CANCER

Sec. 1363.001. APPLICABILITY OF CHAPTER. This chapter applies only to a health benefit plan, including a small employer health benefit plan written under Chapter 1501 or coverage that is provided by a health group cooperative under Subchapter B of that chapter, that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

- (i) an insurance company;
- (ii) a group hospital service corporation operating under Chapter 842;
- (iii) a fraternal benefit society operating under Chapter 885;
- (iv) a Lloyd's plan operating under Chapter 941;
- (v) a stipulated premium company operating under Chapter 884;
- (vi) a health maintenance organization operating under Chapter 843; or
- (vii) a reciprocal or interinsurance exchange operating under Chapter 942; and

(B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:

- (i) a multiple employer welfare arrangement as defined by Section 3 of that Act; or
- (ii) another analogous benefit arrangement;

(2) is offered by an approved nonprofit health corporation operating under Chapter 844; or

(3) provides health and accident coverage through a risk pool created under Chapter 172, Local Government Code, notwithstanding Section 172.014, Local Government Code, or any other law.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2021, 87th Leg., R.S., Ch. 308 (S.B. [1028](#)), Sec. 1, eff.

September 1, 2021.

Sec. 1363.002. EXCEPTION. This chapter does not apply to:

- (1) a plan that provides coverage:
 - (A) only for a specified disease or other limited benefit;
 - (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) only for indemnity for hospital confinement; or
 - (F) only for dental or vision care;
- (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 credit-only insurance policy;
- (4) a workers' compensation insurance policy;
- (5) medical payment insurance coverage provided under a motor vehicle insurance policy;
- (6) a limited benefit policy that does not provide coverage for physical examinations or wellness exams;
- (7) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; or
- (8) a long-term care 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 as described by Section 1363.001.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2021, 87th Leg., R.S., Ch. 308 (S.B. [1028](#)), Sec. 2, eff. September 1, 2021.

Sec. 1363.003. MINIMUM COVERAGE REQUIRED. (a) A health benefit plan that provides coverage for screening medical procedures must provide to each individual enrolled in the plan who is 45 years of age or older and at normal risk for developing colon cancer

coverage for expenses incurred in conducting a medically recognized screening examination for the detection of colorectal cancer.

(b) The minimum coverage required under this section must include:

(1) all colorectal cancer examinations, preventive services, and laboratory tests assigned a grade of "A" or "B" by the United States Preventive Services Task Force for average-risk individuals, including the services that may be assigned a grade of "A" or "B" in the future; and

(2) an initial colonoscopy or other medical test or procedure for colorectal cancer screening and a follow-up colonoscopy if the results of the initial colonoscopy, test, or procedure are abnormal.

(c) For an enrollee in a managed care plan as defined by Section 1451.151, the plan may impose a cost-sharing requirement for coverage described by this section only if the enrollee obtains the covered benefit or service outside the plan's network.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2021, 87th Leg., R.S., Ch. 308 (S.B. 1028), Sec. 3, eff. September 1, 2021.

Sec. 1363.004. NOTICE OF COVERAGE. (a) A health benefit plan issuer shall provide to each individual enrolled in the plan written notice of the coverage required under this chapter.

(b) The notice must be provided in accordance with rules adopted by the commissioner.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1363.005. RULES. The commissioner shall adopt rules as necessary to administer this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

CHAPTER 1364. COVERAGE PROVISIONS RELATING TO HIV, AIDS, OR HIV-RELATED ILLNESSES

SUBCHAPTER A. EXCLUSION FROM OR DENIAL OF COVERAGE PROHIBITED

Sec. 1364.001. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a group health benefit plan that is delivered, issued for delivery, or renewed and that is:

- (1) a group accident and health insurance policy;
- (2) a group contract issued by a group hospital service corporation operating under Chapter 842; or
- (3) a group evidence of coverage issued by a health maintenance organization operating under Chapter 843.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1364.002. EXCEPTION. This subchapter does not apply to:

- (1) a credit accident and health insurance policy subject to Chapter 1153;
- (2) any group specifically provided for or authorized by law in existence and covered under a policy filed with the State Board of Insurance before April 1, 1975;
- (3) accident or health coverage that is incidental to any form of a group automobile, casualty, property, workers' compensation, or employers' liability policy approved by the department; or
- (4) any policy or contract of insurance with a state agency, department, or board providing health services:
 - (A) to eligible individuals under Chapter 32, Human Resources Code; or
 - (B) under a state plan adopted in accordance with 42 U.S.C. Sections 1396-1396g, as amended, or 42 U.S.C. Section 1397aa et seq., as amended.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1364.003. PROHIBITION. A group health benefit plan may not exclude or deny coverage for:

- (1) human immunodeficiency virus (HIV);
- (2) acquired immune deficiency syndrome (AIDS); or
- (3) an HIV-related illness.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1364.004. RULES. The commissioner may adopt rules necessary to administer this subchapter. A rule adopted under this section is subject to notice and hearing as provided by Section 1201.007 for a rule adopted under Chapter 1201.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

SUBCHAPTER B. CANCELLATION OF GROUP COVERAGE PROHIBITED

Sec. 1364.051. DEFINITIONS. In this subchapter, "AIDS" and "HIV" have the meanings assigned by Section 81.101, Health and Safety Code.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1364.052. APPLICABILITY OF SUBCHAPTER. This subchapter applies to an insurer that delivers or issues for delivery a group health insurance policy or contract in this state, including a group hospital service corporation operating under Chapter 842.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1364.053. PROHIBITION. (a) Except as provided by Subsection (b), an insurer may not cancel during the term of a group health insurance policy or contract an individual's coverage provided by the policy or contract because the individual:

- (1) has been diagnosed as having AIDS or HIV;
- (2) has been treated for AIDS or HIV; or
- (3) is being treated for AIDS or HIV.

(b) The insurer may cancel the coverage provided by the policy or contract for fraud or misrepresentation in the obtaining of coverage by failure to disclose a diagnosis of AIDS or an HIV-related condition.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

SUBCHAPTER C. CERTAIN COVERAGES PROVIDED BY LOCAL GOVERNMENTS

Sec. 1364.101. PROHIBITION ON EXCLUSION OR LIMITATION OF COVERAGES. A political subdivision that provides group health insurance coverage, health maintenance organization coverage, or self-insured health care coverage to the political subdivision's officers or employees may not contract for or provide coverage that excludes or limits coverage or services for:

(1) acquired immune deficiency syndrome, as defined by the Centers for Disease Control and Prevention of the United States Public Health Service; or

(2) human immunodeficiency virus infection.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

CHAPTER 1365. LOSS OR IMPAIRMENT OF SPEECH OR HEARING**SUBCHAPTER A. GENERAL PROVISIONS**

Sec. 1365.001. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a group health benefit plan that provides hospital and medical coverage on an expense-incurred, service, or prepaid basis, including a group policy, contract, or plan that is offered in this state by:

(1) an insurer;

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

(3) a health maintenance organization operating under Chapter 843.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 8 (H.B. 109), Sec. 2, eff. September 1, 2023.

Sec. 1365.002. APPLICABILITY OF GENERAL PROVISIONS OF OTHER LAW. The provisions of Chapter 1201, including provisions relating to the applicability, purpose, and enforcement of that chapter, construction of policies under that chapter, rulemaking under that chapter, and definitions of terms applicable in that chapter, apply to this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2023, 88th Leg., R.S., Ch. 8 (H.B. 109), Sec. 2, eff.
September 1, 2023.

Sec. 1365.003. OFFER OF COVERAGE REQUIRED. (a) A group health benefit plan issuer shall offer and make available under the plan coverage for the necessary care and treatment of loss or impairment of speech or hearing.

(b) Coverage required under this section:

(1) may not be less favorable than coverage for physical illness generally under the plan; and

(2) must be subject to the same durational limits, dollar limits, deductibles, and coinsurance factors as coverage for physical illness generally under the plan.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1365.004. RIGHT TO REJECT COVERAGE OR SELECT ALTERNATIVE BENEFITS. An offer of coverage required under Section 1365.003 is subject to the right of the group contract holder to reject the coverage or to select an alternative level of benefits that is offered by or negotiated with the group health benefit plan issuer.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.028, eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.028, eff. September 1, 2007.

SUBCHAPTER B. HEARING AID COVERAGE

Sec. 1365.051. APPLICABILITY. (a) This subchapter applies only to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or

similar coverage document that is offered by:

- (1) an insurance company;
- (2) a group hospital service corporation operating under Chapter 842;
- (3) a health maintenance organization operating under Chapter 843;
- (4) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844;
- (5) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846;
- (6) a stipulated premium company operating under Chapter 884;
- (7) a fraternal benefit society operating under Chapter 885;
- (8) a Lloyd's plan operating under Chapter 941; or
- (9) an exchange operating under Chapter 942.

(b) This subchapter applies to coverage under a group health benefit plan described by Subsection (a) provided to a resident of this state, regardless of whether the group policy, agreement, or contract is delivered, issued for delivery, or renewed within or outside this state.

(c) Notwithstanding any other law, this subchapter applies to:

- (1) a small employer health benefit plan subject to Chapter 1501, including coverage provided through a health group cooperative under Subchapter B of that chapter;
- (2) a standard health benefit plan issued under Chapter 1507;
- (3) a basic coverage plan under Chapter 1551;
- (4) a basic plan under Chapter 1575;
- (5) a primary care coverage plan under Chapter 1579;
- (6) a plan providing basic coverage under Chapter 1601;
- (7) a regional or local health care program operated under Section 75.104, Health and Safety Code; and
- (8) a self-funded health benefit plan sponsored by a professional employer organization under Chapter 91, Labor Code.

Added by Acts 2023, 88th Leg., R.S., Ch. 8 (H.B. 109), Sec. 3, eff. September 1, 2023.

Sec. 1365.052. EXCEPTION. This subchapter does not apply to:

(1) a plan that provides coverage:

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

(B) only for hospital expenses; or

(2) the state Medicaid program, including the Medicaid managed care program operated under Chapter 533, Government Code.

Added by Acts 2023, 88th Leg., R.S., Ch. 8 (H.B. 109), Sec. 3, eff. September 1, 2023.

Sec. 1365.053. CHOICE OF HEARING AID. (a) A health benefit plan that provides coverage for hearing aids may not deny an enrollee's claim for a hearing aid solely on the basis that the price of the hearing aid is more than the benefit available under the health benefit plan.

(b) Notwithstanding Section 1367.253(d), this section applies to a health benefit plan subject to Subchapter F, Chapter 1367.

(c) Nothing in this section requires a health benefit plan to pay an enrollee's claim for a hearing aid in an amount that is more than the benefit available under the health benefit plan.

Added by Acts 2023, 88th Leg., R.S., Ch. 8 (H.B. 109), Sec. 3, eff. September 1, 2023.

CHAPTER 1366. BENEFITS RELATED TO FERTILITY AND CHILDBIRTH
SUBCHAPTER A. COVERAGE FOR IN VITRO FERTILIZATION PROCEDURES

Sec. 1366.001. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a group health benefit plan that provides benefits for hospital, medical, or surgical expenses incurred as a result of accident or sickness, including a group health insurance policy, health care service contract or plan, or other provision of group health benefits, coverage, or services in this state that is issued, entered into, or provided by:

(1) an insurer;

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

(3) a health maintenance organization operating under

Chapter 843; or

(4) an employer, multiple employer, union, association, trustee, or other self-funded or self-insured welfare or benefit plan, program, or arrangement.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1366.002. EXCEPTION. This subchapter does not apply to:

(1) a credit accident and health insurance policy subject to Chapter 1153;

(2) any group specifically provided for or authorized by law in existence and covered under a policy filed with the State Board of Insurance before April 1, 1975;

(3) accident and health coverages that are incidental to any form of a group automobile, casualty, property, workers' compensation, or employers' liability policy approved by the commissioner; or

(4) any policy or contract of insurance with a state agency, department, or board providing health services:

(A) to eligible individuals under Chapter 32, Human Resources Code; or

(B) under a state plan adopted in accordance with 42 U.S.C. Sections 1396-1396g, as amended, or 42 U.S.C. Section 1397aa et seq., as amended.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1366.003. OFFER OF COVERAGE REQUIRED. (a) Subject to this subchapter, an issuer of a group health benefit plan that provides pregnancy-related benefits for individuals covered under the plan shall offer and make available to each holder or sponsor of the plan coverage for services and benefits on an expense incurred, service, or prepaid basis for outpatient expenses that arise from in vitro fertilization procedures.

(b) Benefits for in vitro fertilization procedures required under this section must be provided to the same extent as benefits provided for other pregnancy-related procedures under the plan.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1366.004. REJECTION OF OFFER. A rejection of an offer under Section 1366.003 to provide coverage for in vitro fertilization procedures must be in writing.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1366.005. CONDITIONS APPLICABLE TO COVERAGE. The coverage offered under Section 1366.003 is required only if:

(1) the patient for the in vitro fertilization procedure is an individual covered under the group health benefit plan;

(2) the fertilization or attempted fertilization of the patient's oocytes is made only with the sperm of the patient's spouse;

(3) the patient and the patient's spouse have a history of infertility of at least five continuous years' duration or the infertility is associated with:

(A) endometriosis;

(B) exposure in utero to diethylstilbestrol (DES);

(C) blockage of or surgical removal of one or both fallopian tubes; or

(D) oligospermia;

(4) the patient has been unable to attain a successful pregnancy through any less costly applicable infertility treatments for which coverage is available under the group health benefit plan; and

(5) the in vitro fertilization procedures are performed at a medical facility that conforms to the minimal standards for programs of in vitro fertilization adopted by the American Society for Reproductive Medicine.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1366.006. CERTAIN ISSUERS OF HEALTH BENEFIT PLANS NOT REQUIRED TO OFFER COVERAGE. An insurer, health maintenance organization, or self-insuring employer that is owned by or that is part of an entity, group, or order that is directly affiliated with a bona fide religious denomination that includes as an integral part of

its beliefs and practices that in vitro fertilization is contrary to moral principles that the religious denomination considers to be an essential part of its beliefs is not required to offer coverage for in vitro fertilization under Section 1366.003.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1366.007. RULES. The commissioner may adopt rules necessary to administer this subchapter. A rule adopted under this section is subject to notice and hearing as provided by Section 1201.007 for a rule adopted under Chapter 1201.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

**SUBCHAPTER B. MINIMUM INPATIENT STAY FOLLOWING BIRTH OF CHILD AND
POSTDELIVERY CARE**

Sec. 1366.051. SHORT TITLE. This subchapter may be cited as the Lee Alexandria Hanley Act.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1366.052. DEFINITIONS. In this subchapter:

(1) "Attending physician" means an obstetrician, pediatrician, or other physician who attends a woman who has given birth to a child or who attends a newborn child.

(2) "Postdelivery care" means postpartum health care services provided in accordance with accepted maternal and neonatal physical assessments. The term includes parent education, assistance and training in breast-feeding and bottle-feeding, and the performance of any necessary and appropriate clinical tests.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1366.053. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness,

including:

(A) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

- (i) an insurance company;
- (ii) a group hospital service corporation operating under Chapter 842;
- (iii) a fraternal benefit society operating under Chapter 885;
- (iv) a stipulated premium company operating under Chapter 884; or
- (v) a health maintenance organization operating under Chapter 843; and

(B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:

- (i) a multiple employer welfare arrangement as defined by Section 3 of that Act;
 - (ii) an entity not authorized under this code or another insurance law of this state that contracts directly for health care services on a risk-sharing basis, including a capitation basis; or
 - (iii) another analogous benefit arrangement; or
- (2) is offered by an approved nonprofit health corporation that holds a certificate of authority under Chapter 844.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1366.054. EXCEPTION. This subchapter does not apply to:

- (1) a plan that provides coverage:
 - (A) only for a specified disease or for another limited benefit;
 - (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; or
- (G) only for indemnity for hospital confinement;
- (2) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);
- (3) a workers' compensation insurance policy;
- (4) medical payment insurance coverage provided under a motor vehicle insurance policy; or
- (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 as described by Section 1366.053.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1366.055. COVERAGE FOR INPATIENT CARE REQUIRED. (a) Except as provided by Subsection (b), a health benefit plan that provides maternity benefits, including benefits for childbirth, must provide to a woman who has given birth to a child and the newborn child coverage for inpatient care in a health care facility for not less than:

- (1) 48 hours after an uncomplicated vaginal delivery; and
- (2) 96 hours after an uncomplicated delivery by cesarean section.

(b) A health benefit plan that provides to a woman who has given birth to a child and the newborn child coverage for in-home postdelivery care is not required to provide the coverage required under Subsection (a) unless:

- (1) the attending physician determines that inpatient care is medically necessary; or
- (2) the woman requests inpatient care.

(c) For purposes of Subsection (a), the attending physician shall determine whether a delivery is complicated.

(d) This section does not require a woman who is eligible for coverage under a health benefit plan to:

- (1) give birth to a child in a hospital or other health care facility; or
- (2) remain under inpatient care in a hospital or other health care facility for any fixed term following the birth of a child.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1366.056. COVERAGE FOR POSTDELIVERY CARE REQUIRED. (a) If a decision is made to discharge a woman who has given birth to a child or the newborn child from inpatient care before the expiration of the minimum hours of coverage required under Section 1366.055(a), a health benefit plan must provide to the woman and child coverage for timely postdelivery care.

(b) The timeliness of the postdelivery care shall be determined in accordance with recognized medical standards for that care.

(c) The postdelivery care may be provided by a physician, registered nurse, or other appropriate licensed health care provider.

(d) Subject to Subsection (e), the postdelivery care may be provided at:

- (1) the woman's home;
- (2) a health care provider's office;
- (3) a health care facility; or
- (4) another location determined to be appropriate under rules adopted by the commissioner.

(e) The coverage required under this section must give the woman the option to have the care provided in the woman's home.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1366.057. PROHIBITED CONDUCT. An issuer of a health benefit plan may not:

(1) modify the terms and conditions of coverage based on a request by an enrollee for less than the minimum coverage required under Section 1366.055(a);

(2) offer to a woman who has given birth to a child a financial incentive or other compensation the receipt of which is contingent on the waiver by the woman of the minimum coverage required under Section 1366.055(a);

(3) refuse to accept a physician's recommendation for inpatient care made in consultation with the woman who has given birth to a child if the period of inpatient care recommended by the physician does not exceed the minimum periods recommended in guidelines for perinatal care developed by:

- (A) the American College of Obstetricians and Gynecologists;
- (B) the American Academy of Pediatrics; or
- (C) another nationally recognized professional association of obstetricians and gynecologists or of pediatricians;
- (4) reduce payments or other forms of reimbursement for inpatient care below the usual and customary rate of reimbursement for that care; or
- (5) penalize a physician for recommending inpatient care for a woman or the woman's newborn child by:
 - (A) refusing to permit the physician to participate as a provider in the health benefit plan;
 - (B) reducing payments made to the physician;
 - (C) requiring the physician to:
 - (i) provide additional documentation; or
 - (ii) undergo additional utilization review; or
 - (D) imposing other analogous sanctions or disincentives.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1366.058. NOTICE OF COVERAGE. (a) An issuer of a health benefit plan shall provide to each individual enrolled in the plan written notice of the coverage required under this subchapter.

(b) The notice must be provided in accordance with rules adopted by the commissioner.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1366.059. RULES. The commissioner shall adopt rules necessary to administer this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

SUBCHAPTER C. COVERAGE FOR CERTAIN FERTILITY PRESERVATION SERVICES

Sec. 1366.101. DEFINITION. In this subchapter, "fertility preservation services":

- (1) means the collection and preservation of sperm,

unfertilized oocytes, and ovarian tissue; and

(2) does not include the storage of such unfertilized genetic materials.

Added by Acts 2023, 88th Leg., R.S., Ch. 819 (H.B. 1649), Sec. 2, eff. September 1, 2023.

Sec. 1366.102. APPLICABILITY OF SUBCHAPTER. (a) This subchapter applies only to a health benefit plan 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 issued in this state by:

- (1) an insurance company;
- (2) a group hospital service corporation operating under Chapter 842;
- (3) a health maintenance organization operating under Chapter 843;
- (4) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844;
- (5) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846;
- (6) a stipulated premium company operating under Chapter 884;
- (7) a fraternal benefit society operating under Chapter 885;
- (8) a Lloyd's plan operating under Chapter 941; or
- (9) an exchange operating under Chapter 942.

(b) Notwithstanding any other law, this subchapter applies to:

- (1) a small employer health benefit plan subject to Chapter 1501, including coverage provided through a health group cooperative under Subchapter B of that chapter; and
- (2) a standard health benefit plan issued under Chapter 1507.

Added by Acts 2023, 88th Leg., R.S., Ch. 819 (H.B. 1649), Sec. 2, eff. September 1, 2023.

Sec. 1366.103. EXCEPTIONS. This subchapter does not apply to:

(1) a health benefit plan that provides coverage:

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

(B) only for hospital expenses;

(2) Medicaid managed care programs operated under Chapter 533, Government Code;

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

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

Added by Acts 2023, 88th Leg., R.S., Ch. 819 (H.B. 1649), Sec. 2, eff. September 1, 2023.

Sec. 1366.104. REQUIRED COVERAGE. (a) Subject to Subsection (b), a health benefit plan must provide coverage for fertility preservation services to a covered person who will receive a medically necessary treatment for cancer, including surgery, chemotherapy, or radiation, that the American Society of Clinical Oncology or the American Society for Reproductive Medicine has established may directly or indirectly cause impaired fertility.

(b) The fertility preservation services described by Subsection (a) must be standard procedures to preserve fertility consistent with established medical practices or professional guidelines published by the American Society of Clinical Oncology or the American Society for Reproductive Medicine.

Added by Acts 2023, 88th Leg., R.S., Ch. 819 (H.B. 1649), Sec. 2, eff. September 1, 2023.

CHAPTER 1367. COVERAGE OF CHILDREN

SUBCHAPTER A. NEWBORN CHILDREN

Sec. 1367.001. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a health benefit plan delivered or issued for delivery in this state that is an individual or group policy of accident and health insurance, including a policy issued by a group hospital service corporation operating under Chapter 842.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1367.002. APPLICABILITY OF GENERAL PROVISIONS OF OTHER LAW. The provisions of Chapter 1201, including provisions relating to the applicability, purpose, and enforcement of that chapter, construction of policies under that chapter, rulemaking under that chapter, and definitions of terms applicable in that chapter, apply to this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1367.003. CERTAIN LIMITATIONS ON COVERAGE FOR NEWBORN CHILDREN PROHIBITED. A health benefit plan that provides maternity benefits or accident and health coverage for additional newborn children may not be issued in this state if the plan excludes or limits:

- (1) initial coverage of a newborn child for a period of time;
- (2) coverage for congenital defects of a newborn child; or
- (3) coverage for administration of the newborn screening tests required by Section 33.011, Health and Safety Code, including for the cost of a newborn screening test kit in the amount provided by the Department of State Health Services on its Internet website under Section 33.019 of that code on the date the test was administered.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2019, 86th Leg., R.S., Ch. 599 (S.B. 747), Sec. 5, eff. September 1, 2019.

SUBCHAPTER B. CHILDHOOD IMMUNIZATIONS

Sec. 1367.051. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a health benefit plan that:

- (1) 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 that is offered by:

- (A) an insurance company;
- (B) a group hospital service corporation operating under Chapter 842;
- (C) a fraternal benefit society operating under Chapter 885;
- (D) a stipulated premium company operating under Chapter 884;
- (E) a health maintenance organization operating under Chapter 843; or
- (F) a multiple employer welfare arrangement subject to regulation under Chapter 846;

(2) is offered by an approved nonprofit health corporation that holds a certificate of authority under Chapter 844; or

(3) provides health and accident coverage through a risk pool created under Chapter 172, Local Government Code, notwithstanding Section 172.014, Local Government Code, or any other law.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1367.052. EXCEPTION. This subchapter does not apply to:

- (1) a plan that provides coverage:
 - (A) only for a specified disease or for another limited benefit;
 - (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; or
 - (G) only for indemnity for hospital confinement;
- (2) a small employer health benefit plan written under Chapter 1501;
- (3) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);
- (4) a workers' compensation insurance policy;
- (5) medical payment insurance coverage provided under a

motor vehicle insurance policy; or

(6) 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 as described by Section 1367.051.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1367.053. COVERAGE REQUIRED. (a) A health benefit plan that provides coverage for a family member of an insured or enrollee shall provide for each covered child from birth through the date of the child's sixth birthday coverage for:

(1) immunization against:

- (A) diphtheria;
- (B) haemophilus influenzae type b;
- (C) hepatitis B;
- (D) measles;
- (E) mumps;
- (F) pertussis;
- (G) polio;
- (H) rubella;
- (I) tetanus; and
- (J) varicella; and

(2) any other immunization that is required for the child by law.

(b) For purposes of Subsection (a), a covered child is a child who, as a result of the child's relationship to an insured or enrollee in a health benefit plan, would be entitled to coverage under an accident and health insurance policy under Section 1201.061, 1201.062, 1201.063, or 1201.064.

(c) In addition to the immunizations required under Subsection (a), a health maintenance organization that issues a health benefit plan shall provide under the plan coverage for immunization against rotovirus and any other immunization required for a child by law.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 3B.0281, eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. [3167](#)), Sec. 9.0281,

eff. September 1, 2007.

Sec. 1367.054. COPAYMENT, DEDUCTIBLE, OR COINSURANCE REQUIREMENT PROHIBITED. (a) Coverage required under Section 1367.053(a) may not be made subject to a deductible, copayment, or coinsurance requirement.

(b) This section does not prohibit the application of a deductible, copayment, or coinsurance requirement to another service provided at the same time the immunization is administered.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1367.055. RULES. The commissioner may adopt rules necessary to implement this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.039, eff. September 1, 2005.

SUBCHAPTER C. HEARING TEST

Sec. 1367.101. APPLICABILITY OF SUBCHAPTER. (a) This subchapter applies only to a health benefit plan that:

(1) 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 that is offered by:

- (A) an insurance company;
- (B) a group hospital service corporation operating under Chapter 842;
- (C) a fraternal benefit society operating under Chapter 885;
- (D) a stipulated premium company operating under Chapter 884;
- (E) a health maintenance organization operating under Chapter 843; or
- (F) a multiple employer welfare arrangement subject to

regulation under Chapter 846;

(2) is offered by an approved nonprofit health corporation that holds a certificate of authority under Chapter 844; or

(3) provides health and accident coverage through a risk pool created under Chapter 172, Local Government Code, notwithstanding Section 172.014, Local Government Code, or any other law.

(b) This subchapter applies to a health benefit plan described by Subsection (a) that provides coverage to a resident of this state, regardless of whether the plan issuer is located in or outside this state.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1367.102. EXCEPTION. This subchapter does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease or for another limited benefit;

(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; or

(G) only for indemnity for hospital confinement;

(2) a small employer health benefit plan written under Chapter 1501;

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

(4) a workers' compensation insurance policy;

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

(6) 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 as described by Section 1367.101.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1367.103. COVERAGE REQUIRED. (a) A health benefit plan that provides coverage for a family member of an insured or enrollee shall provide to each covered child coverage for:

(1) a screening test for hearing loss from birth through the date the child is 30 days of age, as provided by Chapter 47, Health and Safety Code; and

(2) necessary diagnostic follow-up care related to the screening test from birth through the date the child is 24 months of age.

(b) For purposes of Subsection (a), a covered child is a child who, as a result of the child's relationship to an insured or enrollee in a health benefit plan, would be entitled to coverage under an accident and health insurance policy under Section 1201.061, 1201.062, 1201.063, or 1201.064.

(c) This section does not require a health benefit plan to provide the coverage described by this section to a child of an individual residing in this state if the individual is:

(1) employed outside this state; and

(2) covered under a health benefit plan maintained for the individual by the individual's employer as an employment benefit.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1367.104. COPAYMENT OR COINSURANCE REQUIREMENT PERMITTED; DEDUCTIBLE REQUIREMENT OR DOLLAR LIMIT PROHIBITED; NOTICE REQUIRED.

(a) Coverage required under this subchapter:

(1) may be subject to a copayment or coinsurance requirement; and

(2) may not be subject to a deductible requirement or a dollar limit.

(b) The requirements of this section must be stated in the coverage document.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1367.105. RULES. The commissioner may adopt rules necessary to implement this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

SUBCHAPTER D. CHILD CRANIOFACIAL ABNORMALITIES

Sec. 1367.151. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

- (i) an insurance company;
- (ii) a group hospital service corporation operating under Chapter 842;
- (iii) a fraternal benefit society operating under Chapter 885;
- (iv) a stipulated premium company operating under Chapter 884; or
- (v) a health maintenance organization operating under Chapter 843; and

(B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:

- (i) a multiple employer welfare arrangement as defined by Section 3 of that Act;
- (ii) an entity not authorized under this code or another insurance law of this state that contracts directly for health care services on a risk-sharing basis, including a capitation basis; or
- (iii) another analogous benefit arrangement; or

(2) is offered by an approved nonprofit health corporation that holds a certificate of authority under Chapter 844.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1367.152. EXCEPTION. This subchapter does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease or for another limited

benefit;

(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; or

(G) only for indemnity for hospital confinement or other hospital expenses;

(2) a small employer health benefit plan written under Chapter 1501;

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

(4) a workers' compensation insurance policy;

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

(6) 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 as described by Section 1367.151.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1367.153. RECONSTRUCTIVE SURGERY FOR CRANIOFACIAL ABNORMALITIES; DEFINITION REQUIRED. A health benefit plan that provides coverage for a child who is younger than 18 years of age must define "reconstructive surgery for craniofacial abnormalities" under the plan to mean surgery to improve the function of, or to attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1367.154. RULES. The commissioner shall adopt rules necessary to administer this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

SUBCHAPTER E. DEVELOPMENTAL DELAYS

Sec. 1367.201. DEFINITION. In this subchapter, rehabilitative and habilitative therapies include:

- (1) occupational therapy evaluations and services;
- (2) physical therapy evaluations and services;
- (3) speech therapy evaluations and services; and
- (4) dietary or nutritional evaluations.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.040(a), eff. September 1, 2005.

Sec. 1367.202. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a health benefit plan that:

- (1) 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 that is offered by:
 - (A) an insurance company;
 - (B) a group hospital service corporation operating under Chapter 842;
 - (C) a fraternal benefit society operating under Chapter 885;
 - (D) a stipulated premium company operating under Chapter 884;
 - (E) a health maintenance organization operating under Chapter 843; or
 - (F) a multiple employer welfare arrangement subject to regulation under Chapter 846;
- (2) is offered by an approved nonprofit health corporation that holds a certificate of authority under Chapter 844; or
- (3) provides health and accident coverage through a risk pool created under Chapter 172, Local Government Code, notwithstanding Section 172.014, Local Government Code, or any other law.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.040(a), eff. September 1, 2005.

Sec. 1367.203. EXCEPTION. This subchapter does not apply to:

- (1) a plan that provides coverage:
 - (A) only for a specified disease or for another limited benefit;
 - (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; or
 - (G) only for indemnity for hospital confinement;
- (2) a small employer health benefit plan written under Chapter 1501;
- (3) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);
- (4) a workers' compensation insurance policy;
- (5) medical payment insurance coverage provided under a motor vehicle insurance policy; or
- (6) 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 as described by Section 1367.202.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.040(a), eff. September 1, 2005.

Sec. 1367.204. OFFER OF COVERAGE REQUIRED. (a) A health benefit plan issuer must offer coverage that complies with this subchapter.

(b) The individual or group policy or contract holder may reject coverage required to be offered under this section.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.040(a), eff. September 1, 2005.

Sec. 1367.205. COVERAGE OF CERTAIN THERAPIES. (a) A health

benefit plan that provides coverage for rehabilitative and habilitative therapies under this subchapter may not prohibit or restrict payment for covered services provided to a child and determined to be necessary to and provided in accordance with an individualized family service plan issued by the Interagency Council on Early Childhood Intervention under Chapter 73, Human Resources Code.

(b) Rehabilitative and habilitative therapies described by Subsection (a) must be covered in the amount, duration, scope, and service setting established in the child's individualized family service plan.

(c) A child is entitled to benefits under this subchapter if the child, as a result of the child's relationship to an insured or enrollee in a health benefit plan, would be entitled to coverage under an accident and health insurance policy under Section 1201.061, 1201.062, 1201.063, or 1201.064.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.040(a), eff. September 1, 2005.

Sec. 1367.206. PROHIBITED ACTIONS. Under the coverage required to be offered under this subchapter, a health benefit plan issuer may not:

- (1) apply the cost of rehabilitative and habilitative therapies described by Section 1367.205(a) to an annual or lifetime maximum plan benefit or similar provision under the plan; or
- (2) use the cost of rehabilitative or habilitative therapies described by Section 1367.205(a) as the sole justification for:
 - (A) increasing plan premiums; or
 - (B) terminating the insured's or enrollee's participation in the plan.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.040(a), eff. September 1, 2005.

Sec. 1367.207. RULES. The commissioner may adopt rules necessary to implement this subchapter.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.040(a), eff. September 1, 2005.

SUBCHAPTER F. HEARING AIDS AND COCHLEAR IMPLANTS

Sec. 1367.251. APPLICABILITY OF SUBCHAPTER. (a) This subchapter applies only to a health benefit plan, including a small employer health benefit plan written under Chapter 1501 or coverage provided through a health group cooperative under Subchapter B of that chapter, that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is offered by:

- (1) an insurance company;
- (2) a group hospital service corporation operating under Chapter 842;
- (3) a fraternal benefit society operating under Chapter 885;
- (4) a Lloyd's plan operating under Chapter 941;
- (5) a stipulated premium insurance company operating under Chapter 884;
- (6) a reciprocal exchange operating under Chapter 942;
- (7) a health maintenance organization operating under Chapter 843;
- (8) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; or
- (9) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844.

(b) This subchapter applies to coverage under a group health benefit plan described by Subsection (a) provided to a resident of this state, regardless of whether the group policy, agreement, or contract is delivered, issued for delivery, or renewed within or outside this state.

(c) This subchapter applies to a self-funded health benefit plan sponsored by a professional employer organization under Chapter 91, Labor Code.

(d) Notwithstanding Section 22.409, Business Organizations Code, or any other law, this subchapter applies to health benefits

provided by or through a church benefits board under Subchapter I, Chapter 22, Business Organizations Code.

(e) Notwithstanding Section 75.104, Health and Safety Code, or any other law, this subchapter applies to a regional or local health care program operated under that section.

(f) Notwithstanding any other law, a standard health benefit plan provided under Chapter 1507 must provide the coverage required by this subchapter.

(g) Notwithstanding any provision in Chapter 1551, 1575, 1579, or 1601 or any other law, this subchapter applies to:

- (1) a basic coverage plan under Chapter 1551;
- (2) a basic plan under Chapter 1575;
- (3) a primary care coverage plan under Chapter 1579; and
- (4) basic coverage under Chapter 1601.

Added by Acts 2017, 85th Leg., R.S., Ch. 979 (H.B. 490), Sec. 1, eff. September 1, 2017.

Text of section effective until April 1, 2025

Sec. 1367.252. EXCEPTION. This subchapter does not apply to:

- (1) a plan that provides coverage:
 - (A) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;
 - (B) as a supplement to a liability insurance policy;
 - (C) for credit insurance;
 - (D) only for dental or vision care;
 - (E) only for hospital expenses; or
 - (F) only for indemnity for hospital confinement;
- (2) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);
- (3) a workers' compensation insurance policy;
- (4) medical payment insurance coverage provided under a motor vehicle insurance policy;
- (5) a long-term care 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 as described by Section 1367.251; or
- (6) the state Medicaid program, including the Medicaid

managed care program operated under Chapter 533, Government Code.

Added by Acts 2017, 85th Leg., R.S., Ch. 979 (H.B. 490), Sec. 1, eff. September 1, 2017.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 2.124, eff. April 1, 2025.

Text of section effective on April 1, 2025

Sec. 1367.252. EXCEPTION. This subchapter does not apply to:

(1) a plan that provides coverage:

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

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

(C) for credit insurance;

(D) only for dental or vision care;

(E) only for hospital expenses; or

(F) only for indemnity for hospital confinement;

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

(3) a workers' compensation insurance policy;

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

(5) a long-term care 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 as described by Section 1367.251; or

(6) the state Medicaid program, including the Medicaid managed care program operated under Chapters 540 and 540A, Government Code.

Added by Acts 2017, 85th Leg., R.S., Ch. 979 (H.B. 490), Sec. 1, eff. September 1, 2017.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 2.124, eff. April 1, 2025.

Sec. 1367.253. COVERAGE REQUIRED. (a) A health benefit plan must provide coverage for the cost of a medically necessary hearing aid or cochlear implant and related services and supplies for a covered individual who is 18 years of age or younger.

(b) Coverage required under this section:

(1) must include:

(A) fitting and dispensing services and the provision of ear molds as necessary to maintain optimal fit of hearing aids;

(B) any treatment related to hearing aids and cochlear implants, including coverage for habilitation and rehabilitation as necessary for educational gain; and

(C) for a cochlear implant, an external speech processor and controller with necessary components replacement every three years; and

(2) is limited to:

(A) one hearing aid in each ear every three years; and

(B) one cochlear implant in each ear with internal replacement as medically or audiotologically necessary.

(c) Except as provided by Subsections (b) and (d), coverage required under this section:

(1) may not be less favorable than coverage for physical illness generally under the plan; and

(2) must be subject to durational limits and coinsurance factors no less favorable than coverage provided for physical illness generally under the plan.

(d) Coverage required under this section is subject to any provision that applies generally to coverage provided for durable medical equipment benefits under the plan, including a provision relating to deductibles, coinsurance, or prior authorization.

(e) This section does not apply to a qualified health plan defined by 45 C.F.R. Section 155.20 if a determination is made under 45 C.F.R. Section 155.170 that:

(1) this subchapter requires the plan to offer benefits in addition to the essential health benefits required under 42 U.S.C. Section 18022(b); and

(2) this state must make payments to defray the cost of the additional benefits mandated by this subchapter.

Added by Acts 2017, 85th Leg., R.S., Ch. 979 (H.B. 490), Sec. 1, eff. September 1, 2017.

CHAPTER 1368. AVAILABILITY OF CHEMICAL DEPENDENCY COVERAGE

Sec. 1368.001. DEFINITIONS. In this chapter:

(1) "Chemical dependency" means the abuse of, a psychological or physical dependence on, or an addiction to alcohol or a controlled substance.

(2) "Chemical dependency treatment center" means a facility that provides a program for the treatment of chemical dependency under a written treatment plan approved and monitored by a physician and that is:

(A) affiliated with a hospital under a contractual agreement with an established system for patient referral;

(B) accredited as a chemical dependency treatment center by the Joint Commission on Accreditation of Healthcare Organizations;

(C) licensed as a chemical dependency treatment program by the Texas Commission on Alcohol and Drug Abuse; or

(D) licensed, certified, or approved as a chemical dependency treatment program or center by another state agency.

(3) "Controlled substance" means an abusable volatile chemical, as defined by Section 485.001, Health and Safety Code, or a substance designated as a controlled substance under Chapter 481, Health and Safety Code.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1368.002. APPLICABILITY OF CHAPTER. This chapter applies only to a group health benefit plan that provides hospital and medical coverage or services on an expense incurred, service, or prepaid basis, including a group insurance policy or contract or self-funded or self-insured plan or arrangement that is offered in this state by:

(1) an insurer;

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

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

(4) an employer, trustee, or other self-funded or self-

insured plan or arrangement.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1368.003. EXCEPTION. This chapter does not apply to:

- (1) an employer, trustee, or other self-funded or self-insured plan or arrangement with 250 or fewer employees or members;
- (2) an individual insurance policy;
- (3) an individual evidence of coverage issued by a health maintenance organization;
- (4) a health insurance policy that provides only:
 - (A) cash indemnity for hospital or other confinement benefits;
 - (B) supplemental or limited benefit coverage;
 - (C) coverage for specified diseases or accidents;
 - (D) disability income coverage; or
 - (E) any combination of those benefits or coverages;
- (5) a blanket insurance policy;
- (6) a short-term travel insurance policy;
- (7) an accident-only insurance policy;
- (8) a limited or specified disease insurance policy;
- (9) an individual conversion insurance policy or contract;
- (10) a policy or contract designed for issuance to a person eligible for Medicare coverage or other similar coverage under a state or federal government plan; or
- (11) an evidence of coverage provided by a health maintenance organization if the plan holder is the subject of a collective bargaining agreement that was in effect on January 1, 1982, and that has not expired since that date.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1368.004. COVERAGE REQUIRED. (a) A group health benefit plan shall provide coverage for the necessary care and treatment of chemical dependency.

(b) Coverage required under this section may be provided:

- (1) directly by the group health benefit plan issuer; or
- (2) by another entity, including a single service health maintenance organization, under contract with the group health

benefit plan issuer.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1368.005. MINIMUM COVERAGE REQUIREMENTS. (a) Except as provided by Subsection (b), coverage required under this chapter:

(1) may not be less favorable than coverage provided for physical illness generally under the plan; and

(2) shall be subject to the same durational limits, dollar limits, deductibles, and coinsurance factors that apply to coverage provided for physical illness generally under the plan.

(b) A group health benefit plan may set dollar or durational limits for coverage required under this chapter that are less favorable than for coverage provided for physical illness generally under the plan if those limits are sufficient to provide appropriate care and treatment under the guidelines and standards adopted under Section 1368.007. If guidelines and standards adopted under Section 1368.007 are not in effect, the dollar and durational limits may not be less favorable than for physical illness generally.

(c) This section does not require payment of a usual, customary, and reasonable rate for treatment of a covered individual if a health maintenance organization or preferred provider organization establishes a negotiated rate for the locality in which the covered individual customarily receives care.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1368.006. LIMITATION ON COVERAGE. (a) In this section, "treatment series" means a planned, structured, and organized program to promote chemical-free status that:

(1) may include different facilities or modalities; and

(2) is completed when the covered individual:

(A) is, on medical advice, discharged from:

(i) inpatient detoxification;

(ii) inpatient rehabilitation or treatment;

(iii) partial hospitalization or intensive outpatient treatment; or

(iv) a series of those levels of treatments without a lapse in treatment; or

(B) fails to materially comply with the treatment program for a period of 30 days.

(b) Notwithstanding Section 1368.005, coverage required under this chapter is limited to a lifetime maximum of three separate treatment series for each covered individual.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1368.007. TREATMENT STANDARDS. (a) Coverage provided under this chapter for necessary care and treatment in a chemical dependency treatment center must be provided as if the care and treatment were provided in a hospital.

(b) The department by rule shall adopt standards formulated and approved by the department and the Texas Commission on Alcohol and Drug Abuse for use by insurers, other third-party reimbursement sources, and chemical dependency treatment centers.

(c) Standards adopted under this section must provide for:

(1) reasonable control of costs necessary for inpatient and outpatient treatment of chemical dependency, including guidelines for treatment periods; and

(2) appropriate utilization review of treatment as well as necessary extensions of treatment.

(d) Coverage required under this chapter is subject to the standards adopted under this section.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1368.008. USE OF ENDORSEMENT OR RIDER TO COMPLY WITH CHAPTER. A group health benefit plan issuer that uses a policy form approved by the commissioner before November 10, 1981, may use an endorsement or rider to comply with this chapter if the endorsement or rider is approved by the commissioner as complying with this chapter and other provisions of this code.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

CHAPTER 1369. BENEFITS RELATED TO PRESCRIPTION DRUGS AND DEVICES AND RELATED SERVICES

SUBCHAPTER A. COVERAGE OF PRESCRIPTION DRUGS IN GENERAL

Sec. 1369.001. DEFINITIONS. In this subchapter:

(1) "Contraindication" means the potential for, or the occurrence of:

(A) an undesirable change in the therapeutic effect of a prescribed drug because of the presence of a disease condition in the patient for whom the drug is prescribed; or

(B) a clinically significant adverse effect of a prescribed drug on a disease condition of the patient for whom the drug is prescribed.

(2) "Drug" has the meaning assigned by Section 551.003, Occupations Code.

(2-a) "Enrollee" means an individual who is covered under a health benefit plan, including a covered dependent.

(3) "Indication" means a symptom, cause, or occurrence in a disease that points out the cause, diagnosis, course of treatment, or prognosis of the disease.

(4) "Peer-reviewed medical literature" means scientific studies published in a peer-reviewed national professional journal.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2017, 85th Leg., R.S., Ch. 727 (S.B. 1076), Sec. 1, eff. September 1, 2017.

Sec. 1369.002. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is offered by:

(1) an insurance company;

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

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

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

- (5) a reciprocal exchange operating under Chapter 942;
- (6) a health maintenance organization operating under Chapter 843;
- (7) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; or
- (8) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1369.003. EXCEPTION. 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;
 - (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 small employer health benefit plan written under Chapter 1501;
- (3) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss), as amended;
- (4) a workers' compensation insurance policy;
- (5) medical payment insurance coverage provided under a motor vehicle insurance policy; or
- (6) 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 as described by Section 1369.002.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1369.004. COVERAGE REQUIRED. (a) A health benefit plan

that covers drugs must cover any drug prescribed to treat an enrollee for a chronic, disabling, or life-threatening illness covered under the plan if the drug:

(1) has been approved by the United States Food and Drug Administration for at least one indication; and

(2) is recognized by the following for treatment of the indication for which the drug is prescribed:

(A) a prescription drug reference compendium approved by the commissioner for purposes of this section; or

(B) substantially accepted peer-reviewed medical literature.

(b) Coverage of a drug required under Subsection (a) must include coverage of medically necessary services associated with the administration of the drug.

(c) A health benefit plan issuer may not, based on a "medical necessity" requirement, deny coverage of a drug required under Subsection (a) unless the reason for the denial is unrelated to the legal status of the drug use.

(d) This section does not require a health benefit plan to cover:

(1) experimental drugs that are not otherwise approved for an indication by the United States Food and Drug Administration;

(2) any disease or condition that is excluded from coverage under the plan; or

(3) a drug that the United States Food and Drug Administration has determined to be contraindicated for treatment of the current indication.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1369.0041. CERTAIN PAYMENTS AND REFILLS. (a) A health benefit plan issuer that covers prescription drugs may not require an enrollee to make a payment for a prescription drug at the point of sale in an amount greater than the lesser of:

(1) the applicable copayment;

(2) the allowable claim amount for the prescription drug;
or

(3) the amount an individual would pay for the drug if the individual purchased the drug without using a health benefit plan or

any other source of drug benefits or discounts.

(b) A health benefit plan that covers prescription eye drops to treat a chronic eye disease or condition must allow the refill of prescription eye drops if the enrollee timely pays at the point of sale the maximum amount allowed by Subsection (a) and:

(1) the original prescription states that additional quantities of the eye drops are needed;

(2) the refill does not exceed the total quantity of dosage units authorized by the prescribing provider on the original prescription, including refills; and

(3) the refill is dispensed on or before the last day of the prescribed dosage period and:

(A) not earlier than the 21st day after the date a prescription for a 30-day supply of eye drops is dispensed;

(B) not earlier than the 42nd day after the date a prescription for a 60-day supply of eye drops is dispensed; or

(C) not earlier than the 63rd day after the date a prescription for a 90-day supply of eye drops is dispensed.

Added by Acts 2017, 85th Leg., R.S., Ch. 727 (S.B. [1076](#)), Sec. 2, eff. September 1, 2017.

Sec. 1369.005. RULES. The commissioner may adopt rules to implement this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

SUBCHAPTER B. REQUIREMENTS AFFECTING COVERAGE OF SPECIFIC PRESCRIPTION DRUGS OR COST SHARING

Sec. 1369.051. DEFINITIONS. In this subchapter:

(1) "Clinical practice guideline" means a statement systematically developed by a multidisciplinary panel of experts composed of physicians and, as necessary, other health care providers to assist a patient or health care provider in making a decision about appropriate health care for a specific clinical circumstance or condition.

(1-a) "Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols, and clinical practice guidelines used by a health benefit plan issuer,

utilization review organization, or independent review organization to determine the medical necessity and appropriateness or the experimental or investigational nature of a health care service or prescription drug.

(1-b) "Drug formulary" means a list of drugs:

(A) for which a health benefit plan provides coverage;

(B) for which a health benefit plan issuer approves payment; or

(C) that a health benefit plan issuer encourages or offers incentives for physicians to prescribe.

(2) "Enrollee" means an individual who is covered under a health benefit plan, including a covered dependent.

(3) "Physician" means a person licensed as a physician by the Texas State Board of Medical Examiners.

(4) "Prescription drug" has the meaning assigned by Section 551.003, Occupations Code.

(5) "Step therapy protocol" means a protocol that requires an enrollee to use a prescription drug or sequence of prescription drugs other than the drug that the enrollee's physician recommends for the enrollee's treatment before the health benefit plan provides coverage for the recommended drug.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 501 (H.B. 1405), Sec. 1, eff. September 1, 2011.

Acts 2017, 85th Leg., R.S., Ch. 103 (S.B. 680), Sec. 1, eff. September 1, 2017.

Sec. 1369.052. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a health benefit plan 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 a small or large employer group contract or similar coverage document that is offered by:

(1) an insurance company;

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

- (3) a fraternal benefit society operating under Chapter 885;
- (4) a stipulated premium company operating under Chapter 884;
- (5) a reciprocal exchange operating under Chapter 942;
- (6) a health maintenance organization operating under Chapter 843;
- (7) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; or
- (8) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 501 (H.B. 1405), Sec. 2, eff. September 1, 2011.

Text of section effective until April 1, 2025

Sec. 1369.053. EXCEPTION. This subchapter does not apply to:

- (1) a health benefit plan that provides coverage:
 - (A) only for a specified disease or for another single benefit;
 - (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 as described by Section 1369.052;

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

(7) a Medicaid managed care program operated under Chapter 533, Government Code, or a Medicaid program operated under Chapter 32, Human Resources Code.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 501 (H.B. 1405), Sec. 3, eff. September 1, 2011.

Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 2.125, eff. April 1, 2025.

Text of section effective on April 1, 2025

Sec. 1369.053. EXCEPTION. This subchapter does not apply to:

- (1) a health benefit plan that provides coverage:
 - (A) only for a specified disease or for another single benefit;
 - (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 as described by Section 1369.052;

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

(7) a Medicaid managed care program operated under Chapter 540 or 540A, Government Code, as applicable, or a Medicaid program operated under Chapter 32, Human Resources Code.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 501 (H.B. 1405), Sec. 3, eff. September 1, 2011.

Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 2.125, eff. April 1, 2025.

Sec. 1369.054. NOTICE AND DISCLOSURE OF CERTAIN INFORMATION REQUIRED. An issuer of a health benefit plan that covers prescription drugs and uses one or more drug formularies to specify the prescription drugs covered under the plan shall:

(1) provide in plain language in the coverage documentation provided to each enrollee:

(A) notice that the plan uses one or more drug formularies;

(B) an explanation of what a drug formulary is;

(C) a statement regarding the method the issuer uses to determine the prescription drugs to be included in or excluded from a drug formulary;

(D) a statement of how often the issuer reviews the contents of each drug formulary; and

(E) notice that an enrollee may contact the issuer to determine whether a specific drug is included in a particular drug formulary;

(2) disclose to an individual on request, not later than the third business day after the date of the request, whether a specific drug is included in a particular drug formulary; and

(3) notify an enrollee and any other individual who requests information under this section that the inclusion of a drug in a drug formulary does not guarantee that an enrollee's health care provider will prescribe that drug for a particular medical condition

or mental illness.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 501 (H.B. 1405), Sec. 4, eff. September 1, 2011.

Sec. 1369.0541. MODIFICATION OF DRUG COVERAGE UNDER PLAN. (a) A health benefit plan issuer may modify drug coverage provided under a health benefit plan if:

- (1) the modification occurs at the time of coverage renewal;
- (2) the modification is effective uniformly among all group health benefit plan sponsors covered by identical or substantially identical health benefit plans or all individuals covered by identical or substantially identical individual health benefit plans, as applicable; and
- (3) not later than the 60th day before the date the modification is effective, the issuer provides written notice of the modification to the commissioner, each affected group health benefit plan sponsor, each affected enrollee in an affected group health benefit plan, and each affected individual health benefit plan holder.

(b) Modifications affecting drug coverage that require notice under Subsection (a) include:

- (1) removing a drug from a formulary;
- (2) adding a requirement that an enrollee receive prior authorization for a drug;
- (3) imposing or altering a quantity limit for a drug;
- (4) imposing a step-therapy restriction for a drug; and
- (5) moving a drug to a higher cost-sharing tier unless a generic drug alternative to the drug is available.

(c) A health benefit plan issuer may elect to offer an enrollee in the plan the option of receiving notifications required by this section by e-mail.

Added by Acts 2011, 82nd Leg., R.S., Ch. 501 (H.B. 1405), Sec. 5, eff. September 1, 2011.

Sec. 1369.0542. EFFECT OF REDUCTIONS IN OUT-OF-POCKET EXPENSES ON COST SHARING. (a) This section applies only to a reduction in out-of-pocket expenses made by or on behalf of an enrollee for a prescription drug covered by the enrollee's health benefit plan for which:

(1) a generic equivalent does not exist;

(2) a generic equivalent does exist but the enrollee has obtained access to the prescription drug under the enrollee's health benefit plan using:

(A) a prior authorization process;

(B) a step therapy protocol; or

(C) the health benefit plan issuer's exceptions and appeals process;

(3) an interchangeable biological product does not exist;

or

(4) an interchangeable biological product does exist but the enrollee has obtained access to the prescription drug under the enrollee's health benefit plan using:

(A) a prior authorization process;

(B) a step therapy protocol; or

(C) the health benefit plan issuer's exceptions and appeals process.

(b) An issuer of a health benefit plan that covers prescription drugs or a pharmacy benefit manager shall apply any third-party payment, financial assistance, discount, product voucher, or other reduction in out-of-pocket expenses made by or on behalf of an enrollee for a prescription drug to the enrollee's deductible, copayment, cost-sharing responsibility, or out-of-pocket maximum applicable to health benefits under the enrollee's plan.

Added by Acts 2023, 88th Leg., R.S., Ch. 489 (H.B. 999), Sec. 2, eff. September 1, 2023.

Sec. 1369.0545. STEP THERAPY PROTOCOLS. (a) A health benefit plan issuer that requires a step therapy protocol before providing coverage for a prescription drug must establish, implement, and administer the step therapy protocol in accordance with clinical review criteria readily available to the health care industry. The health benefit plan issuer shall take into account the needs of

atypical patient populations and diagnoses in establishing the clinical review criteria. The clinical review criteria:

(1) must consider generally accepted clinical practice guidelines that are:

(A) developed and endorsed by a multidisciplinary panel of experts described by Subsection (b);

(B) based on high quality studies, research, and medical practice;

(C) created by an explicit and transparent process that:

(i) minimizes bias and conflicts of interest;

(ii) explains the relationship between treatment options and outcomes;

(iii) rates the quality of the evidence supporting the recommendations; and

(iv) considers relevant patient subgroups and preferences; and

(D) updated at appropriate intervals after a review of new evidence, research, and treatments; or

(2) if clinical practice guidelines described by Subdivision (1) are not reasonably available, may be based on peer-reviewed publications developed by independent experts, which may include physicians, with expertise applicable to the relevant health condition.

(b) A multidisciplinary panel of experts composed of physicians and, as necessary, other health care providers that develops and endorses clinical practice guidelines under Subsection (a)(1) must manage conflicts of interest by:

(1) requiring each member of the panel's writing or review group to:

(A) disclose any potential conflict of interest, including a conflict of interest involving an insurer, health benefit plan issuer, or pharmaceutical manufacturer; and

(B) recuse himself or herself in any situation in which the member has a conflict of interest;

(2) using a methodologist to work with writing groups to provide objectivity in data analysis and the ranking of evidence by preparing evidence tables and facilitating consensus; and

(3) offering an opportunity for public review and comment.

(c) Subsection (b) does not apply to a panel or committee of

experts, including a pharmacy and therapeutics committee, established by a health benefit plan issuer or a pharmacy benefit manager that advises the health benefit plan issuer or pharmacy benefit manager regarding drugs or formularies.

Added by Acts 2017, 85th Leg., R.S., Ch. 103 (S.B. 680), Sec. 2, eff. September 1, 2017.

Sec. 1369.0546. STEP THERAPY PROTOCOL EXCEPTION REQUESTS. (a) A health benefit plan issuer shall establish a process in a user-friendly format that is readily accessible to a patient and prescribing provider, in the health benefit plan's formulary document and otherwise, through which an exception request under this section may be submitted by the provider.

(b) A prescribing provider on behalf of a patient may submit to the patient's health benefit plan issuer a written request for an exception to a step therapy protocol required by the patient's health benefit plan. The provider shall submit the request on the standard form prescribed by the commissioner under Section 1369.304.

(c) A health benefit plan issuer shall grant a written request under Subsection (b) if the request includes the prescribing provider's written statement, with supporting documentation, stating that:

- (1) the drug required under the step therapy protocol:
 - (A) is contraindicated;
 - (B) will likely cause an adverse reaction in or physical or mental harm to the patient; or
 - (C) is expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug regimen;
- (2) the patient previously discontinued taking the drug required under the step therapy protocol, or another prescription drug in the same pharmacologic class or with the same mechanism of action as the required drug, while under the health benefit plan currently in force or while covered under another health benefit plan because the drug was not effective or had a diminished effect or because of an adverse event;
- (3) the drug required under the step therapy protocol is not in the best interest of the patient, based on clinical

appropriateness, because the patient's use of the drug is expected to:

(A) cause a significant barrier to the patient's adherence to or compliance with the patient's plan of care;

(B) worsen a comorbid condition of the patient; or

(C) decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; or

(4)(A) the drug that is subject to the step therapy protocol was prescribed for the patient's condition;

(B) the patient:

(i) received benefits for the drug under the health benefit plan currently in force or a previous health benefit plan; and

(ii) is stable on the drug; and

(C) the change in the patient's prescription drug regimen required by the step therapy protocol is expected to be ineffective or cause harm to the patient based on the known clinical characteristics of the patient and the known characteristics of the required prescription drug regimen.

(d) Except as provided by Subsection (e), if a health benefit plan issuer does not deny an exception request described by Subsection (c) before 72 hours after the health benefit plan issuer receives the request, the request is considered granted.

(e) If an exception request described by Subsection (c) also states that the prescribing provider reasonably believes that denial of the request makes the death of or serious harm to the patient probable, the request is considered granted if the health benefit plan issuer does not deny the request before 24 hours after the health benefit plan issuer receives the request.

(f) The denial of an exception request under this section is an adverse determination for purposes of Section 4201.002 and is subject to appeal under Subchapters H and I, Chapter 4201.

Added by Acts 2017, 85th Leg., R.S., Ch. 103 (S.B. 680), Sec. 2, eff. September 1, 2017.

Sec. 1369.0547. STEP THERAPY PROTOCOLS FOR PRESCRIPTION DRUGS TO TREAT SERIOUS MENTAL ILLNESSES. (a) In this section, "serious

mental illness" has the meaning assigned by Section 1355.001.

(b) This section applies only to a drug prescribed to an enrollee who is 18 years of age or older to treat a diagnosis of a serious mental illness.

(c) A health benefit plan that provides coverage for prescription drugs to treat a serious mental illness may not require, before the health benefit plan provides coverage of a prescription drug approved by the United States Food and Drug Administration, that the enrollee:

(1) fail to successfully respond to more than one different drug for each drug prescribed, excluding the generic or pharmaceutical equivalent of the prescribed drug; or

(2) prove a history of failure of more than one different drug for each drug prescribed, excluding the generic or pharmaceutical equivalent of the prescribed drug.

(d) Subject to Section 1369.0546, a health benefit plan issuer may implement a step therapy protocol to require a trial of a generic or pharmaceutical equivalent of a prescribed prescription drug as a condition of continued coverage of the prescribed drug only:

(1) once in a plan year; and

(2) if the generic or pharmaceutical equivalent drug is added to the plan's drug formulary.

Added by Acts 2023, 88th Leg., R.S., Ch. 684 (H.B. 1337), Sec. 1, eff. September 1, 2023.

Sec. 1369.055. CONTINUATION OF COVERAGE REQUIRED; OTHER DRUGS NOT PRECLUDED. (a) An issuer of a health benefit plan that covers prescription drugs shall offer to each enrollee at the contracted benefit level and until the enrollee's plan renewal date any prescription drug that was approved or covered under the plan for a medical condition or mental illness, regardless of whether the drug has been removed from the health benefit plan's drug formulary before the plan renewal date.

(b) This section does not prohibit a physician or other health professional who is authorized to prescribe a drug from prescribing a drug that is an alternative to a drug for which continuation of coverage is required under Subsection (a) if the alternative drug is:

(1) covered under the health benefit plan; and

(2) medically appropriate for the enrollee.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 501 (H.B. 1405), Sec. 6, eff. September 1, 2011.

Sec. 1369.056. ADVERSE DETERMINATION. (a) The refusal of a health benefit plan issuer to provide benefits to an enrollee for a prescription drug is an adverse determination for purposes of Section 4201.002 if:

(1) the drug is not included in a drug formulary used by the health benefit plan; and

(2) the enrollee's physician has determined that the drug is medically necessary.

(b) The enrollee may appeal the adverse determination under Subchapters H and I, Chapter 4201.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2G.012, eff. April 1, 2009.

Acts 2011, 82nd Leg., R.S., Ch. 501 (H.B. 1405), Sec. 7, eff. September 1, 2011.

Sec. 1369.057. RULES. The commissioner may adopt rules to implement this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

SUBCHAPTER B-1. TRANSPARENCY REQUIREMENTS FOR CERTAIN INDIVIDUAL HEALTH BENEFIT PLANS

Sec. 1369.076. DEFINITIONS. In this subchapter, terms defined by Subchapter B have the meanings assigned by that subchapter.

Added by Acts 2017, 85th Leg., R.S., Ch. 135 (H.B. 1227), Sec. 1, eff. September 1, 2017.

Sec. 1369.077. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to an individual health benefit plan to which Subchapter B applies.

Added by Acts 2017, 85th Leg., R.S., Ch. 135 (H.B. 1227), Sec. 1, eff. September 1, 2017.

Sec. 1369.078. FORMULARY INFORMATION ON INTERNET WEBSITE. (a) A health benefit plan issuer shall display on a public Internet website maintained by the issuer formulary information for each of the issuer's individual health benefit plans as required by the commissioner by rule.

(b) A direct electronic link to the formulary information must be displayed in a conspicuous manner in the electronic summary of benefits and coverage of each individual health benefit plan issued by the health benefit plan issuer on the health benefit plan issuer's Internet website. The information must be publicly accessible to enrollees, prospective enrollees, and others without necessity of providing a password, a user name, or personally identifiable information.

Added by Acts 2015, 84th Leg., R.S., Ch. 1038 (H.B. 1624), Sec. 1, eff. September 1, 2015.

Transferred, redesignated and amended from Insurance Code, Section 1369.0542 by Acts 2017, 85th Leg., R.S., Ch. 135 (H.B. 1227), Sec. 2, eff. September 1, 2017.

Sec. 1369.079. FORMULARY DISCLOSURE REQUIREMENTS. (a) The commissioner shall develop and adopt by rule requirements to promote consistency and clarity in the disclosure of formularies to facilitate comparison shopping among individual health benefit plans.

(b) The requirements adopted under Subsection (a) must apply to each prescription drug:

(1) included in a formulary and dispensed in a network pharmacy; or

(2) covered under an individual health benefit plan and typically administered by a physician or health care provider.

(c) The formulary disclosures must:

(1) be electronically searchable by drug name;

(2) include for each drug the information required by Subsection (d) in the order listed in that subsection; and

(3) indicate each formulary that applies to each individual health benefit plan issued by the issuer.

(d) The formulary disclosures must include for each drug:

(1) the cost-sharing amount for each drug, including as applicable:

(A) the dollar amount of a copayment; or

(B) for a drug subject to coinsurance:

(i) an enrollee's cost-sharing amount stated in dollars; or

(ii) a cost-sharing range, denoted as follows:

(a) under \$100 - \$;

(b) \$100-\$250 - \$\$;

(c) \$251-\$500 - \$\$\$;

(d) \$501-\$1,000 - \$\$\$\$; or

(e) over \$1,000 - \$\$\$\$\$;

(2) a disclosure of prior authorization, step therapy, or other protocol requirements for each drug;

(3) if the individual health benefit plan uses a tier-based formulary, the specific tier for each drug listed in the formulary;

(4) a description of how prescription drugs will specifically be included in or excluded from the deductible, including a description of out-of-pocket costs for a prescription drug that may not apply to the deductible;

(5) identification of preferred formulary drugs; and

(6) an explanation of coverage of each formulary drug.

(e) The commissioner by rule may allow an alternative method of making disclosures required under Subsection (d)(1) relating to cost-sharing through a web-based tool that must:

(1) be publicly accessible to enrollees, prospective enrollees, and others without necessity of providing a password, a user name, or personally identifiable information;

(2) allow consumers to electronically search formulary information by the name under which the individual health benefit plan is marketed; and

(3) be accessible through a direct link that is displayed on each page of the formulary disclosure that lists each drug as required under Subsection (c).

Added by Acts 2015, 84th Leg., R.S., Ch. 1038 (H.B. 1624), Sec. 1, eff. September 1, 2015.

Transferred, redesignated and amended from Insurance Code, Section 1369.0543 by Acts 2017, 85th Leg., R.S., Ch. 135 (H.B. 1227), Sec. 2, eff. September 1, 2017.

Sec. 1369.080. FORMULARY INFORMATION PROVIDED BY TOLL-FREE TELEPHONE NUMBER. In addition to providing the information described by Section 1369.079(d)(1) in the manner required by Section 1369.079, a health benefit plan issuer may make the information available to enrollees, prospective enrollees, and others through a toll-free telephone number that operates at least during normal business hours.

Added by Acts 2015, 84th Leg., R.S., Ch. 1038 (H.B. 1624), Sec. 1, eff. September 1, 2015.

Transferred, redesignated and amended from Insurance Code, Section 1369.0544 by Acts 2017, 85th Leg., R.S., Ch. 135 (H.B. 1227), Sec. 2, eff. September 1, 2017.

SUBCHAPTER B-2. DISCLOSURE OF CERTAIN PRESCRIPTION DRUG INFORMATION SPECIFIED BY DRUG FORMULARY

Sec. 1369.091. DEFINITIONS. In this subchapter:

(1) "Cost-sharing information" means the actual out-of-pocket amount an enrollee is required to pay a dispensing pharmacy or prescribing provider for a prescription drug under the enrollee's health benefit plan.

(2) "Drug formulary," "enrollee," and "prescription drug" have the meanings assigned by Section 1369.051.

(3) "Standard API" means an application interface that meets the requirements of an applicable American National Standards Institute (ANSI) accredited standard to conform to standards adopted under 45 C.F.R. Section 170.215.

Added by Acts 2023, 88th Leg., R.S., Ch. 272 (S.B. 622), Sec. 1, eff. September 1, 2023.

Sec. 1369.092. APPLICABILITY OF SUBCHAPTER. (a) This subchapter applies only to a health benefit plan that provides

benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is offered by:

- (1) an insurance company;
 - (2) a group hospital service corporation operating under Chapter 842;
 - (3) a health maintenance organization operating under Chapter 843;
 - (4) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844;
 - (5) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846;
 - (6) a stipulated premium company operating under Chapter 884;
 - (7) a fraternal benefit society operating under Chapter 885;
 - (8) a Lloyd's plan operating under Chapter 941; or
 - (9) an exchange operating under Chapter 942.
- (b) Notwithstanding any other law, this subchapter applies to:
- (1) a small employer health benefit plan subject to Chapter 1501, including coverage provided through a health group cooperative under Subchapter B of that chapter;
 - (2) a standard health benefit plan issued under Chapter 1507;
 - (3) a basic coverage plan under Chapter 1551;
 - (4) a basic plan under Chapter 1575;
 - (5) a primary care coverage plan under Chapter 1579;
 - (6) a plan providing basic coverage under Chapter 1601;
 - (7) alternative health benefit coverage offered by a subsidiary of the Texas Mutual Insurance Company under Subchapter M, Chapter 2054;
 - (8) a regional or local health care program operated under Section 75.104, Health and Safety Code; and
 - (9) a self-funded health benefit plan sponsored by a professional employer organization under Chapter 91, Labor Code.

Added by Acts 2023, 88th Leg., R.S., Ch. 272 (S.B. [622](#)), Sec. 1, eff. September 1, 2023.

Sec. 1369.093. EXCEPTIONS TO APPLICABILITY OF SUBCHAPTER. This subchapter does not apply to an issuer or provider of health benefits under or a pharmacy benefit manager administering pharmacy benefits under:

- (1) the state Medicaid program, including the Medicaid managed care program operated under Chapter 533, Government Code;
- (2) the child health plan program under Chapter 62, Health and Safety Code;
- (3) the TRICARE military health system; or
- (4) a workers' compensation insurance policy or other form of providing medical benefits under Title 5, Labor Code.

Added by Acts 2023, 88th Leg., R.S., Ch. 272 (S.B. 622), Sec. 1, eff. September 1, 2023.

Sec. 1369.094. DISCLOSURE OF PRESCRIPTION DRUG INFORMATION.

(a) This section applies only with respect to a prescription drug covered under a health benefit plan's pharmacy benefit.

(b) A health benefit plan issuer that covers prescription drugs shall provide information regarding a covered prescription drug to an enrollee or the enrollee's prescribing provider on request. The information provided must include the issuer's drug formulary and, for the prescription drug and any formulary alternative:

- (1) the enrollee's eligibility;
- (2) cost-sharing information, including any deductible, copayment, or coinsurance, which must:
 - (A) be consistent with cost-sharing requirements under the enrollee's plan;
 - (B) be accurate at the time the cost-sharing information is provided; and
 - (C) include any variance in cost-sharing based on the patient's preferred dispensing retail or mail-order pharmacy or the prescribing provider; and
- (3) applicable utilization management requirements.

(c) In providing the information required under Subsection (b), a health benefit plan issuer shall:

- (1) respond in real time to a request made through a

standard API;

(2) allow the use of an integrated technology or service as necessary to provide the required information;

(3) ensure that the information provided is current no later than one business day after the date a change is made; and

(4) provide the information if the request is made using the drug's unique billing code and National Drug Code.

(d) A health benefit plan issuer may not:

(1) deny or delay a response to a request for information under Subsection (b) for the purpose of blocking the release of the information;

(2) restrict a prescribing provider from communicating to the enrollee the information provided under Subsection (b), information about the cash price of the drug, or any additional information on any lower cost or clinically appropriate alternative drug, whether or not the drug is covered under the enrollee's plan;

(3) except as required by law, interfere with, prevent, or materially discourage access to or the exchange or use of the information provided under Subsection (b), including by:

(A) charging a fee to access the information;

(B) not responding to a request within the time required by this section; or

(C) instituting a consent requirement for an enrollee to access the information; or

(4) penalize, including by taking any action intended to punish or discourage future similar behavior by the prescribing provider, a prescribing provider for:

(A) disclosing the information provided under Subsection (b); or

(B) prescribing, administering, or ordering a lower cost or clinically appropriate alternative drug.

(e) A health benefit plan issuer with fewer than 10,000 enrollees may:

(1) register with the department to receive an additional 12 months after the effective date of this subchapter to comply with the requirements of this subchapter; and

(2) after the additional 12 months provided for in Subdivision (1), request from the department a temporary exception from one or more requirements of this section by submitting a report to the department that demonstrates that compliance would impose an

unreasonable cost relative to the public value that would be gained from full compliance.

Added by Acts 2023, 88th Leg., R.S., Ch. 272 (S.B. 622), Sec. 1, eff. September 1, 2023.

SUBCHAPTER C. COVERAGE OF PRESCRIPTION CONTRACEPTIVE DRUGS AND DEVICES AND RELATED SERVICES

Sec. 1369.101. DEFINITIONS. In this subchapter:

(1) "Enrollee" means a person who is entitled to benefits under a health benefit plan.

(2) "Outpatient contraceptive service" means a consultation, examination, procedure, or medical service that is provided on an outpatient basis and that is related to the use of a drug or device intended to prevent pregnancy.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1369.102. APPLICABILITY OF SUBCHAPTER. Except as otherwise provided by this subchapter, this subchapter applies only to a health benefit plan, including a small employer health benefit plan written under Chapter 1501, that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is offered by:

- (1) an insurance company;
- (2) a group hospital service corporation operating under Chapter 842;
- (3) a fraternal benefit society operating under Chapter 885;
- (4) a stipulated premium company operating under Chapter 884;
- (5) a reciprocal exchange operating under Chapter 942;
- (6) a health maintenance organization operating under Chapter 843;
- (7) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; or

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

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 395 (H.B. 916), Sec. 1, eff. September 1, 2023.

Sec. 1369.103. EXCEPTION. This subchapter does not apply to:

- (1) a health benefit plan that provides coverage only:
 - (A) for a specified disease or for another limited benefit other than for cancer;
 - (B) 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) for dental or vision care; or
 - (G) 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; or
- (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 as described by Section 1369.102.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1369.1031. CERTAIN COVERAGE REQUIRED. (a) This section applies to a health benefit plan described by Section 1369.102.

(b) Notwithstanding any other law, this section applies to:

- (1) a standard health benefit plan issued under Chapter 1507;
- (2) a basic coverage plan under Chapter 1551;

(3) a basic plan under Chapter 1575;
(4) a primary care coverage plan under Chapter 1579;
(5) a plan providing basic coverage under Chapter 1601;
(6) group health coverage made available by a school district in accordance with Section 22.004, Education Code; and
(7) the state Medicaid program, including the Medicaid managed care program operated under Chapter 533, Government Code.

(c) A health benefit plan that provides benefits for a prescription contraceptive drug must provide for an enrollee to obtain up to:

(1) a three-month supply of the covered prescription contraceptive drug at one time the first time the enrollee obtains the drug; and

(2) a 12-month supply of the covered prescription contraceptive drug at one time each subsequent time the enrollee obtains the same drug, regardless of whether the enrollee was enrolled in the health benefit plan the first time the enrollee obtained the drug.

(d) An enrollee may obtain only one 12-month supply of a covered prescription contraceptive drug during each 12-month period.

Added by Acts 2023, 88th Leg., R.S., Ch. 395 (H.B. 916), Sec. 2, eff. September 1, 2023.

Sec. 1369.104. EXCLUSION OR LIMITATION PROHIBITED. (a) A health benefit plan that provides benefits for prescription drugs or devices may not exclude or limit benefits to enrollees for:

(1) a prescription contraceptive drug or device approved by the United States Food and Drug Administration; or

(2) an outpatient contraceptive service.

(b) This section does not prohibit a limitation that applies to all prescription drugs or devices or all services for which benefits are provided under a health benefit plan.

(c) This section does not require a health benefit plan to cover abortifacients or any other drug or device that terminates a pregnancy.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1369.105. CERTAIN COST-SHARING PROVISIONS PROHIBITED. (a) A health benefit plan may not impose a deductible, copayment, coinsurance, or other cost-sharing provision applicable to benefits for prescription contraceptive drugs or devices unless the amount of the required cost-sharing is the same as or less than the amount of the required cost-sharing applicable to benefits for other prescription drugs or devices under the plan.

(b) A health benefit plan may not impose a deductible, copayment, coinsurance, or other cost-sharing provision applicable to benefits for outpatient contraceptive services unless the amount of the required cost-sharing is the same as or less than the amount of the required cost-sharing applicable to benefits for other outpatient services under the plan.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1369.106. CERTAIN WAITING PERIODS PROHIBITED. (a) A health benefit plan may not impose a waiting period applicable to benefits for prescription contraceptive drugs or devices unless the waiting period is the same as or shorter than any waiting period applicable to benefits for other prescription drugs or devices under the plan.

(b) A health benefit plan may not impose a waiting period applicable to benefits for outpatient contraceptive services unless the waiting period is the same as or shorter than any waiting period applicable to benefits for other outpatient services under the plan.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1369.107. PROHIBITED CONDUCT. A health benefit plan issuer may not:

(1) solely because of the applicant's or enrollee's use or potential use of a prescription contraceptive drug or device or an outpatient contraceptive service, deny:

(A) the eligibility of an applicant to enroll in the plan;

(B) the continued eligibility of an enrollee for coverage under the plan; or

(C) the eligibility of an enrollee to renew coverage

under the plan;

(2) provide a monetary incentive to an applicant for enrollment or an enrollee to induce the applicant or enrollee to accept coverage that does not satisfy the requirements of this subchapter; or

(3) reduce or limit a payment to a health care professional, or otherwise penalize the professional, because the professional prescribes a contraceptive drug or device or provides an outpatient contraceptive service.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1369.108. EXEMPTION FOR ENTITIES ASSOCIATED WITH RELIGIOUS ORGANIZATION. (a) This subchapter does not require a health benefit plan that is issued by an entity associated with a religious organization or any physician or health care provider providing medical or health care services under the plan to offer, recommend, offer advice concerning, pay for, provide, assist in, perform, arrange, or participate in providing or performing a medical or health care service that violates the religious convictions of the organization, unless the prescription contraceptive coverage is necessary to preserve the life or health of the enrollee.

(b) An issuer of a health benefit plan that excludes or limits coverage for medical or health care services under this section shall state the exclusion or limitation in:

- (1) the plan's coverage document;
- (2) the plan's statement of benefits;
- (3) plan brochures; and
- (4) other informational materials for the plan.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1369.109. ENFORCEMENT. A health benefit plan issuer that violates this subchapter is subject to the enforcement provisions of Subtitle B, Title 2.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

SUBCHAPTER D. PHARMACY BENEFIT CARDS

Sec. 1369.151. APPLICABILITY OF SUBCHAPTER. (a) This subchapter applies only to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is offered by:

- (1) an insurance company;
- (2) a group hospital service corporation operating under Chapter 842;
- (3) a fraternal benefit society operating under Chapter 885;
- (4) a stipulated premium company operating under Chapter 884;
- (5) a reciprocal exchange operating under Chapter 942;
- (6) a health maintenance organization operating under Chapter 843;
- (7) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; or
- (8) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844.

(b) Notwithstanding any other law, this subchapter applies to coverage under:

- (1) the basic coverage plan under Chapter 1551;
- (2) the basic plan under Chapter 1575;
- (3) the primary care coverage plan under Chapter 1579;
- (4) the basic coverage plan under Chapter 1601;
- (5) the child health plan program under Chapter 62, Health and Safety Code; and
- (6) the medical assistance program under Chapter 32, Human Resources Code.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1117 (H.B. [1138](#)), Sec. 1, eff. September 1, 2009.

Sec. 1369.152. EXCEPTION. 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;
 - (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 small employer health benefit plan written under Chapter 1501;
- (3) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);
- (4) a workers' compensation insurance policy;
- (5) medical payment insurance coverage provided under a motor vehicle insurance policy; or
- (6) 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 as described by Section 1369.151.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1369.153. INFORMATION REQUIRED ON IDENTIFICATION CARD.

- (a) An issuer of a health benefit plan that provides pharmacy benefits to enrollees shall include on the front of the identification card of each enrollee:
 - (1) the name of the entity administering the pharmacy benefits if the entity is different from the health benefit plan issuer;
 - (2) the group number applicable to the enrollee;
 - (3) the identification number of the enrollee, which may not be the enrollee's social security number;
 - (4) the bank identification number necessary for electronic billing;
 - (5) the effective date of the coverage evidenced by the

card; and

(6) copayment information for generic and brand-name prescription drugs.

(b) In addition to the information required under Subsection (a), the issuer of a health benefit plan shall include on the identification card of each enrollee:

(1) the logo of the entity administering the pharmacy benefits if the entity is different from the health benefit plan issuer; and

(2) a telephone number for contacting an appropriate person to obtain information relating to the pharmacy benefits provided under the plan.

(c) In addition to complying with Subsections (a) and (b), an issuer of a health benefit plan may provide the information required under Subsections (a) and (b) in electronically readable form on the back of the identification card.

(d) This section does not require a health benefit plan issuer that administers its own pharmacy benefits to issue an identification card separate from any identification card issued to an enrollee to evidence coverage under the plan if the identification card issued to evidence coverage contains the information required by Subsections (a) and (b).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1117 (H.B. [1138](#)), Sec. 2, eff. September 1, 2009.

Sec. 1369.154. RULES. (a) The commissioner shall adopt rules as necessary to implement this subchapter.

(b) Rules adopted by the commissioner must be consistent with national standards established by the Workgroup for Electronic Data Interchange or by other similar organizations recognized by the commissioner.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1117 (H.B. [1138](#)), Sec. 3, eff. September 1, 2009.

**SUBCHAPTER E. COVERAGE FOR ORALLY ADMINISTERED ANTICANCER
MEDICATIONS**

Sec. 1369.201. DEFINITIONS. In this subchapter:

(1) "Health benefit exchange" means an American Health Benefit Exchange administered by the federal government or created pursuant to Section 1311(b), Patient Protection and Affordable Care Act (42 U.S.C. Section 18031).

(2) "Qualified health plan" has the meaning assigned by Section 1301(a), Patient Protection and Affordable Care Act (42 U.S.C. Section 18021).

Added by Acts 2011, 82nd Leg., R.S., Ch. 105 (H.B. 438), Sec. 1, eff. September 1, 2011.

Sec. 1369.202. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a health benefit plan, including a small employer health benefit plan written under Chapter 1501 or coverage provided by a health group cooperative under Subchapter B of that chapter, that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is offered by:

- (1) an insurance company;
- (2) a group hospital service corporation operating under Chapter 842;
- (3) a fraternal benefit society operating under Chapter 885;
- (4) a stipulated premium company operating under Chapter 884;
- (5) an exchange operating under Chapter 942;
- (6) a Lloyd's plan operating under Chapter 941;
- (7) a health maintenance organization operating under Chapter 843; or
- (8) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844.

Added by Acts 2011, 82nd Leg., R.S., Ch. 105 (H.B. 438), Sec. 1, eff. September 1, 2011.

Sec. 1369.203. EXCEPTION. (a) This subchapter does not apply to:

- (1) a plan that provides coverage:
 - (A) only for fixed indemnity benefits for a specified disease or diseases;
 - (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) only for dental or vision care; or
 - (F) only for indemnity for hospital confinement;
 - (2) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);
 - (3) a workers' compensation insurance policy;
 - (4) medical payment insurance coverage provided under an automobile insurance policy;
 - (5) a credit insurance policy;
 - (6) a limited benefit policy that does not provide coverage for physical examinations or wellness exams;
 - (7) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; or
 - (8) 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 as described by Section 1369.201.
- (b) This subchapter does not apply to a qualified health plan offered through a health benefit exchange.

Added by Acts 2011, 82nd Leg., R.S., Ch. 105 (H.B. 438), Sec. 1, eff. September 1, 2011.

Sec. 1369.204. REQUIRED COVERAGE FOR ORALLY ADMINISTERED ANTICANCER MEDICATIONS. (a) A health benefit plan that provides coverage for cancer treatment must provide coverage for a prescribed, orally administered anticancer medication that is used to kill or slow the growth of cancerous cells on a basis no less favorable than

intravenously administered or injected cancer medications that are covered as medical benefits by the plan.

(b) This section does not prohibit a health benefit plan from requiring prior authorization for an orally administered anticancer medication. If an orally administered anticancer medication is authorized, the cost to the covered individual may not exceed the coinsurance or copayment that would be applied to a chemotherapy or other cancer treatment visit.

(c) A health benefit plan issuer may not reclassify anticancer medications or increase a coinsurance, copayment, deductible, or other out-of-pocket expense imposed on anticancer medications to achieve compliance with this section. Any plan change that otherwise increases an out-of-pocket expense applied to anticancer medications must also be applied to the majority of comparable medical or pharmaceutical benefits under the plan.

(d) This section does not prohibit a health benefit plan issuer from increasing cost-sharing for all benefits, including anticancer treatments.

Added by Acts 2011, 82nd Leg., R.S., Ch. 105 (H.B. 438), Sec. 1, eff. September 1, 2011.

**SUBCHAPTER E-1. COVERAGE OF PRESCRIPTION DRUGS FOR STAGE-FOUR
ADVANCED, METASTATIC CANCER**

Sec. 1369.211. DEFINITIONS. In this subchapter:

(1) "Associated conditions" means the symptoms or side effects associated with stage-four advanced, metastatic cancer or its treatment and which, in the judgment of the health care practitioner, further jeopardize the health of a patient if left untreated.

(2) "Stage-four advanced, metastatic cancer" means cancer that has spread from the primary or original site of the cancer to nearby tissues, lymph nodes, or other areas or parts of the body.

Added by Acts 2019, 86th Leg., R.S., Ch. 1350 (H.B. 1584), Sec. 1, eff. September 1, 2019.

Sec. 1369.212. APPLICABILITY OF SUBCHAPTER. (a) This subchapter applies only to a health benefit plan that provides benefits for medical or surgical expenses or pharmacy benefits

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 issued by:

- (1) an insurance company;
- (2) a group hospital service corporation operating under Chapter 842;
- (3) a health maintenance organization operating under Chapter 843;
- (4) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844;
- (5) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846;
- (6) a stipulated premium company operating under Chapter 884;
- (7) a fraternal benefit society operating under Chapter 885;
- (8) a Lloyd's plan operating under Chapter 941; or
- (9) an exchange operating under Chapter 942.

Text of subsection effective until April 1, 2025

- (b) Notwithstanding any other law, this subchapter applies to:
- (1) a small employer health benefit plan subject to Chapter 1501, including coverage provided through a health group cooperative under Subchapter B of that chapter;
 - (2) a standard health benefit plan issued under Chapter 1507;
 - (3) a basic coverage plan under Chapter 1551;
 - (4) a basic plan under Chapter 1575;
 - (5) a primary care coverage plan under Chapter 1579;
 - (6) a plan providing basic coverage under Chapter 1601;
 - (7) health benefits provided by or through a church benefits board under Subchapter I, Chapter 22, Business Organizations Code;
 - (8) group health coverage made available by a school district in accordance with Section 22.004, Education Code;
 - (9) the state Medicaid program, including the Medicaid managed care program operated under Chapter 533, Government Code;
 - (10) the child health plan program under Chapter 62, Health and Safety Code;

(11) a regional or local health care program operated under Section 75.104, Health and Safety Code; and

(12) a self-funded health benefit plan sponsored by a professional employer organization under Chapter 91, Labor Code.

Text of subsection effective on April 1, 2025

(b) Notwithstanding any other law, this subchapter applies to:

(1) a small employer health benefit plan subject to Chapter 1501, including coverage provided through a health group cooperative under Subchapter B of that chapter;

(2) a standard health benefit plan issued under Chapter 1507;

(3) a basic coverage plan under Chapter 1551;

(4) a basic plan under Chapter 1575;

(5) a primary care coverage plan under Chapter 1579;

(6) a plan providing basic coverage under Chapter 1601;

(7) health benefits provided by or through a church benefits board under Subchapter I, Chapter 22, Business Organizations Code;

(8) group health coverage made available by a school district in accordance with Section 22.004, Education Code;

(9) the state Medicaid program, including the Medicaid managed care program operated under Chapters 540 and 540A, Government Code;

(10) the child health plan program under Chapter 62, Health and Safety Code;

(11) a regional or local health care program operated under Section 75.104, Health and Safety Code; and

(12) a self-funded health benefit plan sponsored by a professional employer organization under Chapter 91, Labor Code.

(c) This subchapter applies to coverage under a group health benefit plan provided to a resident of this state regardless of whether the group policy, agreement, or contract is delivered, issued for delivery, or renewed in this state.

Added by Acts 2019, 86th Leg., R.S., Ch. 1350 (H.B. [1584](#)), Sec. 1, eff. September 1, 2019.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. [4611](#)), Sec. 2.126, eff. April 1, 2025.

Sec. 1369.213. PROHIBITED CONDUCT. (a) A health benefit plan that provides coverage for stage-four advanced, metastatic cancer and associated conditions may not require, before the health benefit plan provides coverage of a prescription drug approved by the United States Food and Drug Administration, that the enrollee:

- (1) fail to successfully respond to a different drug; or
- (2) prove a history of failure of a different drug.

(b) This section applies only to a drug the use of which is:

- (1) consistent with best practices for the treatment of stage-four advanced, metastatic cancer or an associated condition;
 - (2) supported by peer-reviewed, evidence-based literature;
- and
- (3) approved by the United States Food and Drug Administration.

Added by Acts 2019, 86th Leg., R.S., Ch. 1350 (H.B. 1584), Sec. 1, eff. September 1, 2019.

SUBCHAPTER F. AUDITS OF PHARMACISTS AND PHARMACIES

Sec. 1369.251. DEFINITIONS. In this subchapter:

(1) "Desk audit" means an audit conducted by a health benefit plan issuer or pharmacy benefit manager at a location other than the location of the pharmacist or pharmacy. The term includes an audit performed at the offices of the plan issuer or pharmacy benefit manager during which the pharmacist or pharmacy provides requested documents for review by hard copy or by microfiche, disk, or other electronic media. The term does not include a review conducted not later than the third business day after the date a claim is adjudicated provided recoupment is not demanded.

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

(3) "Health benefit plan" means a plan that provides benefits for medical, surgical, or other treatment expenses incurred as a result of a health condition, a mental health condition, an accident, sickness, or substance abuse, including:

(A) 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 issued by:

- (i) an insurance company;
 - (ii) a group hospital service corporation operating under Chapter 842;
 - (iii) a health maintenance organization operating under Chapter 843;
 - (iv) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844;
 - (v) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846;
 - (vi) a stipulated premium company operating under Chapter 884;
 - (vii) a fraternal benefit society operating under Chapter 885;
 - (viii) a Lloyd's plan operating under Chapter 941;
- or
- (ix) an exchange operating under Chapter 942;

(B) a small employer health benefit plan written under Chapter 1501; or

(C) a health benefit plan issued under Chapter 1551, 1575, 1579, or 1601.

(4) "On-site audit" means an audit that is conducted at:

- (A) the location of the pharmacist or pharmacy; or
- (B) another location at which the records under review are stored.

(5) "Pharmacy benefit manager" has the meaning assigned by Section 4151.151.

Added by Acts 2013, 83rd Leg., R.S., Ch. 915 (H.B. [1358](#)), Sec. 1, eff. September 1, 2013.

Sec. 1369.252. EXCEPTIONS TO APPLICABILITY OF SUBCHAPTER.

This subchapter does not apply to an issuer or provider of health benefits under or a pharmacy benefit manager administering pharmacy benefits under:

- (1) the state Medicaid program;

- (2) the federal Medicare program;
- (3) the state child health plan or health benefits plan for children under Chapter 62 or 63, Health and Safety Code;
- (4) the TRICARE military health system;
- (5) a workers' compensation insurance policy or other form of providing medical benefits under Title 5, Labor Code; or
- (6) a self-funded health benefit plan as defined by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.).

Added by Acts 2013, 83rd Leg., R.S., Ch. 915 (H.B. 1358), Sec. 1, eff. September 1, 2013.

Sec. 1369.253. CONFLICT WITH OTHER LAWS. If there is a conflict between this subchapter and a provision of Chapter 843 or 1301 related to a pharmacy benefit manager, this subchapter prevails.

Added by Acts 2013, 83rd Leg., R.S., Ch. 915 (H.B. 1358), Sec. 1, eff. September 1, 2013.

Sec. 1369.254. AUDIT OF PHARMACIST OR PHARMACY; NOTICE; GENERAL PROVISIONS. (a) Except as provided by Subsection (d), a health benefit plan issuer or pharmacy benefit manager that performs an on-site audit under this subchapter of a pharmacist or pharmacy shall provide the pharmacist or pharmacy reasonable notice of the audit and accommodate the pharmacist's or pharmacy's schedule to the greatest extent possible. The notice required under this subsection must be in writing and must be sent by a means that allows tracking of delivery to the pharmacist or pharmacy not later than the 14th day before the date on which the on-site audit is scheduled to occur.

(b) Not later than the seventh day after the date a pharmacist or pharmacy receives notice under Subsection (a), the pharmacist or pharmacy may request that an on-site audit be rescheduled to a mutually convenient date. The request must be reasonably granted.

(c) Unless the pharmacist or pharmacy consents in writing, a health benefit plan issuer or pharmacy benefit manager may not schedule or have an on-site audit conducted:

(1) except as provided by Subsection (d), before the 14th day after the date the pharmacist or pharmacy receives notice under

Subsection (a), if applicable;

(2) more than twice annually in connection with a particular payor; or

(3) during the first five calendar days of January and December.

(d) A health benefit plan issuer or pharmacy benefit manager is not required to provide notice before conducting an audit if, after reviewing claims data, written or oral statements of pharmacy staff, wholesalers, or others, or other investigative information, including patient referrals, anonymous reports, or postings on Internet websites, the plan issuer or pharmacy benefit manager suspects the pharmacist or pharmacy subject to the audit committed fraud or made an intentional misrepresentation related to the pharmacy business. The pharmacist or pharmacy may not request that the audit be rescheduled under Subsection (b).

(e) A pharmacist or pharmacy may be required to submit documents in response to a desk audit not earlier than the 20th day after the date the health benefit plan issuer or pharmacy benefit manager requests the documents.

(f) A contract between a pharmacist or pharmacy and a health benefit plan issuer or pharmacy benefit manager must state detailed audit procedures. If a health benefit plan issuer or pharmacy benefit manager proposes a change to the audit procedures for an on-site audit or a desk audit, the plan issuer or pharmacy benefit manager must notify the pharmacist or pharmacy in writing of a change in an audit procedure not later than the 60th day before the effective date of the change.

(g) The list of the claims subject to an on-site audit must be provided in the notice under Subsection (a) to the pharmacist or pharmacy and must identify the claims only by the prescription numbers or a date range for prescriptions subject to the audit. The last two digits of the prescription numbers provided may be omitted.

(h) If the health benefit plan issuer or pharmacy benefit manager in an on-site audit or a desk audit applies random sampling procedures to select claims for audit, the sample size may not be greater than 300 individual prescription claims.

Added by Acts 2013, 83rd Leg., R.S., Ch. 915 (H.B. [1358](#)), Sec. 1, eff. September 1, 2013.

Sec. 1369.255. COMPLETION OF AUDIT. An audit of a claim under Section 1369.254 must be completed on or before the one-year anniversary of the date the claim is received by the health benefit plan issuer or pharmacy benefit manager.

Added by Acts 2013, 83rd Leg., R.S., Ch. 915 (H.B. 1358), Sec. 1, eff. September 1, 2013.

Sec. 1369.256. AUDIT REQUIRING PROFESSIONAL JUDGMENT. A health benefit plan issuer or pharmacy benefit manager that conducts an on-site audit or a desk audit involving a pharmacist's clinical or professional judgment must conduct the audit in consultation with a licensed pharmacist.

Added by Acts 2013, 83rd Leg., R.S., Ch. 915 (H.B. 1358), Sec. 1, eff. September 1, 2013.

Sec. 1369.257. ACCESS TO PHARMACY AREA. A health benefit plan issuer or pharmacy benefit manager that conducts an on-site audit may not enter the pharmacy area unless escorted by an individual authorized by the pharmacist or pharmacy.

Added by Acts 2013, 83rd Leg., R.S., Ch. 915 (H.B. 1358), Sec. 1, eff. September 1, 2013.

Sec. 1369.258. VALIDATION USING CERTAIN RECORDS AUTHORIZED. A pharmacist or pharmacy that is being audited may:

(1) validate a prescription, refill of a prescription, or change in a prescription with a prescription that complies with applicable federal laws and regulations and state laws and rules adopted under Section 554.051, Occupations Code; and

(2) validate the delivery of a prescription with a written record of a hospital, physician, or other authorized practitioner of the healing arts.

Added by Acts 2013, 83rd Leg., R.S., Ch. 915 (H.B. 1358), Sec. 1, eff. September 1, 2013.

Sec. 1369.2581. AUDIT DISCREPANCIES; WHOLESale INVOICES. (a) A health benefit plan issuer or pharmacy benefit manager that audits wholesale invoices during an audit of a pharmacist or pharmacy may not audit the pharmacy claims of another health benefit plan or pharmacy benefit manager.

(b) A health benefit plan issuer or pharmacy benefit manager shall reverse a finding of a discrepancy if:

(1) the National Drug Code for the dispensed drug is in a quantity that is a subunit or multiple of the drug purchased by the pharmacist or pharmacy as supported by a wholesale invoice;

(2) the pharmacist or pharmacy dispensed the correct quantity of the drug according to the prescription; and

(3) the drug dispensed by the pharmacist or pharmacy shares all but the last two digits of the National Drug Code of the drug reflected on the supplier invoice.

(c) A health benefit plan issuer or pharmacy benefit manager must accept as evidence to support the validity of a pharmacy claim related to a dispensed drug:

(1) subject to validation, including validation by pharmacy purchase order and payment of a supplier invoice, copies of supplier invoices in the pharmacist's or pharmacy's possession, including:

(A) supplier invoices issued before the date the drug was dispensed and not earlier than 60 days before the first day of the audit period; and

(B) invoices and any supporting documents from any supplier authorized by federal or state law to transfer ownership of the drug acquired by the pharmacist or pharmacy; and

(2) reports required by any state board or agency.

(d) A health benefit plan issuer or pharmacy benefit manager must provide, not later than the fifth business day after the date of a request by the pharmacist or pharmacy, any supporting documents the pharmacist's or pharmacy's suppliers provided to the health benefit plan issuer or pharmacy benefit manager.

Added by Acts 2019, 86th Leg., R.S., Ch. 481 (H.B. [1455](#)), Sec. 1, eff. September 1, 2019.

Sec. 1369.259. CALCULATION OF RECOUPMENT; USE OF EXTRAPOLATION PROHIBITED. (a) A health benefit plan issuer or pharmacy benefit

manager may not calculate the amount of a recoupment based on:

(1) an absence of documentation the pharmacist or pharmacy is not required by applicable federal laws and regulations and state laws and rules to maintain; or

(2) an error that does not result in actual financial harm to the patient or enrollee, the health benefit plan issuer, or the pharmacy benefit manager.

(b) A health benefit plan issuer or pharmacy benefit manager may not require extrapolation audits as a condition of participation in a contract, network, or program for a pharmacist or pharmacy.

(c) A health benefit plan issuer or pharmacy benefit manager may not use extrapolation to complete an on-site audit or a desk audit of a pharmacist or pharmacy. Notwithstanding Subsection (a)(2), the amount of a recoupment must be based on the actual overpayment or underpayment and may not be based on an extrapolation.

(d) A health benefit plan issuer or pharmacy benefit manager may not include a dispensing fee amount in the calculation of an overpayment unless:

- (1) the fee was a duplicate charge;
- (2) the prescription for which the fee was charged:
 - (A) was not dispensed; or
 - (B) was dispensed:
 - (i) without the prescriber's authorization;
 - (ii) to the wrong patient; or
 - (iii) with the wrong instructions; or
- (3) the wrong drug was dispensed.

Added by Acts 2013, 83rd Leg., R.S., Ch. 915 (H.B. [1358](#)), Sec. 1, eff. September 1, 2013.

Sec. 1369.260. CLERICAL OR RECORDKEEPING ERROR; FRAUD ALLEGATION. (a) An unintentional clerical or recordkeeping error, such as a typographical error, scrivener's error, or computer error, found during an on-site audit or a desk audit:

- (1) is not prima facie evidence of fraud or intentional misrepresentation; and
- (2) may not be the basis of a recoupment unless the error results in actual financial harm to a patient or enrollee, health benefit plan issuer, or pharmacy benefit manager.

(b) If the health benefit plan issuer or pharmacy benefit manager alleges that the pharmacist or pharmacy committed fraud or intentional misrepresentation described by Subsection (a), the health benefit plan issuer or pharmacy benefit manager must state the allegation in the final audit report required by Section 1369.264.

(c) After an audit is initiated, a pharmacist or pharmacy may resubmit a claim described by Subsection (a) if the deadline for submission of a claim under Section 843.337 or 1301.102 has not expired.

Added by Acts 2013, 83rd Leg., R.S., Ch. 915 (H.B. 1358), Sec. 1, eff. September 1, 2013.

Sec. 1369.261. ACCESS TO PREVIOUS AUDIT REPORTS; UNIFORM AUDIT STANDARDS. (a) Except as provided by Subsection (b), a health benefit plan issuer or pharmacy benefit manager may have access to an audit report of a pharmacist or pharmacy only if the report was prepared in connection with an audit conducted by the health benefit plan issuer or pharmacy benefit manager.

(b) A health benefit plan issuer or pharmacy benefit manager may have access to audit reports other than the reports described by Subsection (a) if, after reviewing claims data, written or oral statements of pharmacy staff, wholesalers, or others, or other investigative information, including patient referrals, anonymous reports, or postings on Internet websites, the plan issuer or the pharmacy benefit manager suspects the audited pharmacist or pharmacy committed fraud or made an intentional misrepresentation related to the pharmacy business.

(c) An auditor must conduct an on-site audit or a desk audit of similarly situated pharmacists or pharmacies under the same audit standards.

Added by Acts 2013, 83rd Leg., R.S., Ch. 915 (H.B. 1358), Sec. 1, eff. September 1, 2013.

Sec. 1369.262. COMPENSATION OF AUDITOR. An individual performing an on-site audit or a desk audit may not directly or indirectly receive compensation based on a percentage of the amount recovered as a result of the audit.

Added by Acts 2013, 83rd Leg., R.S., Ch. 915 (H.B. 1358), Sec. 1, eff. September 1, 2013.

Sec. 1369.263. CONCLUSION OF AUDIT; SUMMARY; PRELIMINARY AUDIT REPORT. (a) At the conclusion of an on-site audit or a desk audit, the health benefit plan issuer or pharmacy benefit manager shall:

(1) provide to the pharmacist or pharmacy a summary of the audit findings; and

(2) allow the pharmacist or pharmacy to respond to questions and alleged discrepancies, if any, and comment on and clarify the findings.

(b) Not later than the 60th day after the date the audit is concluded, the health benefit plan issuer or pharmacy benefit manager shall send by a means that allows tracking of delivery to the pharmacist or pharmacy a preliminary audit report stating the results of the audit and a list identifying documentation, if any, required to resolve discrepancies, if any, found as a result of the audit.

(c) The pharmacist or pharmacy may, by providing documentation or otherwise, challenge a result or remedy a discrepancy stated in the preliminary audit report not later than the 30th day after the date the pharmacist or pharmacy receives the report.

(d) The pharmacist or pharmacy may request an extension to provide documentation supporting a challenge. The request shall be reasonably granted. A health benefit plan issuer or pharmacy benefit manager that grants an extension is not subject to the deadline to send the final audit report under Section 1369.264.

Added by Acts 2013, 83rd Leg., R.S., Ch. 915 (H.B. 1358), Sec. 1, eff. September 1, 2013.

Sec. 1369.264. FINAL AUDIT REPORT. Not later than the 120th day after the date the pharmacist or pharmacy receives a preliminary audit report under Section 1369.263, the health benefit plan issuer or pharmacy benefit manager shall send by a means that allows tracking of delivery to the pharmacist or pharmacy a final audit report that states:

(1) the audit results after review of the documentation submitted by the pharmacist or pharmacy in response to the

preliminary audit report; and

(2) the audit results, including a description of all alleged discrepancies and explanations for and the amount of recoupments claimed after consideration of the pharmacist's or pharmacy's response to the preliminary audit report.

Added by Acts 2013, 83rd Leg., R.S., Ch. 915 (H.B. 1358), Sec. 1, eff. September 1, 2013.

Sec. 1369.265. CERTAIN AUDITS EXEMPT FROM DEADLINES. A health benefit plan issuer or pharmacy benefit manager is not subject to the deadlines for sending a report under Sections 1369.263 and 1369.264 if, after reviewing claims data, written or oral statements of pharmacy staff, wholesalers, or others, or other investigative information, including patient referrals, anonymous reports, or postings on Internet websites, the plan issuer or pharmacy benefit manager suspects the audited pharmacist or pharmacy committed fraud or made an intentional misrepresentation related to the pharmacy business.

Added by Acts 2013, 83rd Leg., R.S., Ch. 915 (H.B. 1358), Sec. 1, eff. September 1, 2013.

Sec. 1369.266. RECOUPMENT AND INTEREST CHARGED AFTER AUDIT.

(a) If an audit under this subchapter is conducted, the health benefit plan issuer or pharmacy benefit manager:

(1) may recoup from the pharmacist or pharmacy an amount based only on a final audit report; and

(2) may not accrue or assess interest on an amount due until the date the pharmacist or pharmacy receives the final audit report under Section 1369.264.

(b) The limitations on recoupment and interest accrual or assessment under Subsection (a) do not apply to a health benefit plan issuer or pharmacy benefit manager that, after reviewing claims data, written or oral statements of pharmacy staff, wholesalers, or others, or other investigative information, including patient referrals, anonymous reports, or postings on Internet websites, suspects the audited pharmacist or pharmacy committed fraud or made an intentional misrepresentation related to the pharmacy business.

Added by Acts 2013, 83rd Leg., R.S., Ch. 915 (H.B. 1358), Sec. 1, eff. September 1, 2013.

Sec. 1369.267. WAIVER PROHIBITED. The provisions of this subchapter may not be waived, voided, or nullified by contract.

Added by Acts 2013, 83rd Leg., R.S., Ch. 915 (H.B. 1358), Sec. 1, eff. September 1, 2013.

Sec. 1369.268. REMEDIES NOT EXCLUSIVE. This subchapter may not be construed to waive a remedy at law available to a pharmacist or pharmacy.

Added by Acts 2013, 83rd Leg., R.S., Ch. 915 (H.B. 1358), Sec. 1, eff. September 1, 2013.

Sec. 1369.269. ENFORCEMENT; RULES. The commissioner may enforce this subchapter and adopt and enforce reasonable rules necessary to accomplish the purposes of this subchapter.

Added by Acts 2013, 83rd Leg., R.S., Ch. 915 (H.B. 1358), Sec. 1, eff. September 1, 2013.

Sec. 1369.270. LEGISLATIVE DECLARATION. Except as provided by Section 1369.252, it is the intent of the legislature that the requirements contained in this subchapter regarding the audit of claims to providers who are pharmacists or pharmacies apply to all health benefit plan issuers and pharmacy benefit managers unless otherwise prohibited by federal law.

Added by Acts 2013, 83rd Leg., R.S., Ch. 915 (H.B. 1358), Sec. 1, eff. September 1, 2013.

**SUBCHAPTER G. STANDARD REQUEST FORM FOR PRIOR AUTHORIZATION OF
PRESCRIPTION DRUG BENEFITS**

Sec. 1369.301. DEFINITION. In this subchapter, "prescription

drug" has the meaning assigned by Section 551.003, Occupations Code.

Added by Acts 2013, 83rd Leg., R.S., Ch. 1328 (S.B. 644), Sec. 1, eff. September 1, 2013.

Redesignated from Insurance Code, Section 1369.251 by Acts 2015, 84th Leg., R.S., Ch. 1236 (S.B. 1296), Sec. 21.001(38), eff. September 1, 2015.

Sec. 1369.302. APPLICABILITY OF SUBCHAPTER. (a) This subchapter applies only to a health benefit plan 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 a small or large employer group contract or similar coverage document that is offered by:

- (1) an insurance company;
- (2) a group hospital service corporation operating under Chapter 842;
- (3) a fraternal benefit society operating under Chapter 885;
- (4) a stipulated premium company operating under Chapter 884;
- (5) a reciprocal exchange operating under Chapter 942;
- (6) a health maintenance organization operating under Chapter 843;
- (7) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; or
- (8) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844.

(b) This subchapter applies to group health coverage made available by a school district in accordance with Section 22.004, Education Code.

(c) Notwithstanding any provision in Chapter 1551, 1575, 1579, or 1601 or any other law, this subchapter applies to:

- (1) a basic coverage plan under Chapter 1551;
- (2) a basic plan under Chapter 1575;
- (3) a primary care coverage plan under Chapter 1579; and
- (4) basic coverage under Chapter 1601.

(d) Notwithstanding any other law, this subchapter applies to

coverage under:

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

(2) the medical assistance program under Chapter 32, Human Resources Code.

Added by Acts 2013, 83rd Leg., R.S., Ch. 1328 (S.B. 644), Sec. 1, eff. September 1, 2013.

Redesignated from Insurance Code, Section 1369.252 by Acts 2015, 84th Leg., R.S., Ch. 1236 (S.B. 1296), Sec. 21.001(38), eff. September 1, 2015.

Sec. 1369.303. EXCEPTION. This subchapter does not apply to:

(1) a health benefit plan that provides coverage:

- (A) only for a specified disease or for another single benefit;
 - (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);
- (3) medical payment insurance coverage provided under a motor vehicle insurance policy;
- (4) 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 as described by Section 1369.302;
- (5) health and accident coverage provided by a risk pool created under Chapter 172, Local Government Code; or
- (6) a workers' compensation insurance policy.

Added by Acts 2013, 83rd Leg., R.S., Ch. 1328 (S.B. 644), Sec. 1, eff. September 1, 2013.

Redesignated from Insurance Code, Section 1369.253 by Acts 2015, 84th Leg., R.S., Ch. 1236 (S.B. 1296), Sec. 21.001(38), eff. September 1, 2015.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1236 (S.B. 1296), Sec. 21.002(14), eff. September 1, 2015.

Sec. 1369.304. STANDARD FORM. (a) The commissioner by rule shall:

(1) prescribe a single, standard form for requesting prior authorization of prescription drug benefits;

(2) require a health benefit plan issuer or the agent of the health benefit plan issuer that manages or administers prescription drug benefits to use the form for any prior authorization of prescription drug benefits required by the plan;

(3) require that the department and a health benefit plan issuer or the agent of the health benefit plan issuer that manages or administers prescription drug benefits make the form available electronically on the website of:

(A) the department;

(B) the health benefit plan issuer; and

(C) the agent of the health benefit plan issuer; and

(4) establish penalties for failure to accept the form and acknowledge receipt of the form as required by commissioner rule.

(b) Not later than the second anniversary of the date national standards for electronic prior authorization of benefits are adopted, a health benefit plan issuer or the agent of the health benefit plan issuer that manages or administers prescription drug benefits shall exchange prior authorization requests electronically with a prescribing provider who has e-prescribing capability and who initiates a request electronically.

(c) In prescribing a form under this section, the commissioner shall:

(1) develop the form with input from the advisory committee on uniform prior authorization forms established under Section 1369.305; and

(2) take into consideration:

(A) any form for requesting prior authorization of benefits that is widely used in this state or any form currently used

by the department;

(B) request forms for prior authorization of benefits established by the federal Centers for Medicare and Medicaid Services; and

(C) national standards, or draft standards, pertaining to electronic prior authorization of benefits.

Added by Acts 2013, 83rd Leg., R.S., Ch. 1328 (S.B. 644), Sec. 1, eff. September 1, 2013.

Redesignated from Insurance Code, Section 1369.254 by Acts 2015, 84th Leg., R.S., Ch. 1236 (S.B. 1296), Sec. 21.001(38), eff. September 1, 2015.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1236 (S.B. 1296), Sec. 21.002(15), eff. September 1, 2015.

Sec. 1369.305. ADVISORY COMMITTEE ON UNIFORM PRIOR AUTHORIZATION FORMS. (a) The commissioner shall appoint a committee to advise the commissioner on the technical, operational, and practical aspects of developing the single, standard prior authorization form required under Section 1369.304 for requesting prior authorization of prescription drug benefits.

(b) The advisory committee shall determine the following:

- (1) a single standard form for requesting prior authorization of prescription drug benefits;
- (2) the length of the standard prior authorization form;
- (3) the length of time allowed for acknowledgement of receipt of the form by the health benefit plan issuer or the agent of the health benefit plan issuer that manages or administers prescription drug benefits;
- (4) the acceptable methods to acknowledge receipt; and
- (5) the penalty imposed on the health benefit plan issuer or the agent of the health benefit plan issuer that manages or administers prescription drug benefits for failure to acknowledge receipt of the form.

(c) The commissioner shall consult the advisory committee with respect to any rule relating to a subject described by Section 1369.304 or this section before adopting the rule and may consult the committee as needed with respect to a subsequent amendment of an

adopted rule.

(d) Not later than the second anniversary of the final approval of the standard prior authorization form, and every two years subsequently, the commissioner shall convene the advisory committee to review the standard prior authorization form, examine the form's effectiveness and impact on patient safety, and determine whether changes are needed.

(e) The advisory committee shall be composed of the commissioner of insurance or the commissioner's designee, the executive commissioner of the Health and Human Services Commission or the executive commissioner's designee, and an equal number of members from each of the following groups:

- (1) physicians;
- (2) other prescribing health care providers;
- (3) consumers experienced with prior authorizations;
- (4) hospitals;
- (5) pharmacists;
- (6) specialty pharmacies;
- (7) pharmacy benefit managers;
- (8) specialty drug distributors;
- (9) health benefit plan issuers for the Texas Health Insurance Pool established under Chapter 1506;
- (10) health benefit plan issuers; and
- (11) health benefit plan networks of providers.

(f) A member of the advisory committee serves without compensation.

(g) Section 39.003(a) of this code and Chapter 2110, Government Code, do not apply to the advisory committee.

Added by Acts 2013, 83rd Leg., R.S., Ch. 1328 (S.B. 644), Sec. 1, eff. September 1, 2013.

Redesignated from Insurance Code, Section 1369.255 by Acts 2015, 84th Leg., R.S., Ch. 1236 (S.B. 1296), Sec. 21.001(38), eff. September 1, 2015.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1236 (S.B. 1296), Sec. 21.002(16), eff. September 1, 2015.

Sec. 1369.306. FAILURE TO USE OR ACKNOWLEDGE STANDARD FORM. If

a health benefit plan issuer or the agent of the health benefit plan issuer that manages or administers prescription drug benefits fails to use or accept the form prescribed under this subchapter or fails to acknowledge the receipt of a completed form submitted by a prescribing provider, as required by commissioner rule, the health benefit plan issuer or the agent of the health benefit plan issuer is subject to the penalties established by the commissioner.

Added by Acts 2013, 83rd Leg., R.S., Ch. 1328 (S.B. 644), Sec. 1, eff. September 1, 2013.

Redesignated from Insurance Code, Section 1369.256 by Acts 2015, 84th Leg., R.S., Ch. 1236 (S.B. 1296), Sec. 21.001(38), eff. September 1, 2015.

SUBCHAPTER H. MAXIMUM ALLOWABLE COST

Sec. 1369.351. DEFINITIONS. In this subchapter:

(1) "Health benefit plan" has the meaning assigned by Section 1369.251, as added by Chapter 915 (H.B. 1358), Acts of the 83rd Legislature, Regular Session, 2013.

(2) "Pharmacy benefit manager" has the meaning assigned by Section 4151.151.

Added by Acts 2015, 84th Leg., R.S., Ch. 596 (S.B. 332), Sec. 1, eff. January 1, 2016.

Text of section effective until April 1, 2025

Sec. 1369.352. CERTAIN BENEFITS EXCLUDED. This subchapter does not apply to maximum allowable costs for pharmacy benefits provided under:

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

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

(3) the child health plan program under Chapter 62, Health and Safety Code;

(4) the health benefits plan for children under Chapter 63, Health and Safety Code;

(5) a health benefit plan issued under Chapter 1551, 1575,

1579, or 1601; or

(6) a workers' compensation insurance policy or other form of providing medical benefits under Title 5, Labor Code.

Added by Acts 2015, 84th Leg., R.S., Ch. 596 (S.B. 332), Sec. 1, eff. January 1, 2016.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 2.127, eff. April 1, 2025.

Text of section effective on April 1, 2025

Sec. 1369.352. CERTAIN BENEFITS EXCLUDED. This subchapter does not apply to maximum allowable costs for pharmacy benefits provided under:

- (1) a Medicaid managed care program operated under Chapter 540 or 540A, Government Code, as applicable;
- (2) a Medicaid program operated under Chapter 32, Human Resources Code;
- (3) the child health plan program under Chapter 62, Health and Safety Code;
- (4) the health benefits plan for children under Chapter 63, Health and Safety Code;
- (5) a health benefit plan issued under Chapter 1551, 1575, 1579, or 1601; or
- (6) a workers' compensation insurance policy or other form of providing medical benefits under Title 5, Labor Code.

Added by Acts 2015, 84th Leg., R.S., Ch. 596 (S.B. 332), Sec. 1, eff. January 1, 2016.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 2.127, eff. April 1, 2025.

Sec. 1369.353. CRITERIA FOR DRUGS ON MAXIMUM ALLOWABLE COST LISTS. A health benefit plan issuer or pharmacy benefit manager may not include a drug on a maximum allowable cost list unless:

- (1) the drug:
 - (A) has an "A" or "B" rating in the most recent version

of the United States Food and Drug Administration's Approved Drug Products with Therapeutic Equivalence Evaluations, also known as the Orange Book; or

(B) is rated "NR" or "NA" or has a similar rating by a nationally recognized reference; and

(2) the drug is:

(A) generally available for purchase by pharmacists and pharmacies in this state from a national or regional wholesaler; and

(B) not obsolete.

Added by Acts 2015, 84th Leg., R.S., Ch. 596 (S.B. 332), Sec. 1, eff. January 1, 2016.

Sec. 1369.354. FORMULATION OF MAXIMUM ALLOWABLE COSTS; DISCLOSURES. (a) In formulating the maximum allowable cost price for a drug, a health benefit plan issuer or pharmacy benefit manager may only use the price of that drug and any drug listed as therapeutically equivalent to that drug in the most recent version of the United States Food and Drug Administration's Approved Drug Products with Therapeutic Equivalence Evaluations, also known as the Orange Book.

(b) Notwithstanding Subsection (a), if a therapeutically equivalent generic drug is unavailable or has limited market presence, a health benefit plan issuer or pharmacy benefit manager may place on a maximum allowable cost list a drug that has:

(1) a "B" rating in the most recent version of the United States Food and Drug Administration's Approved Drug Products with Therapeutic Equivalence Evaluations, also known as the Orange Book; or

(2) an "NR" or "NA" rating or a similar rating by a nationally recognized reference.

(c) A health benefit plan issuer or pharmacy benefit manager must, in accordance with Subsection (d), disclose to a pharmacist or pharmacy the sources of the pricing data used in formulating maximum allowable cost prices.

(d) The information described by Subsection (c) must be disclosed:

(1) on the date the health benefit plan issuer or pharmacy benefit manager enters into the contract with the pharmacist or

pharmacy; and

(2) after that contract date, on the request of the pharmacist or pharmacy.

Added by Acts 2015, 84th Leg., R.S., Ch. 596 (S.B. 332), Sec. 1, eff. January 1, 2016.

Sec. 1369.355. UPDATES. (a) A health benefit plan issuer or pharmacy benefit manager shall establish a process that will in a timely manner eliminate drugs from maximum allowable cost lists or modify maximum allowable cost prices to remain consistent with changes in pricing data used in formulating maximum allowable cost prices and product availability.

(b) A health benefit plan issuer or pharmacy benefit manager shall review and update maximum allowable cost price information for each drug at least once every seven days to reflect any modification of maximum allowable cost pricing.

Added by Acts 2015, 84th Leg., R.S., Ch. 596 (S.B. 332), Sec. 1, eff. January 1, 2016.

Sec. 1369.356. ACCESS TO MAXIMUM ALLOWABLE COST LISTS. A health benefit plan issuer or pharmacy benefit manager must provide to each pharmacist or pharmacy under contract with the health benefit plan issuer or pharmacy benefit manager a process to readily access the maximum allowable cost list that applies to the pharmacist or pharmacy.

Added by Acts 2015, 84th Leg., R.S., Ch. 596 (S.B. 332), Sec. 1, eff. January 1, 2016.

Sec. 1369.357. APPEAL FROM MAXIMUM ALLOWABLE COST PRICE DETERMINATION. (a) A health benefit plan issuer or pharmacy benefit manager must provide in the contract with each pharmacist or pharmacy a procedure for the pharmacist or pharmacy to appeal a maximum allowable cost price of a drug on or before the 10th day after the date a pharmacy benefit claim for the drug is made.

(b) The health benefit plan issuer or pharmacy benefit manager

shall respond to an appeal described by Subsection (a) in a documented communication not later than the 10th day after the date the appeal is received by the health benefit plan issuer or pharmacy benefit manager.

(c) If the appeal is successful, the health benefit plan issuer or pharmacy benefit manager shall:

(1) adjust the maximum allowable cost price that is the subject of the appeal effective on the day after the date the appeal is decided;

(2) apply the adjusted maximum allowable cost price to all similarly situated pharmacists and pharmacies as determined by the health benefit plan issuer or pharmacy benefit manager; and

(3) allow the pharmacist or pharmacy that succeeded in the appeal to reverse and rebill the pharmacy benefit claim giving rise to the appeal.

(d) If the appeal is not successful, the health benefit plan issuer or pharmacy benefit manager shall disclose to the pharmacist or pharmacy:

(1) each reason the appeal is denied; and

(2) the national drug code number from the national or regional wholesalers from which the drug is generally available for purchase by pharmacists and pharmacies in this state at the maximum allowable cost price that is the subject of the appeal.

Added by Acts 2015, 84th Leg., R.S., Ch. 596 (S.B. 332), Sec. 1, eff. January 1, 2016.

Sec. 1369.358. CONFIDENTIALITY OF MAXIMUM ALLOWABLE COST LIST. A maximum allowable cost list that applies to a pharmacist or pharmacy and is maintained by a health benefit plan issuer or pharmacy benefit manager is confidential. This section may not be construed to alter a health benefit plan issuer's or pharmacy benefit manager's obligations under Section 1369.356.

Added by Acts 2015, 84th Leg., R.S., Ch. 596 (S.B. 332), Sec. 1, eff. January 1, 2016.

Sec. 1369.359. WAIVER PROHIBITED. The provisions of this subchapter may not be waived, voided, or nullified by contract.

Added by Acts 2015, 84th Leg., R.S., Ch. 596 (S.B. 332), Sec. 1, eff. January 1, 2016.

Sec. 1369.360. REMEDIES NOT EXCLUSIVE. This subchapter may not be construed to waive a remedy at law available to a pharmacist or pharmacy.

Added by Acts 2015, 84th Leg., R.S., Ch. 596 (S.B. 332), Sec. 1, eff. January 1, 2016.

Sec. 1369.361. ENFORCEMENT. The commissioner shall enforce this subchapter.

Added by Acts 2015, 84th Leg., R.S., Ch. 596 (S.B. 332), Sec. 1, eff. January 1, 2016.

Sec. 1369.362. LEGISLATIVE DECLARATION. It is the intent of the legislature that, except with respect to the benefits excluded under Section 1369.352, the requirements contained in this subchapter apply to all health benefit plan issuers and pharmacy benefit managers unless otherwise prohibited by federal law.

Added by Acts 2015, 84th Leg., R.S., Ch. 596 (S.B. 332), Sec. 1, eff. January 1, 2016.

SUBCHAPTER I. PHARMACY BENEFIT CLAIM ADJUDICATION

Sec. 1369.401. DEFINITION. In this subchapter, "pharmacy benefit manager" has the meaning assigned by Section 4151.151.

Added by Acts 2015, 84th Leg., R.S., Ch. 10 (S.B. 94), Sec. 1, eff. September 1, 2015.

Sec. 1369.402. CERTAIN FEES PROHIBITED. A health benefit plan issuer or a pharmacy benefit manager may not directly or indirectly charge or hold a pharmacist or pharmacy responsible for a fee for any step of or component or mechanism related to the claim adjudication

process, including:

- (1) the adjudication of a pharmacy benefit claim;
- (2) the processing or transmission of a pharmacy benefit claim;
- (3) the development or management of a claim processing or adjudication network; or
- (4) participation in a claim processing or adjudication network.

Added by Acts 2015, 84th Leg., R.S., Ch. 10 (S.B. 94), Sec. 1, eff. September 1, 2015.

SUBCHAPTER J. COVERAGE RELATED TO PRESCRIPTION DRUG SYNCHRONIZATION

Sec. 1369.451. DEFINITIONS. In this subchapter:

- (1) "Cost-sharing amount" includes an amount charged for a deductible, coinsurance, or copayment.
- (2) "Health care provider" means a person who provides health care services under a license, certificate, registration, or other similar evidence of regulation issued by this or another state of the United States.
- (3) "Physician" means an individual licensed to practice medicine in this or another state of the United States.

Added by Acts 2017, 85th Leg., R.S., Ch. 1007 (H.B. 1296), Sec. 1, eff. September 1, 2017.

Sec. 1369.452. APPLICABILITY OF SUBCHAPTER. (a) This subchapter applies only to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is offered by:

- (1) an insurance company;
- (2) a group hospital service corporation operating under Chapter 842;
- (3) a health maintenance organization operating under Chapter 843;
- (4) an approved nonprofit health corporation that holds a

certificate of authority under Chapter 844;

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

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

(7) a fraternal benefit society operating under Chapter 885; or

(8) an exchange operating under Chapter 942.

(b) This subchapter applies to group health coverage made available by a school district in accordance with Section 22.004, Education Code.

(c) Notwithstanding any provision in Chapter 1551, 1575, 1579, or 1601 or any other law, this subchapter applies to health benefit plan coverage provided under:

(1) Chapter 1551;

(2) Chapter 1575;

(3) Chapter 1579; and

(4) Chapter 1601.

(d) Notwithstanding Section 1501.251 or any other law, this subchapter applies to coverage under a small employer health benefit plan subject to Chapter 1501.

(e) This subchapter applies to a standard health benefit plan issued under Chapter 1507.

Text of subsection effective until April 1, 2025

(f) To the extent allowed by federal law, the child health plan program operated under Chapter 62, Health and Safety Code, and the state Medicaid program, including the Medicaid managed care program operated under Chapter 533, Government Code, shall provide the coverage required under this subchapter to a recipient.

Text of subsection effective on April 1, 2025

(f) To the extent allowed by federal law, the child health plan program operated under Chapter 62, Health and Safety Code, and the state Medicaid program, including the Medicaid managed care program operated under Chapters 540 and 540A, Government Code, shall provide the coverage required under this subchapter to a recipient.

Added by Acts 2017, 85th Leg., R.S., Ch. 1007 (H.B. [1296](#)), Sec. 1, eff. September 1, 2017.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. [4611](#)), Sec. 2.128, eff.

April 1, 2025.

Sec. 1369.453. APPLICABILITY TO CERTAIN MEDICATIONS. This subchapter applies with respect to only a medication that:

- (1) is covered by the enrollee's health benefit plan;
- (2) meets the prior authorization criteria specifically applicable to the medication under the health benefit plan on the date the request for synchronization is made;
- (3) is used for treatment and management of a chronic illness, as that term is defined by Section 1369.456;
- (4) may be prescribed with refills;
- (5) is a formulation that can be effectively dispensed in accordance with the medication synchronization plan described by Section 1369.456; and
- (6) is not, according to the schedules established by the commissioner of the Department of State Health Services under Chapter 481, Health and Safety Code:
 - (A) a Schedule II controlled substance; or
 - (B) a Schedule III controlled substance containing hydrocodone.

Added by Acts 2017, 85th Leg., R.S., Ch. 1007 (H.B. 1296), Sec. 1, eff. September 1, 2017.

Sec. 1369.454. PRORATION OF COST-SHARING AMOUNT REQUIRED. (a) A health benefit plan that provides benefits for prescription drugs shall prorate any cost-sharing amount charged for a partial supply of a prescription drug if:

- (1) the pharmacy or the enrollee's prescribing physician or health care provider notifies the health benefit plan that:
 - (A) the quantity dispensed is to synchronize the dates that the pharmacy dispenses the enrollee's prescription drugs; and
 - (B) the synchronization of the dates is in the best interest of the enrollee; and
 - (2) the enrollee agrees to the synchronization.
- (b) The proration described by Subsection (a) must be based on the number of days' supply of the drug actually dispensed.

Added by Acts 2017, 85th Leg., R.S., Ch. 1007 (H.B. 1296), Sec. 1,

eff. September 1, 2017.

Sec. 1369.455. PRORATION OF DISPENSING FEE PROHIBITED. A health benefit plan that prorates a cost-sharing amount as required by Section 1369.454 may not prorate the fee paid to the pharmacy for dispensing the drug for which the cost-sharing amount was prorated.

Added by Acts 2017, 85th Leg., R.S., Ch. 1007 (H.B. 1296), Sec. 1, eff. September 1, 2017.

Sec. 1369.456. IMPLEMENTATION OF CERTAIN MEDICATION SYNCHRONIZATION PLANS. (a) For the purposes of this section:

(1) "Chronic illness" means an illness or physical condition that may be:

(A) reasonably expected to continue for an uninterrupted period of at least three months; and

(B) controlled but not cured by medical treatment.

(2) "Medication synchronization plan" means a plan established for the purpose of synchronizing the filling or refilling of multiple prescriptions.

(b) A health benefit plan shall establish a process through which the following parties may jointly approve a medication synchronization plan for medication to treat an enrollee's chronic illness:

(1) the health benefit plan;

(2) the enrollee;

(3) the prescribing physician or health care provider; and

(4) a pharmacist.

(c) A health benefit plan shall provide coverage for a medication dispensed in accordance with the dates established in the medication synchronization plan described by Subsection (b).

(d) A health benefit plan shall establish a process that allows a pharmacist or pharmacy to override the health benefit plan's denial of coverage for a medication described by Subsection (b).

(e) A health benefit plan shall allow a pharmacist or pharmacy to override the health benefit plan's denial of coverage through the process described by Subsection (d), and the health benefit plan shall provide coverage for the medication if:

(1) the prescription for the medication is being refilled in accordance with the medication synchronization plan described by Subsection (b); and

(2) the reason for the denial is that the prescription is being refilled before the date established by the plan's general prescription refill guidelines.

Added by Acts 2017, 85th Leg., R.S., Ch. 1007 (H.B. 1296), Sec. 1, eff. September 1, 2017.

SUBCHAPTER K. PRESCRIPTION DRUG COST TRANSPARENCY

Sec. 1369.501. DEFINITIONS. In this subchapter:

(1) "Animal health product" means a medical product approved and licensed for use in animal or veterinary medicine, including a pharmaceutical, a biologic, an insecticide, and a parasiticide.

(2) "Health benefit plan" means an individual, blanket, or group plan, policy, or contract for health care services issued or delivered by a health benefit plan issuer in this state.

(3) "Health benefit plan issuer" means an insurance company, a health maintenance organization, or a hospital and medical service corporation.

(4) "Pharmaceutical drug manufacturer" means a person engaged in the business of producing, preparing, propagating, compounding, converting, processing, packaging, labeling, or distributing a prescription drug. The term does not include a wholesale distributor or retailer of prescription drugs or a pharmacist licensed under Subtitle J, Title 3, Occupations Code.

(5) "Pharmacy benefit manager" has the meaning assigned by Section 4151.151.

(6) "Prescription drug" has the meaning assigned by Section 551.003, Occupations Code, except that the term "prescription drug" does not include a device or an animal health product.

(7) "Rebate" means a discount or concession that affects the price of a prescription drug to a pharmacy benefit manager or health benefit plan issuer for a prescription drug manufactured by the pharmaceutical drug manufacturer.

(8) "Specialty drug" means a prescription drug covered under Medicare Part D that exceeds the specialty tier cost threshold

established by the Centers for Medicare and Medicaid Services.

(9) "Utilization management" means a set of formal techniques designed to monitor the use of, or evaluate the medical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings.

Added by Acts 2019, 86th Leg., R.S., Ch. 1291 (H.B. 2536), Sec. 2, eff. September 1, 2019.

Sec. 1369.502. PHARMACY BENEFIT MANAGER INFORMATION. (a) Not later than March 1 of each year, each pharmacy benefit manager shall file a report with the commissioner. The report must state for the immediately preceding calendar year:

(1) the aggregated rebates, fees, price protection payments, and any other payments collected from pharmaceutical drug manufacturers; and

(2) the aggregated dollar amount of rebates, fees, price protection payments, and any other payments collected from pharmaceutical drug manufacturers that were:

(A) passed to:

(i) health benefit plan issuers; or

(ii) enrollees at the point of sale of a prescription drug; or

(B) retained as revenue by the pharmacy benefit manager.

(b) A report submitted by a pharmacy benefit manager may not disclose the identity of a specific health benefit plan or enrollee, the price charged for a specific prescription drug or class of prescription drugs, or the amount of any rebate or fee provided for a specific prescription drug or class of prescription drugs.

(c) Not later than June 1 of each year, the commissioner shall publish the aggregated data from all reports for that year required by this section in an appropriate location on the department's Internet website. The combined aggregated data from the reports must be published in a manner that does not disclose or tend to disclose proprietary or confidential information of any pharmacy benefit manager.

Added by Acts 2019, 86th Leg., R.S., Ch. 1291 (H.B. 2536), Sec. 2, eff. September 1, 2019.

Amended by:

Acts 2021, 87th Leg., R.S., Ch. 50 (H.B. 1033), Sec. 6, eff. September 1, 2021.

Sec. 1369.503. HEALTH BENEFIT PLAN ISSUER INFORMATION. (a) Not later than March 1 of each year, each health benefit plan issuer shall submit to the commissioner a report that states for the immediately preceding calendar year:

- (1) the names of the 25 most frequently prescribed prescription drugs across all plans;
- (2) the percent increase in annual net spending for prescription drugs across all plans;
- (3) the percent increase in premiums that were attributable to prescription drugs across all plans;
- (4) the percentage of specialty drugs with utilization management requirements across all plans; and
- (5) the premium reductions that were attributable to specialty drug utilization management.

(b) A report submitted by a health benefit plan issuer may not disclose the identity of a specific health benefit plan or the price charged for a specific prescription drug or class of prescription drugs.

(c) Not later than June 1 of each year, the commissioner shall publish the aggregated data from all reports for that year required by this section in an appropriate location on the department's Internet website. The combined aggregated data from the reports must be published in a manner that does not disclose or tend to disclose proprietary or confidential information of any health benefit plan issuer.

Added by Acts 2019, 86th Leg., R.S., Ch. 1291 (H.B. 2536), Sec. 2, eff. September 1, 2019.

Amended by:

Acts 2021, 87th Leg., R.S., Ch. 50 (H.B. 1033), Sec. 7, eff. September 1, 2021.

Sec. 1369.5035. CONTENT OF REPORTS. The reports required by Sections 1369.502 and 1369.503 must include information relating to

private health benefit plans that cover prescription drugs and are regulated by the department. The reports may not include information relating to:

- (1) the child health plan program under Chapter 62, Health and Safety Code, or the health benefits plan for children under Chapter 63, Health and Safety Code; or
- (2) the medical assistance program under Chapter 32, Human Resources Code.

Added by Acts 2021, 87th Leg., R.S., Ch. 50 (H.B. [1033](#)), Sec. 8, eff. September 1, 2021.

Sec. 1369.504. RULES. The commissioner may adopt rules to implement this subchapter.

Added by Acts 2019, 86th Leg., R.S., Ch. 1291 (H.B. [2536](#)), Sec. 2, eff. September 1, 2019.

SUBCHAPTER L. CONTRACTS WITH PHARMACISTS AND PHARMACIES

SUBCHAPTER L. AFFILIATED PROVIDERS

Sec. 1369.551. DEFINITIONS. In this subchapter:

(1) "Affiliated provider" means a pharmacy or durable medical equipment provider that directly, or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with a health benefit plan issuer or pharmacy benefit manager.

(2) "Health benefit plan" has the meaning assigned by Section 1369.251.

(3) "Pharmacy benefit manager" has the meaning assigned by Section 4151.151.

Added by Acts 2021, 87th Leg., R.S., Ch. 1012 (H.B. [1919](#)), Sec. 1, eff. September 1, 2021.

Text of section effective until April 1, 2025

Sec. 1369.552. EXCEPTIONS TO APPLICABILITY OF SUBCHAPTER. Notwithstanding the definition of "health benefit plan" provided by Section 1369.551, this subchapter does not apply to an issuer or

provider of health benefits under or a pharmacy benefit manager administering pharmacy benefits under:

- (1) the state Medicaid program, including the Medicaid managed care program operated under Chapter 533, Government Code;
- (2) the child health plan program under Chapter 62, Health and Safety Code;
- (3) the TRICARE military health system;
- (4) a basic coverage plan under Chapter 1551;
- (5) a basic plan under Chapter 1575;
- (6) a coverage plan under Chapter 1579;
- (7) a plan providing basic coverage under Chapter 1601; or
- (8) a workers' compensation insurance policy or other form of providing medical benefits under Title 5, Labor Code.

Added by Acts 2021, 87th Leg., R.S., Ch. 1012 (H.B. [1919](#)), Sec. 1, eff. September 1, 2021.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. [4611](#)), Sec. 2.129, eff. April 1, 2025.

Text of section effective on April 1, 2025

Sec. 1369.552. EXCEPTIONS TO APPLICABILITY OF SUBCHAPTER.

Notwithstanding the definition of "health benefit plan" provided by Section 1369.551, this subchapter does not apply to an issuer or provider of health benefits under or a pharmacy benefit manager administering pharmacy benefits under:

- (1) the state Medicaid program, including the Medicaid managed care program operated under Chapters 540 and 540A, Government Code;
- (2) the child health plan program under Chapter 62, Health and Safety Code;
- (3) the TRICARE military health system;
- (4) a basic coverage plan under Chapter 1551;
- (5) a basic plan under Chapter 1575;
- (6) a coverage plan under Chapter 1579;
- (7) a plan providing basic coverage under Chapter 1601; or
- (8) a workers' compensation insurance policy or other form of providing medical benefits under Title 5, Labor Code.

Added by Acts 2021, 87th Leg., R.S., Ch. 1012 (H.B. 1919), Sec. 1, eff. September 1, 2021.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 2.129, eff. April 1, 2025.

Sec. 1369.553. TRANSFER OR ACCEPTANCE OF CERTAIN RECORDS PROHIBITED. (a) In this section, "commercial purpose" does not include pharmacy reimbursement, formulary compliance, pharmaceutical care, utilization review by a health care provider, or a public health activity authorized by law.

(b) A health benefit plan issuer or pharmacy benefit manager may not transfer to or receive from the issuer's or manager's affiliated provider a record containing patient- or prescriber-identifiable prescription information for a commercial purpose.

Added by Acts 2021, 87th Leg., R.S., Ch. 1012 (H.B. 1919), Sec. 1, eff. September 1, 2021.

Sec. 1369.554. PROHIBITION ON CERTAIN COMMUNICATIONS. (a) A health benefit plan issuer or pharmacy benefit manager may not steer or direct a patient to use the issuer's or manager's affiliated provider through any oral or written communication, including:

(1) online messaging regarding the provider; or
(2) patient- or prospective patient-specific advertising, marketing, or promotion of the provider.

(b) This section does not prohibit a health benefit plan issuer or pharmacy benefit manager from including the issuer's or manager's affiliated provider in a patient or prospective patient communication, if the communication:

(1) is regarding information about the cost or service provided by pharmacies or durable medical equipment providers in the network of a health benefit plan in which the patient or prospective patient is enrolled; and

(2) includes accurate comparable information regarding pharmacies or durable medical equipment providers in the network that are not the issuer's or manager's affiliated providers.

Added by Acts 2021, 87th Leg., R.S., Ch. 1012 (H.B. 1919), Sec. 1,

eff. September 1, 2021.

Sec. 1369.555. PROHIBITION ON CERTAIN REFERRALS AND SOLICITATIONS. (a) A health benefit plan issuer or pharmacy benefit manager may not require a patient to use the issuer's or manager's affiliated provider in order for the patient to receive the maximum benefit for the service under the patient's health benefit plan.

(b) A health benefit plan issuer or pharmacy benefit manager may not offer or implement a health benefit plan that requires or induces a patient to use the issuer's or manager's affiliated provider, including by providing for reduced cost-sharing if the patient uses the affiliated provider.

(c) A health benefit plan issuer or pharmacy benefit manager may not solicit a patient or prescriber to transfer a patient prescription to the issuer's or manager's affiliated provider.

(d) A health benefit plan issuer or pharmacy benefit manager may not require a pharmacy or durable medical equipment provider that is not the issuer's or manager's affiliated provider to transfer a patient's prescription to the issuer's or manager's affiliated provider without the prior written consent of the patient.

Added by Acts 2021, 87th Leg., R.S., Ch. 1012 (H.B. 1919), Sec. 1, eff. September 1, 2021.

SUBCHAPTER M. CONTRACTS WITH PHARMACISTS AND PHARMACIES

Sec. 1369.601. DEFINITIONS. In this subchapter:

(1) "Pharmacy benefit manager" has the meaning assigned by Section 4151.151.

(2) "Pharmacy benefit network" means a network of pharmacies that have contracted with a pharmacy benefit manager to provide pharmacist services to enrollees.

(3) "Pharmacy services administrative organization" means an entity that contracts with a pharmacist or pharmacy to conduct on behalf of the pharmacist or pharmacy the pharmacist's or pharmacy's business with a third-party payor, including a pharmacy benefit manager, in connection with pharmacy benefits and to assist the pharmacist or pharmacy by providing administrative services, including negotiating, executing, and administering a contract with a

third-party payor and communicating with the third-party payor in connection with a contract or pharmacy benefits.

Added by Acts 2021, 87th Leg., R.S., Ch. 142 (H.B. 1763), Sec. 1, eff. September 1, 2021.

Redesignated from Insurance Code, Section 1369.551 by Acts 2023, 88th Leg., R.S., Ch. 768 (H.B. 4595), Sec. 24.001(27), eff. September 1, 2023.

Sec. 1369.602. APPLICABILITY OF SUBCHAPTER. (a) This subchapter applies only to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is offered by:

- (1) an insurance company;
- (2) a group hospital service corporation operating under Chapter 842;
- (3) a health maintenance organization operating under Chapter 843;
- (4) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844;
- (5) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846;
- (6) a stipulated premium company operating under Chapter 884;
- (7) a fraternal benefit society operating under Chapter 885;
- (8) a Lloyd's plan operating under Chapter 941; or
- (9) an exchange operating under Chapter 942.

(b) Notwithstanding any other law, this subchapter applies to:

- (1) a small employer health benefit plan subject to Chapter 1501, including coverage provided through a health group cooperative under Subchapter B of that chapter;
- (2) a standard health benefit plan issued under Chapter 1507;
- (3) health benefits provided by or through a church benefits board under Subchapter I, Chapter 22, Business Organizations

Code;

(4) group health coverage made available by a school district in accordance with Section 22.004, Education Code;

(5) a regional or local health care program operated under Section 75.104, Health and Safety Code; and

(6) a self-funded health benefit plan sponsored by a professional employer organization under Chapter 91, Labor Code.

(c) This subchapter does not apply to an issuer or provider of health benefits under or a pharmacy benefit manager administering pharmacy benefits under a workers' compensation insurance policy or other form of providing medical benefits under Title 5, Labor Code.

Added by Acts 2021, 87th Leg., R.S., Ch. 142 (H.B. 1763), Sec. 1, eff. September 1, 2021.

Redesignated from Insurance Code, Section 1369.552 by Acts 2023, 88th Leg., R.S., Ch. 768 (H.B. 4595), Sec. 24.001(27), eff. September 1, 2023.

Sec. 1369.603. REDUCTION OF CERTAIN CLAIM PAYMENT AMOUNTS PROHIBITED. (a) A health benefit plan issuer or pharmacy benefit manager may not directly or indirectly reduce the amount of a claim payment to a pharmacist or pharmacy after adjudication of the claim through the use of an aggregated effective rate, quality assurance program, other direct or indirect remuneration fee, or otherwise, except in accordance with an audit performed under Subchapter F.

(b) Nothing in this section prohibits a health benefit plan issuer or pharmacy benefit manager from increasing a claim payment amount after adjudication of the claim.

Added by Acts 2021, 87th Leg., R.S., Ch. 142 (H.B. 1763), Sec. 1, eff. September 1, 2021.

Redesignated from Insurance Code, Section 1369.553 by Acts 2023, 88th Leg., R.S., Ch. 768 (H.B. 4595), Sec. 24.001(27), eff. September 1, 2023.

Sec. 1369.604. REIMBURSEMENT OF AFFILIATED AND NONAFFILIATED PHARMACISTS AND PHARMACIES. (a) In this section:

(1) "Affiliated pharmacist or pharmacy" means a pharmacist or pharmacy that directly, or indirectly through one or more

intermediaries, controls or is controlled by, or is under common control with, a pharmacy benefit manager.

(2) "Nonaffiliated pharmacist or pharmacy" means a pharmacist or pharmacy that does not directly, or indirectly through one or more intermediaries, control and is not controlled by or under common control with a pharmacy benefit manager.

(b) A pharmacy benefit manager may not pay an affiliated pharmacist or pharmacy a reimbursement amount that is more than the amount the pharmacy benefit manager pays a nonaffiliated pharmacist or pharmacy for the same pharmacist service.

Added by Acts 2021, 87th Leg., R.S., Ch. 142 (H.B. 1763), Sec. 1, eff. September 1, 2021.

Redesignated from Insurance Code, Section 1369.554 by Acts 2023, 88th Leg., R.S., Ch. 768 (H.B. 4595), Sec. 24.001(27), eff. September 1, 2023.

Sec. 1369.605. NETWORK CONTRACT FEE SCHEDULE. A pharmacy benefit network contract must specify or reference a separate fee schedule. Unless otherwise available in the contract, the fee schedule must be provided electronically in an easily accessible and complete spreadsheet format and, on request, in writing to each contracted pharmacist and pharmacy. The fee schedule must describe:

- (1) specific services or procedures that the pharmacist or pharmacy may deliver and the amount of the corresponding payment;
- (2) a methodology for calculating the amount of the payment based on a published fee schedule; or
- (3) any other reasonable manner that provides an ascertainable amount for payment for services.

Added by Acts 2021, 87th Leg., R.S., Ch. 142 (H.B. 1763), Sec. 1, eff. September 1, 2021.

Redesignated from Insurance Code, Section 1369.555 by Acts 2023, 88th Leg., R.S., Ch. 768 (H.B. 4595), Sec. 24.001(27), eff. September 1, 2023.

Sec. 1369.606. DISCLOSURE OF PHARMACY SERVICES ADMINISTRATIVE ORGANIZATION CONTRACT. A pharmacist or pharmacy that is a member of a pharmacy services administrative organization that enters into a

contract with a health benefit plan issuer or pharmacy benefit manager on the pharmacist's or pharmacy's behalf is entitled to receive from the pharmacy services administrative organization a copy of the contract provisions applicable to the pharmacist or pharmacy, including each provision relating to the pharmacist's or pharmacy's rights and obligations under the contract.

Added by Acts 2021, 87th Leg., R.S., Ch. 142 (H.B. 1763), Sec. 1, eff. September 1, 2021.

Redesignated from Insurance Code, Section 1369.556 by Acts 2023, 88th Leg., R.S., Ch. 768 (H.B. 4595), Sec. 24.001(27), eff. September 1, 2023.

Sec. 1369.607. DELIVERY OF DRUGS. (a) Except in a case in which the health benefit plan issuer or pharmacy benefit manager makes a credible allegation of fraud against the pharmacist or pharmacy and provides reasonable notice of the allegation and the basis of the allegation to the pharmacist or pharmacy, a health benefit plan issuer or pharmacy benefit manager may not as a condition of a contract with a pharmacist or pharmacy prohibit the pharmacist or pharmacy from:

- (1) mailing or delivering a drug to a patient on the patient's request, to the extent permitted by law; or
- (2) charging a shipping and handling fee to a patient requesting a prescription be mailed or delivered if the pharmacist or pharmacy discloses to the patient before the delivery:
 - (A) the fee that will be charged; and
 - (B) that the fee may not be reimbursable by the health benefit plan issuer or pharmacy benefit manager.

(b) A pharmacist or pharmacy may not charge a health benefit plan issuer or pharmacy benefit manager for the delivery of a prescription drug as described by this section unless the charge is specifically agreed to by the health benefit plan issuer or pharmacy benefit manager.

Added by Acts 2021, 87th Leg., R.S., Ch. 142 (H.B. 1763), Sec. 1, eff. September 1, 2021.

Redesignated from Insurance Code, Section 1369.557 by Acts 2023, 88th Leg., R.S., Ch. 768 (H.B. 4595), Sec. 24.001(27), eff. September 1, 2023.

Sec. 1369.608. PROFESSIONAL STANDARDS AND SCOPE OF PRACTICE REQUIREMENTS. A health benefit plan issuer or pharmacy benefit manager may not as a condition of a contract with a pharmacist or pharmacy:

(1) require pharmacist or pharmacy accreditation standards or recertification requirements inconsistent with, more stringent than, or in addition to federal and state requirements; or

(2) prohibit a licensed pharmacist or pharmacy from dispensing any drug that may be dispensed under the pharmacist's or pharmacy's license unless:

(A) applicable state or federal law prohibits the pharmacist or pharmacy from dispensing the drug; or

(B) the manufacturer of the drug requires that a pharmacist or pharmacy possess one or more accreditations or certifications to dispense the drug and the pharmacist or pharmacy does not meet the requirement.

Added by Acts 2021, 87th Leg., R.S., Ch. 142 (H.B. 1763), Sec. 1, eff. September 1, 2021.

Redesignated from Insurance Code, Section 1369.558 by Acts 2023, 88th Leg., R.S., Ch. 768 (H.B. 4595), Sec. 24.001(27), eff. September 1, 2023.

Sec. 1369.609. RETALIATION PROHIBITED. (a) A pharmacy benefit manager may not retaliate against a pharmacist or pharmacy based on the pharmacist's or pharmacy's exercise of any right or remedy under this chapter. Retaliation prohibited by this section includes:

(1) terminating or refusing to renew a contract with the pharmacist or pharmacy;

(2) subjecting the pharmacist or pharmacy to increased audits; or

(3) failing to promptly pay the pharmacist or pharmacy any money owed by the pharmacy benefit manager to the pharmacist or pharmacy.

(b) For purposes of this section, a pharmacy benefit manager is not considered to have retaliated against a pharmacist or pharmacy if the pharmacy benefit manager:

(1) takes an action in response to a credible allegation of fraud against the pharmacist or pharmacy; and

(2) provides reasonable notice to the pharmacist or pharmacy of the allegation of fraud and the basis of the allegation before taking the action.

Added by Acts 2021, 87th Leg., R.S., Ch. 142 (H.B. 1763), Sec. 1, eff. September 1, 2021.

Redesignated from Insurance Code, Section 1369.559 by Acts 2023, 88th Leg., R.S., Ch. 768 (H.B. 4595), Sec. 24.001(27), eff. September 1, 2023.

Sec. 1369.610. WAIVER PROHIBITED. The provisions of this subchapter may not be waived, voided, or nullified by contract.

Added by Acts 2021, 87th Leg., R.S., Ch. 142 (H.B. 1763), Sec. 1, eff. September 1, 2021.

Redesignated from Insurance Code, Section 1369.560 by Acts 2023, 88th Leg., R.S., Ch. 768 (H.B. 4595), Sec. 24.001(27), eff. September 1, 2023.

SUBCHAPTER N. COVERAGE OF PRESCRIPTION DRUGS FOR AUTOIMMUNE DISEASES AND CERTAIN BLOOD DISORDERS

Sec. 1369.651. DEFINITION. In this subchapter, "prescription drug" has the meaning assigned by Section 551.003, Occupations Code.

Added by Acts 2023, 88th Leg., R.S., Ch. 669 (H.B. 755), Sec. 1, eff. September 1, 2023.

Sec. 1369.652. APPLICABILITY OF SUBCHAPTER. (a) This subchapter applies only to a health benefit plan that provides benefits for medical, surgical, or prescription drug 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 issued by:

(1) an insurance company;

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

(3) a health maintenance organization operating under Chapter 843;

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

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

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

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

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

(9) an exchange operating under Chapter 942.

(b) Notwithstanding any other law, this subchapter applies to:

(1) a small employer health benefit plan subject to Chapter 1501, including coverage provided through a health group cooperative under Subchapter B of that chapter;

(2) a standard health benefit plan issued under Chapter 1507;

(3) a basic coverage plan under Chapter 1551;

(4) a basic plan under Chapter 1575;

(5) a primary care coverage plan under Chapter 1579;

(6) a plan providing basic coverage under Chapter 1601;

(7) group health coverage made available by a school district in accordance with Section 22.004, Education Code; and

(8) a self-funded health benefit plan sponsored by a professional employer organization under Chapter 91, Labor Code.

(c) This subchapter applies to coverage under a group health benefit plan provided to a resident of this state regardless of whether the group policy, agreement, or contract is delivered, issued for delivery, or renewed in this state.

Added by Acts 2023, 88th Leg., R.S., Ch. 669 (H.B. [755](#)), Sec. 1, eff. September 1, 2023.

Sec. 1369.653. EXCEPTIONS. (a) This subchapter does not apply to:

(1) a plan that provides coverage:

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

(B) only for hospital expenses;

(2) the state Medicaid program, including the Medicaid managed care program operated under Chapter 533, Government Code; or

(3) the child health plan program under Chapter 62, Health and Safety Code.

(b) This subchapter does not apply to an individual health benefit plan issued on or before March 23, 2010, that has not had any significant changes since that date that reduce benefits or increase costs to the individual.

Added by Acts 2023, 88th Leg., R.S., Ch. 669 (H.B. 755), Sec. 1, eff. September 1, 2023.

Sec. 1369.654. PROHIBITION ON MULTIPLE PRIOR AUTHORIZATIONS.

(a) A health benefit plan issuer that provides prescription drug benefits may not require an enrollee to receive more than one prior authorization annually of the prescription drug benefit for a prescription drug prescribed to treat an autoimmune disease, hemophilia, or Von Willebrand disease.

(b) This section does not apply to:

(1) opioids, benzodiazepines, barbiturates, or carisoprodol;

(2) prescription drugs that have a typical treatment period of less than 12 months;

(3) drugs that:

(A) have a boxed warning assigned by the United States Food and Drug Administration for use; and

(B) must have specific provider assessment; or

(4) the use of a drug approved for use by the United States Food and Drug Administration in a manner other than the approved use.

Added by Acts 2023, 88th Leg., R.S., Ch. 669 (H.B. 755), Sec. 1, eff. September 1, 2023.

SUBCHAPTER Q. CLINICIAN-ADMINISTERED DRUGS

Sec. 1369.761. DEFINITIONS. In this subchapter:

(1) "Administer" means to directly apply a drug to the body of a patient by injection, inhalation, ingestion, or any other means.

(2) "Clinician-administered drug" means an outpatient prescription drug other than a vaccine that:

(A) cannot reasonably be:

(i) self-administered by the patient to whom the drug is prescribed; or

(ii) administered by an individual assisting the patient with the self-administration; and

(B) is typically administered:

(i) by a physician or other health care provider authorized under the laws of this state to administer the drug, including when acting under a physician's delegation and supervision; and

(ii) in a physician's office.

(3) "Health care provider" means an individual who is licensed, certified, or otherwise authorized to provide health care services in this state.

(4) "Physician" means an individual licensed to practice medicine in this state.

Added by Acts 2023, 88th Leg., R.S., Ch. 417 (H.B. 1647), Sec. 1, eff. September 1, 2023.

Sec. 1369.762. APPLICABILITY OF SUBCHAPTER. (a) This subchapter applies only to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is offered by:

(1) an insurance company;

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

(3) a health maintenance organization operating under Chapter 843;

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

(5) a multiple employer welfare arrangement that holds a

certificate of authority under Chapter 846;

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

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

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

(9) an exchange operating under Chapter 942.

(b) Notwithstanding any other law, this subchapter applies to:

(1) a small employer health benefit plan subject to Chapter 1501, including coverage provided through a health group cooperative under Subchapter B of that chapter;

(2) a standard health benefit plan issued under Chapter 1507;

(3) group health coverage made available by a school district in accordance with Section 22.004, Education Code;

(4) a regional or local health care program operating under Section 75.104, Health and Safety Code; and

(5) a self-funded health benefit plan sponsored by a professional employer organization under Chapter 91, Labor Code.

Added by Acts 2023, 88th Leg., R.S., Ch. 417 (H.B. 1647), Sec. 1, eff. September 1, 2023.

Sec. 1369.763. EXCEPTIONS TO APPLICABILITY OF SUBCHAPTER. (a) This subchapter does not apply to an issuer or provider of health benefits under or a pharmacy benefit manager administering pharmacy benefits under:

(1) the state Medicaid program, including the Medicaid managed care program under Chapter 533, Government Code;

(2) the child health plan program under Chapter 62, Health and Safety Code;

(3) the TRICARE military health system; or

(4) a workers' compensation insurance policy or other form of providing medical benefits under Title 5, Labor Code.

(b) This subchapter does not apply to a prescription drug administered in a hospital, hospital facility-based practice setting, or hospital outpatient infusion center.

Added by Acts 2023, 88th Leg., R.S., Ch. 417 (H.B. 1647), Sec. 1, eff. September 1, 2023.

Sec. 1369.764. CERTAIN LIMITATIONS ON COVERAGE OF CLINICIAN-ADMINISTERED DRUGS PROHIBITED. (a) Subject to Subsection (b), a health benefit plan issuer may not, for an enrollee with a chronic, complex, rare, or life-threatening medical condition:

(1) require clinician-administered drugs to be dispensed only by certain pharmacies or only by pharmacies participating in the health benefit plan issuer's network;

(2) if a clinician-administered drug is otherwise covered, limit or exclude coverage for such drugs based on the enrollee's choice of pharmacy or because the drug was not dispensed by a pharmacy that participates in the health benefit plan issuer's network;

(3) require a physician or health care provider participating in the health benefit plan issuer's network to bill for or be reimbursed for the delivery and administration of clinician-administered drugs under the pharmacy benefit instead of the medical benefit without:

(A) informed written consent of the patient; and

(B) a written attestation by the patient's physician or health care provider that a delay in the drug's administration will not place the patient at an increased health risk; or

(4) require that an enrollee pay an additional fee, higher copay, higher coinsurance, second copay, second coinsurance, or any other price increase for clinician-administered drugs based on the enrollee's choice of pharmacy or because the drug was not dispensed by a pharmacy that participates in the health benefit plan issuer's network.

(b) Subsection (a) applies only if the patient's physician or health care provider determines that:

(1) a delay of care would make disease progression probable; or

(2) the use of a pharmacy within the health benefit plan issuer's network would:

(A) make death or patient harm probable;

(B) potentially cause a barrier to the patient's adherence to or compliance with the patient's plan of care; or

(C) because of the timeliness of the delivery or dosage requirements, necessitate delivery by a different pharmacy.

(c) Nothing in this section may be construed to:

- (1) authorize a person to administer a drug when otherwise prohibited under the laws of this state or federal law; or
- (2) modify drug administration requirements under the laws of this state, including any requirements related to delegation and supervision of drug administration.

Added by Acts 2023, 88th Leg., R.S., Ch. 417 (H.B. 1647), Sec. 1, eff. September 1, 2023.

CHAPTER 1370. CERTAIN TESTS FOR DETECTION OF HUMAN PAPILLOMAVIRUS, OVARIAN CANCER, AND CERVICAL CANCER

Sec. 1370.001. APPLICABILITY OF CHAPTER. (a) This chapter applies only to a health benefit plan 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, an individual or group evidence of coverage, or a similar coverage document, that is offered by:

- (1) an insurance company;
- (2) a group hospital service corporation operating under Chapter 842;
- (3) a fraternal benefit society operating under Chapter 885;
- (4) a stipulated premium company operating under Chapter 884;
- (5) a health maintenance organization operating under Chapter 843;
- (6) a reciprocal exchange operating under Chapter 942;
- (7) a Lloyd's plan operating under Chapter 941;
- (8) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844; or
- (9) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846.

(b) This chapter applies to a small employer health benefit plan written under Chapter 1501.

Added by Acts 2005, 79th Leg., Ch. 577 (H.B. 1485), Sec. 1, eff. September 1, 2005.

Sec. 1370.002. EXCEPTIONS. (a) This chapter does not apply to:

(1) a plan that provides coverage:

- (A) only for benefits for a specified disease or for another limited benefit, other than a plan that provides benefits for cancer treatment or similar services;
 - (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) only for dental or vision care; or
 - (F) only for indemnity for hospital confinement;
- (2) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);
- (3) a workers' compensation insurance policy;
- (4) medical payment insurance coverage provided under an automobile insurance policy;
- (5) a credit insurance policy;
- (6) a limited benefit policy that does not provide coverage for physical examinations or wellness exams; or
- (7) 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 as described by Section 1370.001.

(b) To the extent that providing coverage for ovarian cancer screening under this chapter would otherwise require this state to make a payment under 42 U.S.C. Section 18031(d)(3)(B)(ii), a qualified health plan, as defined by 45 C.F.R. Section 155.20, is not required to provide a benefit for the ovarian cancer screening under this chapter that exceeds the specified essential health benefits required under 42 U.S.C. Section 18022(b).

Added by Acts 2005, 79th Leg., Ch. 577 (H.B. 1485), Sec. 1, eff. September 1, 2005.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 176 (H.B. 2813), Sec. 2, eff. September 1, 2015.

Sec. 1370.003. COVERAGE REQUIRED. (a) A health benefit plan

that provides coverage for diagnostic medical procedures must provide to each woman 18 years of age or older enrolled in the plan coverage for expenses for an annual medically recognized diagnostic examination for the early detection of ovarian cancer and cervical cancer.

(b) Coverage required under this section includes at a minimum:

(1) a CA 125 blood test;

(2) a conventional Pap smear screening or a screening using liquid-based cytology methods, as approved by the United States Food and Drug Administration, alone or in combination with a test approved by the United States Food and Drug Administration for the detection of the human papillomavirus; and

(3) any other test or screening approved by the United States Food and Drug Administration for the detection of ovarian cancer.

(c) A screening test required under this section must be performed in accordance with the guidelines adopted by:

(1) the American College of Obstetricians and Gynecologists; or

(2) another similar national organization of medical professionals recognized by the commissioner.

Added by Acts 2005, 79th Leg., Ch. 577 (H.B. 1485), Sec. 1, eff. September 1, 2005.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 176 (H.B. 2813), Sec. 3, eff. September 1, 2015.

Acts 2021, 87th Leg., R.S., Ch. 312 (H.B. 428), Sec. 1, eff. September 1, 2021.

Sec. 1370.004. NOTICE OF COVERAGE. (a) A health benefit plan issuer shall provide to each woman 18 years of age or older enrolled in the plan written notice of the coverage required under this chapter.

(b) The notice must be provided in accordance with rules adopted by the commissioner.

Added by Acts 2005, 79th Leg., Ch. 577 (H.B. 1485), Sec. 1, eff. September 1, 2005.

CHAPTER 1371. COVERAGE FOR CERTAIN PROSTHETIC DEVICES, ORTHOTIC DEVICES, AND RELATED SERVICES

Sec. 1371.001. DEFINITIONS. In this chapter:

(1) "Enrollee" means an individual entitled to coverage under a health benefit plan.

(2) "Orthotic device" means a custom-fitted or custom-fabricated medical device that is applied to a part of the human body to correct a deformity, improve function, or relieve symptoms of a disease.

(3) "Prosthetic device" means an artificial device designed to replace, wholly or partly, an arm or leg.

Added by Acts 2009, 81st Leg., R.S., Ch. 30 (H.B. 806), Sec. 1, eff. September 1, 2009.

Sec. 1371.002. APPLICABILITY OF CHAPTER. (a) This chapter applies only to a health benefit plan, including a small employer health benefit plan written under Chapter 1501 or coverage provided by a health group cooperative under Subchapter B of that chapter, that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is offered by:

- (1) an insurance company;
- (2) a group hospital service corporation operating under Chapter 842;
- (3) a fraternal benefit society operating under Chapter 885;
- (4) a stipulated premium company operating under Chapter 884;
- (5) a reciprocal exchange operating under Chapter 942;
- (6) a Lloyd's plan operating under Chapter 941;
- (7) a health maintenance organization operating under Chapter 843;
- (8) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; or
- (9) an approved nonprofit health corporation that holds a

certificate of authority under Chapter 844.

(b) Notwithstanding any provision in Chapter 1551, 1575, 1579, or 1601 or any other law, this chapter applies to:

- (1) a basic coverage plan under Chapter 1551;
- (2) a basic plan under Chapter 1575;
- (3) a primary care coverage plan under Chapter 1579; and
- (4) basic coverage under Chapter 1601.

Added by Acts 2009, 81st Leg., R.S., Ch. 30 (H.B. 806), Sec. 1, eff. September 1, 2009.

Sec. 1371.003. REQUIRED COVERAGE FOR PROSTHETIC DEVICES, ORTHOTIC DEVICES, AND RELATED SERVICES. (a) A health benefit plan must provide coverage for prosthetic devices, orthotic devices, and professional services related to the fitting and use of those devices that equals the coverage provided under federal laws for health insurance for the aged and disabled under Sections 1832, 1833, and 1834, Social Security Act (42 U.S.C. Sections 1395k, 1395l, and 1395m), and 42 C.F.R. Sections 410.100, 414.202, 414.210, and 414.228, as applicable.

(b) Covered benefits under this chapter are limited to the most appropriate model of prosthetic device or orthotic device that adequately meets the medical needs of the enrollee as determined by the enrollee's treating physician or podiatrist and prosthetist or orthotist, as applicable.

(c) Subject to applicable copayments and deductibles, the repair and replacement of a prosthetic device or orthotic device is a covered benefit under this chapter unless the repair or replacement is necessitated by misuse or loss by the enrollee.

(d) Coverage required under this section:

(1) must be provided in a manner determined to be appropriate in consultation with the treating physician or podiatrist and prosthetist or orthotist, as applicable, and the enrollee;

(2) may be subject to annual deductibles, copayments, and coinsurance that are consistent with annual deductibles, copayments, and coinsurance required for other coverage under the health benefit plan; and

(3) may not be subject to annual dollar limits.

(e) Covered benefits under this chapter may be provided by a

pharmacy that has employees who are qualified under the Medicare system and applicable Medicaid regulations to service and bill for orthotic services. This chapter does not preclude a pharmacy from being reimbursed by a health benefit plan for the provision of orthotic services.

Added by Acts 2009, 81st Leg., R.S., Ch. 30 (H.B. 806), Sec. 1, eff. September 1, 2009.

Sec. 1371.004. PREAUTHORIZATION. A health benefit plan may require prior authorization for a prosthetic device or an orthotic device in the same manner that the health benefit plan requires prior authorization for any other covered benefit.

Added by Acts 2009, 81st Leg., R.S., Ch. 30 (H.B. 806), Sec. 1, eff. September 1, 2009.

Sec. 1371.005. MANAGED CARE PLAN. A health benefit plan provider may require that, if coverage is provided through a managed care plan, the benefits mandated under this chapter are covered benefits only if the prosthetic devices or orthotic devices are provided by a vendor or a provider, and related services are rendered by a provider, that contracts with or is designated by the health benefit plan provider. If the health benefit plan provider provides in-network and out-of-network services, the coverage for prosthetic devices or orthotic devices provided through out-of-network services must be comparable to that provided through in-network services.

Added by Acts 2009, 81st Leg., R.S., Ch. 30 (H.B. 806), Sec. 1, eff. September 1, 2009.

CHAPTER 1372. COVERAGE FOR BIOMARKER TESTING

Sec. 1372.001. DEFINITIONS. In this chapter:

(1) "Biomarker" means a characteristic that is objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes, or pharmacologic responses to a specific therapeutic intervention. The term includes:

(A) gene mutations; and

(B) protein expression.

(2) "Biomarker testing" means the analysis of a patient's tissue, blood, or other biospecimen for the presence of a biomarker. The term includes:

- (A) single-analyte tests;
- (B) multiplex panel tests; and
- (C) whole genome sequencing.

(3) "Consensus statements" means statements that:

(A) address specific clinical circumstances based on the best available evidence for the purpose of optimizing clinical care outcomes; and

(B) are developed by an independent, multidisciplinary panel of experts that uses a transparent methodology and reporting structure and is subject to a conflict of interest policy.

(4) "Nationally recognized clinical practice guidelines" means evidence-based clinical practice guidelines that:

(A) establish a standard of care informed by a systematic review of evidence and an assessment of the benefits and costs of alternative care options;

(B) include recommendations intended to optimize patient care; and

(C) are developed by an independent organization or medical professional society that uses a transparent methodology and reporting structure and is subject to a conflict of interest policy.

Added by Acts 2023, 88th Leg., R.S., Ch. 279 (S.B. 989), Sec. 1, eff. September 1, 2023.

Sec. 1372.002. APPLICABILITY OF CHAPTER. (a) This chapter applies only to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is offered by:

- (1) an insurance company;
- (2) a group hospital service corporation operating under Chapter 842;
- (3) a health maintenance organization operating under

Chapter 843;

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

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

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

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

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

(9) an exchange operating under Chapter 942.

(b) Notwithstanding any other law, this chapter applies to:

(1) a small employer health benefit plan subject to Chapter 1501, including coverage provided through a health group cooperative under Subchapter B of that chapter;

(2) a standard health benefit plan issued under Chapter 1507;

(3) a basic coverage plan under Chapter 1551;

(4) a basic plan under Chapter 1575;

(5) a primary care coverage plan under Chapter 1579;

(6) a plan providing basic coverage under Chapter 1601;

(7) the state Medicaid program, including the Medicaid managed care program operated under Chapter 533, Government Code;

(8) the child health plan program under Chapter 62, Health and Safety Code; and

(9) a self-funded health benefit plan sponsored by a professional employer organization under Chapter 91, Labor Code.

Added by Acts 2023, 88th Leg., R.S., Ch. 279 (S.B. 989), Sec. 1, eff. September 1, 2023.

Sec. 1372.003. COVERAGE REQUIRED. (a) Subject to Subsection (b), a health benefit plan must provide coverage for biomarker testing for the purpose of diagnosis, treatment, appropriate management, or ongoing monitoring of an enrollee's disease or condition to guide treatment when the test is supported by the following kinds of medical and scientific evidence:

(1) a labeled indication for a test approved or cleared by the United States Food and Drug Administration;

(2) an indicated test for a drug approved by the United States Food and Drug Administration;

(3) a national coverage determination made by the Centers for Medicare and Medicaid Services or a local coverage determination made by a Medicare administrative contractor;

(4) nationally recognized clinical practice guidelines; or

(5) consensus statements.

(b) A health benefit plan issuer must provide coverage under Subsection (a) only when use of biomarker testing provides clinical utility because use of the test for the condition:

(1) is evidence-based;

(2) is scientifically valid based on the medical and scientific evidence described by Subsection (a);

(3) informs a patient's outcome and a provider's clinical decision; and

(4) predominately addresses the acute or chronic issue for which the test is being ordered, except that a test may include some information that cannot be immediately used in the formulation of a clinical decision.

(c) A health benefit plan must provide coverage under Subsection (a) in a manner that limits disruptions in care, including limiting the number of biopsies and biospecimen samples.

Added by Acts 2023, 88th Leg., R.S., Ch. 279 (S.B. 989), Sec. 1, eff. September 1, 2023.

CHAPTER 1376. CERTAIN TESTS FOR EARLY DETECTION OF CARDIOVASCULAR DISEASE

Sec. 1376.001. APPLICABILITY OF CHAPTER. (a) This chapter applies only to a health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(i) an insurance company;

(ii) a group hospital service corporation operating

under Chapter 842;

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

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

(v) a stipulated premium company operating under Chapter 884; or

(vi) a health maintenance organization operating under Chapter 843;

(B) a health benefit plan that is offered by a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846;

(C) a small employer health benefit plan written under Chapter 1501; or

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

(2) is offered by an approved nonprofit health corporation operating under Chapter 844.

(b) Notwithstanding any provision in Chapter 1601 or any other law, this chapter applies to basic coverage under Chapter 1601.

Added by Acts 2009, 81st Leg., R.S., Ch. 1270 (H.B. [1290](#)), Sec. 1, eff. September 1, 2009.

Sec. 1376.002. EXCEPTIONS. This chapter does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease or other limited benefit;

(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; or

(E) only for indemnity for hospital confinement;

(2) a standard health benefit plan issued under Chapter 1507;

(3) a workers' compensation insurance policy;

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

(5) a long-term care 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 as described by Section 1376.001.

Added by Acts 2009, 81st Leg., R.S., Ch. 1270 (H.B. 1290), Sec. 1, eff. September 1, 2009.

Sec. 1376.003. MINIMUM COVERAGE REQUIRED. (a) A health benefit plan that provides coverage for screening medical procedures must provide the minimum coverage required by this section to each covered individual:

(1) who is:

(A) a male older than 45 years of age and younger than 76 years of age; or

(B) a female older than 55 years of age and younger than 76 years of age; and

(2) who:

(A) is diabetic; or

(B) has a risk of developing coronary heart disease, based on a score derived using the Framingham Heart Study coronary prediction algorithm, that is intermediate or higher.

(b) The minimum coverage required to be provided under this section is coverage of up to \$200 for one of the following noninvasive screening tests for atherosclerosis and abnormal artery structure and function every five years, performed by a laboratory that is certified by a national organization recognized by the commissioner by rule for the purposes of this section:

(1) computed tomography (CT) scanning measuring coronary artery calcification; or

(2) ultrasonography measuring carotid intima-media thickness and plaque.

Added by Acts 2009, 81st Leg., R.S., Ch. 1270 (H.B. 1290), Sec. 1, eff. September 1, 2009.

**CHAPTER 1377. COVERAGE FOR CERTAIN AMINO ACID-BASED ELEMENTAL
FORMULAS
SUBCHAPTER A. GENERAL PROVISIONS**

Sec. 1377.001. DEFINITION. In this chapter, "enrollee" means an individual entitled to coverage under a health benefit plan.

Added by Acts 2009, 81st Leg., R.S., Ch. 1129 (H.B. 2000), Sec. 1, eff. September 1, 2009.

Sec. 1377.002. APPLICABILITY OF CHAPTER. (a) This chapter applies only to a health benefit plan, including a small employer health benefit plan written under Chapter 1501 or coverage provided by a health group cooperative under Subchapter B of that chapter, that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is offered by:

- (1) an insurance company;
- (2) a group hospital service corporation operating under Chapter 842;
- (3) a fraternal benefit society operating under Chapter 885;
- (4) a stipulated premium company operating under Chapter 884;
- (5) an exchange operating under Chapter 942;
- (6) a Lloyd's plan operating under Chapter 941;
- (7) a health maintenance organization operating under Chapter 843;
- (8) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; or
- (9) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844.

(b) Notwithstanding any provision in Chapter 1551, 1575, 1579, or 1601 or any other law, this chapter applies to:

- (1) a basic coverage plan under Chapter 1551;
- (2) a basic plan under Chapter 1575;
- (3) a primary care coverage plan under Chapter 1579; and
- (4) basic coverage under Chapter 1601.

Added by Acts 2009, 81st Leg., R.S., Ch. 1129 (H.B. 2000), Sec. 1, eff. September 1, 2009.

Sec. 1377.003. EXCEPTION. This chapter does not apply to:

(1) a plan that provides coverage:

(A) only for benefits for a specified disease or for another limited benefit, other than a plan that provides benefits for a disease or disorder listed in Section 1377.051(a);

(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) only for dental or vision care; or

(F) only for indemnity for hospital confinement;

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

(3) a workers' compensation insurance policy;

(4) medical payment insurance coverage provided under an automobile insurance policy;

(5) a credit insurance policy;

(6) a limited benefit policy that does not provide coverage for physical examinations or wellness exams; or

(7) 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 as described by Section 1377.002.

Added by Acts 2009, 81st Leg., R.S., Ch. 1129 (H.B. 2000), Sec. 1, eff. September 1, 2009.

SUBCHAPTER B. COVERAGE FOR CERTAIN AMINO ACID-BASED ELEMENTAL FORMULAS

Sec. 1377.051. REQUIRED COVERAGE FOR CERTAIN AMINO ACID-BASED ELEMENTAL FORMULAS. (a) A health benefit plan must provide coverage as provided by this chapter for amino acid-based elemental formulas, regardless of the formula delivery method, that are used for the diagnosis and treatment of:

(1) immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins;

(2) severe food protein-induced enterocolitis syndrome;
 (3) eosinophilic disorders, as evidenced by the results of a biopsy; and
 (4) impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract.

(b) Subject to Subsection (c), the coverage required under Subsection (a) is required if the treating physician has issued a written order stating that the amino acid-based elemental formula is medically necessary for the treatment of an enrollee who is diagnosed with a disease or disorder listed in Subsection (a). The coverage must include coverage of any medically necessary services associated with the administration of the formula.

(c) A health benefit plan must provide the coverage described by Subsection (a) on a basis no less favorable than the basis on which prescription drugs and other medications and related services are covered by the plan, and to the same extent that the plan provides coverage for drugs that are available only on the orders of a physician.

Added by Acts 2009, 81st Leg., R.S., Ch. 1129 (H.B. 2000), Sec. 1, eff. September 1, 2009.

Sec. 1377.052. UTILIZATION REVIEW. (a) A utilization review agent acting on behalf of a health benefit plan issuer may review a treating physician's determination of the medical necessity of the use of an amino acid-based elemental formula for the treatment of an enrollee who is diagnosed with a disease or disorder listed in Section 1377.051(a).

(b) Utilization review under this section is subject to Chapter 4201.

Added by Acts 2009, 81st Leg., R.S., Ch. 1129 (H.B. 2000), Sec. 1, eff. September 1, 2009.

CHAPTER 1379. COVERAGE FOR ROUTINE PATIENT CARE COSTS FOR ENROLLEES PARTICIPATING IN CERTAIN CLINICAL TRIALS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1379.001. DEFINITIONS. In this chapter:

(1) "Enrollee" means an individual entitled to coverage under a health benefit plan.

(2) "Life-threatening disease or condition" means a disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

(3) "Research institution" means the institution or other person or entity conducting a phase I, phase II, phase III, or phase IV clinical trial.

Added by Acts 2009, 81st Leg., R.S., Ch. 719 (S.B. 39), Sec. 1, eff. September 1, 2009.

Sec. 1379.002. APPLICABILITY OF CHAPTER. (a) This chapter applies only to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is offered by:

- (1) an insurance company;
- (2) a group hospital service corporation operating under Chapter 842;
- (3) a fraternal benefit society operating under Chapter 885;
- (4) a stipulated premium company operating under Chapter 884;
- (5) an exchange operating under Chapter 942;
- (6) a health maintenance organization operating under Chapter 843;
- (7) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; or
- (8) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844.

(b) This chapter applies to group health coverage made available by a school district in accordance with Section 22.004, Education Code.

(c) Notwithstanding any provision in Chapter 1551, 1575, 1579, or 1601 or any other law, this chapter applies to:

- (1) a basic coverage plan under Chapter 1551;

- (2) a basic plan under Chapter 1575;
- (3) a primary care coverage plan under Chapter 1579; and
- (4) basic coverage under Chapter 1601.

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

Added by Acts 2009, 81st Leg., R.S., Ch. 719 (S.B. 39), Sec. 1, eff. September 1, 2009.

Sec. 1379.003. APPLICABILITY TO CERTAIN GOVERNMENT PROGRAMS.

To the extent allowed by federal law, the state Medicaid program, and a managed care organization that contracts with the Health and Human Services Commission to provide health care services to Medicaid recipients through a managed care plan, shall provide the benefits required under this chapter to a Medicaid recipient.

Added by Acts 2009, 81st Leg., R.S., Ch. 719 (S.B. 39), Sec. 1, eff. September 1, 2009.

Sec. 1379.004. EXCEPTION. This chapter does not apply to:

- (1) a plan that provides coverage:
 - (A) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;
 - (B) as a supplement to a liability insurance policy;
 - (C) for credit insurance;
 - (D) for a specified disease or diseases;
 - (E) only for dental or vision care;
 - (F) only for hospital expenses; or
 - (G) only for indemnity for hospital confinement;
- (2) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);
- (3) a workers' compensation insurance policy;
- (4) medical payment insurance coverage provided under a motor vehicle insurance policy; or
- (5) a long-term care 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 as described by Section 1379.002.

Added by Acts 2009, 81st Leg., R.S., Ch. 719 (S.B. 39), Sec. 1, eff. September 1, 2009.

Sec. 1379.005. RULES. The commissioner, in accordance with Subchapter A, Chapter 36, may adopt rules to implement this chapter.

Added by Acts 2009, 81st Leg., R.S., Ch. 719 (S.B. 39), Sec. 1, eff. September 1, 2009.

SUBCHAPTER B. COVERAGE FOR ROUTINE PATIENT CARE COSTS

Sec. 1379.051. ROUTINE PATIENT CARE COSTS. For purposes of this chapter, routine patient care costs means the costs of any medically necessary health care service for which benefits are provided under a health benefit plan, without regard to whether the enrollee is participating in a clinical trial. Routine patient care costs do not include:

(1) the cost of an investigational new drug or device that is not approved for any indication by the United States Food and Drug Administration, including a drug or device that is the subject of the clinical trial;

(2) the cost of a service that is not a health care service, regardless of whether the service is required in connection with participation in a clinical trial;

(3) the cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;

(4) a cost associated with managing a clinical trial; or

(5) the cost of a health care service that is specifically excluded from coverage under a health benefit plan.

Added by Acts 2009, 81st Leg., R.S., Ch. 719 (S.B. 39), Sec. 1, eff. September 1, 2009.

Sec. 1379.052. COVERAGE REQUIRED. A health benefit plan issuer shall provide benefits for routine patient care costs to an enrollee in connection with a phase I, phase II, phase III, or phase IV

clinical trial if the clinical trial is conducted in relation to the prevention, detection, or treatment of a life-threatening disease or condition and is approved by:

- (1) the Centers for Disease Control and Prevention of the United States Department of Health and Human Services;
- (2) the National Institutes of Health;
- (3) the United States Food and Drug Administration;
- (4) the United States Department of Defense;
- (5) the United States Department of Veterans Affairs; or
- (6) an institutional review board of an institution in this state that has an agreement with the Office for Human Research Protections of the United States Department of Health and Human Services.

Added by Acts 2009, 81st Leg., R.S., Ch. 719 (S.B. 39), Sec. 1, eff. September 1, 2009.

Sec. 1379.053. RESEARCH INSTITUTION. (a) A health benefit plan issuer is not required to reimburse the research institution conducting the clinical trial for the cost of routine patient care provided through the research institution unless the research institution, and each health care professional providing routine patient care through the research institution, agrees to accept reimbursement under the health benefit plan, at the rates that are established under the plan, as payment in full for the routine patient care provided in connection with the clinical trial.

(b) A health benefit plan issuer is not required to provide benefits under this section for services that are a part of the subject matter of the clinical trial and that are customarily paid for by the research institution conducting the clinical trial.

Added by Acts 2009, 81st Leg., R.S., Ch. 719 (S.B. 39), Sec. 1, eff. September 1, 2009.

Sec. 1379.054. LIMITATIONS ON COVERAGE. (a) Notwithstanding Section 1379.053, this chapter does not require a health benefit plan issuer to provide benefits for routine patient care services provided outside of the plan's health care provider network unless out-of-network benefits are otherwise provided under the plan.

(b) This chapter does not require a health benefit plan issuer to provide benefits for health care services provided outside this state unless the health benefit plan otherwise provides benefits for health care services provided outside this state.

Added by Acts 2009, 81st Leg., R.S., Ch. 719 (S.B. 39), Sec. 1, eff. September 1, 2009.

Sec. 1379.055. DEDUCTIBLE, COINSURANCE, AND COPAYMENT REQUIREMENTS. The benefits required under this chapter may be made subject to a deductible, coinsurance, or copayment requirement comparable to other deductible, coinsurance, or copayment requirements applicable under the health benefit plan.

Added by Acts 2009, 81st Leg., R.S., Ch. 719 (S.B. 39), Sec. 1, eff. September 1, 2009.

Sec. 1379.056. CANCELLATION OR NONRENEWAL PROHIBITED. The issuer of a health benefit plan may not cancel or refuse to renew coverage under a plan solely because an enrollee in the plan participates in a clinical trial described by Section 1379.052.

Added by Acts 2009, 81st Leg., R.S., Ch. 719 (S.B. 39), Sec. 1, eff. September 1, 2009.

CHAPTER 1380. HUMAN ORGAN TRANSPLANT

Sec. 1380.001. DEFINITION. In this chapter, "forced organ harvesting" means the removal of one or more organs from a living person by means of coercion, abduction, deception, fraud, or abuse of power or a position of vulnerability.

Added by Acts 2023, 88th Leg., R.S., Ch. 1155 (S.B. 1040), Sec. 1, eff. September 1, 2023.

Sec. 1380.002. APPLICABILITY OF CHAPTER. (a) This chapter applies only to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health

condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is offered by:

- (1) an insurance company;
 - (2) a group hospital service corporation operating under Chapter 842;
 - (3) a health maintenance organization operating under Chapter 843;
 - (4) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844;
 - (5) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846;
 - (6) a stipulated premium company operating under Chapter 884;
 - (7) a fraternal benefit society operating under Chapter 885;
 - (8) a Lloyd's plan operating under Chapter 941; or
 - (9) an exchange operating under Chapter 942.
- (b) Notwithstanding any other law, this chapter applies to:
- (1) a small employer health benefit plan subject to Chapter 1501, including coverage provided through a health group cooperative under Subchapter B of that chapter;
 - (2) a standard health benefit plan issued under Chapter 1507;
 - (3) a basic coverage plan under Chapter 1551;
 - (4) a basic plan under Chapter 1575;
 - (5) a primary care coverage plan under Chapter 1579;
 - (6) a plan providing basic coverage under Chapter 1601;
 - (7) health benefits provided by or through a church benefits board under Subchapter I, Chapter 22, Business Organizations Code;
 - (8) the state Medicaid program, including the Medicaid managed care program operated under Chapter 533, Government Code;
 - (9) the child health plan program under Chapter 62, Health and Safety Code;
 - (10) a regional or local health care program operated under Section 75.104, Health and Safety Code;
 - (11) a self-funded health benefit plan sponsored by a professional employer organization under Chapter 91, Labor Code;

(12) county employee group health benefits provided under Chapter 157, Local Government Code; and

(13) health and accident coverage provided by a risk pool created under Chapter 172, Local Government Code.

Added by Acts 2023, 88th Leg., R.S., Ch. 1155 (S.B. 1040), Sec. 1, eff. September 1, 2023.

Sec. 1380.003. COVERAGE PROHIBITED. (a) A health benefit plan issuer may not cover a human organ transplant or post-transplant care if:

(1) the transplant operation is performed in China or another country known to have participated in forced organ harvesting, as designated by the commissioner of state health services; or

(2) the human organ to be transplanted was procured by a sale or donation originating in China or another country known to have participated in forced organ harvesting, as designated by the commissioner of state health services.

(b) The commissioner of state health services may designate additional countries with governments that fund, sponsor, or otherwise facilitate forced organ harvesting and shall provide written notice to the commissioner, Teacher Retirement System of Texas, Employees Retirement System of Texas, and executive commissioner of the Health and Human Services Commission when the commissioner of state health services designates an additional country.

Added by Acts 2023, 88th Leg., R.S., Ch. 1155 (S.B. 1040), Sec. 1, eff. September 1, 2023.

CHAPTER 1425. APPLICATION OF SUBTITLE TO CERTAIN COVERAGE
SUBCHAPTER A. EXCEPTED BENEFITS

Sec. 1425.001. EXEMPTION FROM APPLICATION OF SUBTITLE. (a) Except as provided by Section 1425.002, a provision of this subtitle that becomes effective on or after January 2, 2010, does not apply to:

(1) a plan that provides coverage only:

(A) for a specified disease or diseases or under an

individual limited benefit policy;

(B) for accidental death or dismemberment;

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

(D) for dental or vision care;

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

(3) credit insurance coverage;

(4) a hospital confinement indemnity policy;

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

(6) a workers' compensation insurance policy;

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

(8) a long-term care insurance policy, including a nursing home fixed indemnity policy, except as provided by Subsection (b); or

(9) an occupational accident policy.

(b) A long-term care insurance policy, including a nursing home fixed indemnity policy, is subject to this subtitle if the commissioner determines that the policy provides benefits so comprehensive that it is a health benefit plan and should not be subject to the exemption provided under this section.

Added by Acts 2009, 81st Leg., R.S., Ch. 228 (S.B. 1479), Sec. 1, eff. May 27, 2009.

Sec. 1425.002. SPECIFIC LANGUAGE CONTROLS. A provision of this subtitle that becomes effective on or after January 2, 2010, and that requires coverage or the offer of coverage of a health care service or benefit applies to a plan or policy described by Section 1425.001(a) only to the extent expressly and specifically provided by law.

Added by Acts 2009, 81st Leg., R.S., Ch. 228 (S.B. 1479), Sec. 1, eff. May 27, 2009.

SUBCHAPTER B. BENEFITS REQUIRING DEFRAVAL

Sec. 1425.051. DEFINITION. In this subchapter, "qualified health plan" has the meaning assigned by 45 C.F.R. Section 155.20.

Added by Acts 2021, 87th Leg., R.S., Ch. 890 (S.B. 2016), Sec. 3, eff. June 16, 2021.

Sec. 1425.052. EXEMPTION FROM SUBTITLE FOR BENEFITS REQUIRING DEFRAVAL. (a) A provision of this subtitle that is enacted on or after January 1, 2012, does not apply to a qualified health plan if a determination is made under 45 C.F.R. Section 155.170 that:

(1) the provision requires the qualified health plan to offer benefits in addition to the essential health benefits required under 42 U.S.C. Section 18022(b); and

(2) this state must make payments to defray the cost of the additional benefits mandated by the provision.

(b) If a determination described by Subsection (a) is made as to a qualified health plan, the provision to which the determination relates does not apply to a non-qualified health plan if the non-qualified health plan is offered in the same market as the qualified health plan.

Added by Acts 2021, 87th Leg., R.S., Ch. 890 (S.B. 2016), Sec. 3, eff. June 16, 2021.

SUBTITLE F. PHYSICIANS AND HEALTH CARE PROVIDERS

CHAPTER 1451. ACCESS TO CERTAIN PRACTITIONERS AND FACILITIES

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1451.001. DEFINITIONS; HEALTH CARE PRACTITIONERS. In this chapter:

(1) "Acupuncturist" means an individual licensed to practice acupuncture by the Texas State Board of Medical Examiners.

(2) "Advanced practice nurse" means an individual licensed by the Texas Board of Nursing as a registered nurse and recognized by that board as an advanced practice nurse.

(3) "Audiologist" means an individual licensed to practice audiology by the Texas Department of Licensing and Regulation.

(4) "Chemical dependency counselor" means an individual licensed by the Texas Commission on Alcohol and Drug Abuse.

(5) "Chiropractor" means an individual licensed by the Texas Board of Chiropractic Examiners.

(6) "Dentist" means an individual licensed to practice

dentistry by the State Board of Dental Examiners.

(7) "Dietitian" means an individual licensed by the Texas Department of Licensing and Regulation under Chapter 701, Occupations Code.

(8) "Hearing instrument fitter and dispenser" means an individual licensed by the Texas Department of Licensing and Regulation under Chapter 402, Occupations Code.

(9) "Licensed clinical social worker" means an individual licensed as a clinical social worker under Chapter 505, Occupations Code.

(10) "Licensed professional counselor" means an individual licensed under Chapter 503, Occupations Code.

(11) "Marriage and family therapist" means an individual licensed under Chapter 502, Occupations Code.

(12) "Occupational therapist" means an individual licensed as an occupational therapist by the Texas Board of Occupational Therapy Examiners.

(13) "Optometrist" means an individual licensed to practice optometry by the Texas Optometry Board.

(13-a) "Pharmacist" means an individual licensed to practice pharmacy by the Texas State Board of Pharmacy.

(14) "Physical therapist" means an individual licensed as a physical therapist by the Texas Board of Physical Therapy Examiners.

(15) "Physician" means an individual licensed to practice medicine by the Texas State Board of Medical Examiners. The term includes a doctor of osteopathic medicine.

(16) "Physician assistant" means an individual licensed by the Texas State Board of Physician Assistant Examiners.

(17) "Podiatrist" means an individual licensed to practice podiatry by the Texas Department of Licensing and Regulation.

(18) "Psychological associate" means an individual licensed as a psychological associate by the Texas Behavioral Health Executive Council.

(19) "Psychologist" means an individual licensed as a psychologist by the Texas Behavioral Health Executive Council.

(20) "Speech-language pathologist" means an individual licensed to practice speech-language pathology by the Texas Department of Licensing and Regulation.

(21) "Surgical assistant" means an individual licensed as a surgical assistant by the Texas State Board of Medical Examiners.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.041(a), eff. September 1, 2005.

Acts 2007, 80th Leg., R.S., Ch. 889 (H.B. 2426), Sec. 71, eff. September 1, 2007.

Acts 2017, 85th Leg., R.S., Ch. 324 (S.B. 1488), Sec. 10.002, eff. September 1, 2017.

Acts 2019, 86th Leg., R.S., Ch. 281 (H.B. 1757), Sec. 1, eff. September 1, 2019.

Acts 2019, 86th Leg., R.S., Ch. 467 (H.B. 4170), Sec. 19.015, eff. September 1, 2019.

Acts 2019, 86th Leg., R.S., Ch. 768 (H.B. 1501), Sec. 3.006, eff. September 1, 2019.

SUBCHAPTER B. DESIGNATION OF PRACTITIONERS UNDER ACCIDENT AND HEALTH INSURANCE POLICY

Sec. 1451.051. APPLICABILITY OF SUBCHAPTER. (a) This subchapter applies to an accident and health insurance policy, including an individual, blanket, or group policy.

(b) This subchapter applies to an accident and health insurance policy issued by a stipulated premium company subject to Chapter 884.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1451.052. APPLICABILITY OF GENERAL PROVISIONS OF OTHER LAW. The provisions of Chapter 1201, including provisions relating to the applicability, purpose, and enforcement of that chapter, the construction of policies under that chapter, rulemaking under that chapter, and definitions of terms applicable in that chapter, apply to this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1451.053. PRACTITIONER DESIGNATION. (a) An accident and health insurance policy may not make a benefit contingent on treatment or examination by one or more particular health care practitioners listed in Section 1451.001 unless the policy contains a

provision that designates the practitioners whom the insurer will and will not recognize.

(b) The insurer may include the provision anywhere in the policy or in an endorsement attached to the policy.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1451.054. TERMS USED TO DESIGNATE HEALTH CARE PRACTITIONERS. A provision of an accident and health insurance policy that designates the health care practitioners whom the insurer will and will not recognize must use the terms defined by Section 1451.001 with the meanings assigned by that section.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

SUBCHAPTER C. SELECTION OF PRACTITIONERS

Sec. 1451.101. DEFINITIONS. In this subchapter:

- (1) "Health insurance policy" means a policy, contract, or agreement described by Section 1451.102.
- (2) "Insured" means an individual who is issued, is a party to, or is a beneficiary under a health insurance policy.
- (3) "Insurer" means an insurer, association, or organization described by Section 1451.102.
- (4) "Nurse first assistant" has the meaning assigned by Section 301.1525, Occupations Code.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1451.102. APPLICABILITY OF SUBCHAPTER. Except as provided by this subchapter, this subchapter applies only to an individual, group, blanket, or franchise insurance policy, insurance agreement, or group hospital service contract that provides health benefits, accident benefits, or health and accident benefits for medical or surgical expenses incurred as a result of an accident or sickness and that is delivered, issued for delivery, or renewed in this state by any incorporated or unincorporated insurance company, association, or organization, including:

- (1) a fraternal benefit society operating under Chapter

885;

(2) a general casualty company operating under Chapter 861;

(3) a life, health, and accident insurance company operating under Chapter 841 or 982;

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

(5) a local mutual aid association operating under Chapter 886;

(6) a mutual insurance company writing insurance other than life insurance operating under Chapter 883;

(7) a mutual life insurance company operating under Chapter 882;

(8) a reciprocal exchange operating under Chapter 942;

(9) a statewide mutual assessment company, mutual assessment company, or mutual assessment life, health, and accident association operating under Chapter 881 or 887; and

(10) a stipulated premium company operating under Chapter 884.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1451.103. CONFLICTING PROVISIONS VOID. (a) A provision of a health insurance policy that conflicts with this subchapter is void to the extent of the conflict.

(b) The presence in a health insurance policy of a provision void under Subsection (a) does not affect the validity of other policy provisions.

(c) An insurer shall bring each approved policy form that contains a provision that conflicts with this subchapter into compliance with this subchapter by use of:

(1) a rider or endorsement approved by the commissioner;

or

(2) a new or revised policy form approved by the commissioner.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1451.104. NONDISCRIMINATORY PAYMENT OR REIMBURSEMENT; EXCEPTION. (a) An insurer may not classify, differentiate, or discriminate between scheduled services or procedures provided by a

health care practitioner selected under this subchapter and performed in the scope of that practitioner's license and the same services or procedures provided by another type of health care practitioner whose services or procedures are covered by a health insurance policy, in regard to:

- (1) the payment schedule or payment provisions of the policy; or
- (2) the amount or manner of payment or reimbursement under the policy.

(b) An insurer may not deny payment or reimbursement for services or procedures in accordance with the policy payment schedule or payment provisions solely because the services or procedures were performed by a health care practitioner selected under this subchapter.

(c) Notwithstanding Subsection (a), a health insurance policy may provide for a different amount of payment or reimbursement for scheduled services or procedures performed by an advanced practice nurse, nurse first assistant, licensed surgical assistant, or physician assistant if the methodology used to compute the amount is the same as the methodology used to compute the amount of payment or reimbursement when the services or procedures are provided by a physician.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1451.105. SELECTION OF ACUPUNCTURIST. An insured may select an acupuncturist to provide the services or procedures scheduled in the health insurance policy that are within the scope of the acupuncturist's license.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1451.106. SELECTION OF ADVANCED PRACTICE NURSE. An insured may select an advanced practice nurse to provide the services scheduled in the health insurance policy that are within the scope of the nurse's license.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1451.107. SELECTION OF AUDIOLOGIST. An insured may select an audiologist to measure hearing to determine the presence or extent of the insured's hearing loss or provide aural rehabilitation services to the insured if the insured has a hearing loss and the services or procedures are scheduled in the health insurance policy.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1451.108. SELECTION OF CHEMICAL DEPENDENCY COUNSELOR. An insured may select a chemical dependency counselor to provide services or procedures scheduled in the health insurance policy that are within the scope of the counselor's license.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1451.109. SELECTION OF CHIROPRACTOR. (a) An insured may select a chiropractor to provide the medical or surgical services or procedures scheduled in the health insurance policy that are within the scope of the chiropractor's license.

(b) If physical modalities and procedures are covered services under a health insurance policy and within the scope of the license of a chiropractor and one or more other type of practitioner, a health insurance policy issuer may not:

(1) deny payment or reimbursement for physical modalities and procedures provided by a chiropractor if:

(A) the chiropractor provides the modalities and procedures in strict compliance with state law; and

(B) the health insurance policy issuer allows payment or reimbursement for the same physical modalities and procedures performed by another type of practitioner that an insured may select under this subchapter;

(2) make payment or reimbursement for particular covered physical modalities and procedures within the scope of a chiropractor's license contingent on treatment or examination by a practitioner that is not a chiropractor; or

(3) establish other limitations on the provision of covered physical modalities and procedures that would prohibit an insured from seeking the covered physical modalities and procedures from a chiropractor to the same extent that the insured may obtain covered

physical modalities and procedures from another type of practitioner.

(c) Nothing in this section requires a health insurance policy issuer to cover particular services or affects the ability of a health insurance policy issuer to determine whether specific procedures for which payment or reimbursement is requested are medically necessary.

Text of subsection effective until April 1, 2025

(d) This section does not apply to:

- (1) workers' compensation insurance coverage as defined by Section 401.011, Labor Code;
- (2) a self-insured employee welfare benefit plan subject to the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.);
- (3) the child health plan program under Chapter 62, Health and Safety Code, or the health benefits plan for children under Chapter 63, Health and Safety Code; or
- (4) a Medicaid managed care program operated under Chapter 533, Government Code, or a Medicaid program operated under Chapter 32, Human Resources Code.

Text of subsection effective on April 1, 2025

(d) This section does not apply to:

- (1) workers' compensation insurance coverage as defined by Section 401.011, Labor Code;
- (2) a self-insured employee welfare benefit plan subject to the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.);
- (3) the child health plan program under Chapter 62, Health and Safety Code, or the health benefits plan for children under Chapter 63, Health and Safety Code; or
- (4) a Medicaid managed care program operated under Chapter 540 or 540A, Government Code, as applicable, or a Medicaid program operated under Chapter 32, Human Resources Code.

(e) A health insurance policy issuer that violates this section is subject to an administrative penalty as provided by Chapter 84 of not more than \$1,000 for each claim that remains unpaid in violation of this section. Each day the violation continues constitutes a separate violation.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 11.01, eff. September 28, 2011.

Acts 2019, 86th Leg., R.S., Ch. 116 (S.B. 1739), Sec. 3, eff. September 1, 2019.

Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 2.130, eff. April 1, 2025.

Sec. 1451.110. SELECTION OF DENTIST. An insured may select a dentist to provide the medical or surgical services or procedures scheduled in the health insurance policy that are within the scope of the dentist's license.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1451.111. SELECTION OF DIETITIAN. An insured may select a licensed dietitian or a provisionally licensed dietitian acting under the supervision of a licensed dietitian to provide the services scheduled in the health insurance policy that are within the scope of the dietitian's license.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1451.112. SELECTION OF HEARING INSTRUMENT FITTER AND DISPENSER. An insured may select a hearing instrument fitter and dispenser to provide the services or procedures scheduled in the health insurance policy that are within the scope of the license of the fitter and dispenser.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1451.113. SELECTION OF LICENSED CLINICAL SOCIAL WORKER. An insured may select a licensed clinical social worker to provide the services or procedures scheduled in the health insurance policy that:

(1) are within the scope of the social worker's license, including the provision of direct, diagnostic, preventive, or clinical services to individuals, families, and groups whose

functioning is threatened or affected by social or psychological stress or health impairment; and

(2) are specified as services under the terms of the health insurance policy.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.042(a), eff. September 1, 2005.

Sec. 1451.114. SELECTION OF LICENSED PROFESSIONAL COUNSELOR.

An insured may select a licensed professional counselor to provide the services scheduled in the health insurance policy that are within the scope of the counselor's license.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 221 (S.B. 1291), Sec. 1, eff. September 1, 2009.

Sec. 1451.115. SELECTION OF SURGICAL ASSISTANT. An insured may select a surgical assistant to provide the services or procedures scheduled in the health insurance policy that are within the scope of the assistant's license.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1451.116. SELECTION OF MARRIAGE AND FAMILY THERAPIST. An insured may select a marriage and family therapist to provide the services scheduled in the health insurance policy that are within the scope of the therapist's license.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 221 (S.B. 1291), Sec. 2, eff. September 1, 2009.

Sec. 1451.117. SELECTION OF NURSE FIRST ASSISTANT. An insured may select a nurse first assistant to provide the services scheduled in the health insurance policy that:

- (1) are within the scope of the nurse's license; and
- (2) are requested by the physician whom the nurse is assisting.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1451.118. SELECTION OF OCCUPATIONAL THERAPIST. An insured may select an occupational therapist to provide the services scheduled in the health insurance policy that are within the scope of the therapist's license.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1451.119. SELECTION OF OPTOMETRIST. An insured may select an optometrist to provide the services or procedures scheduled in the health insurance policy that are within the scope of the optometrist's license.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1451.120. SELECTION OF PHYSICAL THERAPIST. An insured may select a physical therapist to provide the services scheduled in the health insurance policy that are within the scope of the therapist's license.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1451.121. SELECTION OF PHYSICIAN ASSISTANT. An insured may select a physician assistant to provide the services scheduled in the health insurance policy that are within the scope of the assistant's license.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1451.122. SELECTION OF PODIATRIST. An insured may select a podiatrist to provide the medical or surgical services or procedures scheduled in the health insurance policy that are within the scope of the podiatrist's license.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1451.123. SELECTION OF PSYCHOLOGICAL ASSOCIATE. An insured may select a psychological associate to provide the services scheduled in the health insurance policy that are within the scope of the associate's license.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1451.124. SELECTION OF PSYCHOLOGIST. An insured may select a psychologist to provide the services or procedures scheduled in the health insurance policy that are within the scope of the psychologist's license.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1451.125. SELECTION OF SPEECH-LANGUAGE PATHOLOGIST. An insured may select a speech-language pathologist to evaluate speech or language, provide habilitative or rehabilitative services to restore speech or language loss, or correct a speech or language impairment if the services or procedures are scheduled in the health insurance policy.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1451.126. REIMBURSEMENT FOR PHYSICAL MODALITIES AND PROCEDURES BY HEALTH INSURER, ADMINISTRATOR, HEALTH MAINTENANCE ORGANIZATION, OR PREFERRED PROVIDER BENEFIT PLAN ISSUER. (a) A health insurer or licensed third-party administrator may not deny reimbursement to a health care practitioner for the provision of covered services of physical modalities and procedures that are within the scope of the practitioner's practice if the services are

performed in strict compliance with:

(1) laws and rules related to that practitioner's license;

and

(2) the terms of the insurance policy or other coverage agreement.

(b) A health maintenance organization or preferred provider benefit plan issuer may not deny reimbursement to a participating health care practitioner for services provided under a coverage agreement solely because of the type of practitioner providing the services if the services are performed in strict compliance with:

(1) laws and rules related to that practitioner's license;

and

(2) the terms of the insurance policy or other coverage agreement.

(c) This section may not be construed to circumvent any contractual provider network agreement between a health insurer or third-party administrator and a licensed health care practitioner.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1451.1261. REIMBURSEMENT FOR CERTAIN SERVICES AND PROCEDURES PERFORMED BY PHARMACISTS. (a) Notwithstanding any other law, in addition to applying to a policy, agreement, or contract described by Section 1451.102, this section applies to any other individual or group health benefit plan that provides benefits described by Section 1451.102, including:

(1) a health benefit plan issued by:

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

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

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

(2) a small employer health benefit plan subject to Chapter 1501;

(3) a standard health benefit plan issued under Chapter 1507;

(4) health benefits provided by or through a church benefits board under Subchapter I, Chapter 22, Business Organizations

Code;

(5) a regional or local health care program operated under Section 75.104, Health and Safety Code; and

(6) a self-funded health benefit plan sponsored by a professional employer organization under Chapter 91, Labor Code.

Text of subsection effective until April 1, 2025

(b) This section does not apply to:

(1) a basic coverage plan under Chapter 1551;

(2) a basic plan under Chapter 1575;

(3) a primary care coverage plan under Chapter 1579;

(4) a plan providing basic coverage under Chapter 1601;

(5) the state Medicaid program, including the Medicaid managed care program operated under Chapter 533, Government Code; or

(6) the child health plan program under Chapter 62, Health and Safety Code.

Text of subsection effective on April 1, 2025

(b) This section does not apply to:

(1) a basic coverage plan under Chapter 1551;

(2) a basic plan under Chapter 1575;

(3) a primary care coverage plan under Chapter 1579;

(4) a plan providing basic coverage under Chapter 1601;

(5) the state Medicaid program, including the Medicaid managed care program operated under Chapters 540 and 540A, Government Code; or

(6) the child health plan program under Chapter 62, Health and Safety Code.

(c) Notwithstanding Section 1451.102, this section applies to coverage under a group health benefit plan provided to a resident of this state regardless of whether the group policy, agreement, or contract is delivered, issued for delivery, or renewed in this state.

(d) An insurer or other health benefit plan issuer or a third-party administrator or pharmacy benefit manager of a health benefit plan may not deny reimbursement to a pharmacist for the provision of a service or procedure within the scope of the pharmacist's license to practice pharmacy under Subtitle J, Title 3, Occupations Code, that:

(1) would be covered by the insurance policy or other coverage agreement if the service or procedure were provided by:

(A) a physician;

- (B) an advanced practice nurse; or
 - (C) a physician assistant; and
- (2) is performed by the pharmacist in strict compliance with laws and rules related to:
- (A) the provision of the service or procedure; and
 - (B) the pharmacist's license.

(e) This section may not be construed to require an insurer or other health benefit plan issuer or a third-party administrator or pharmacy benefit manager to reimburse a pharmacist or pharmacy as an in-network or preferred provider.

Added by Acts 2019, 86th Leg., R.S., Ch. 324 (H.B. [3441](#)), Sec. 1, eff. September 1, 2019.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. [4611](#)), Sec. 2.131, eff. April 1, 2025.

Sec. 1451.127. DUTY OF PERSON ARRANGING PROVIDER CONTRACTS FOR HEALTH INSURER OR HEALTH MAINTENANCE ORGANIZATION. (a) A person who arranges contracts with providers on behalf of a health maintenance organization or health insurer shall comply with laws related to the duties of the organization or insurer to notify and consider providers for those contracts.

(b) A violation of this section:

- (1) is an unlawful practice under Section 15.05, Business & Commerce Code; and
- (2) constitutes restraint of trade.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1451.128. SELECTION OF PHARMACIST. An insured may select a pharmacist to provide the services scheduled in the health insurance policy that are within the scope of the pharmacist's license to practice pharmacy under Subtitle J, Title 3, Occupations Code.

Added by Acts 2019, 86th Leg., R.S., Ch. 281 (H.B. [1757](#)), Sec. 2, eff. September 1, 2019.

SUBCHAPTER D. ACCESS TO OPTOMETRISTS USED UNDER MANAGED CARE PLAN

Sec. 1451.151. DEFINITION. In this subchapter, "managed care plan" means a plan under which a health maintenance organization, preferred provider benefit plan issuer, vision benefit plan issuer, vision benefit plan administrator, or other organization provides or arranges for health care benefits or vision benefits to plan participants and requires or encourages plan participants to use health care practitioners the plan designates.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 898 (H.B. 1696), Sec. 2, eff. September 1, 2023.

Sec. 1451.152. APPLICABILITY AND CONSTRUCTION OF SUBCHAPTER.

(a) This subchapter applies only to a managed care plan that provides or arranges for benefits for vision or medical eye care services or procedures that are within the scope of an optometrist's or therapeutic optometrist's license.

(b) This subchapter does not require a managed care plan to provide vision or medical eye care services or procedures.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1451.153. USE OF OPTOMETRIST OR THERAPEUTIC OPTOMETRIST.

(a) A managed care plan may not:

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

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

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

(4) identify a participating optometrist or therapeutic optometrist differently from another optometrist or therapeutic

optometrist based on:

(A) a discount or incentive offered on a medical or vision care product or service, as defined by Section 1451.155, that is not a covered product or service, as defined by Section 1451.155, by the optometrist or therapeutic optometrist;

(B) the dollar amount, volume amount, or percent usage amount of any product or good purchased by the optometrist or therapeutic optometrist; or

(C) the brand, source, manufacturer, or supplier of a medical or vision care product or service, as defined by Section 1451.155, utilized by the optometrist or therapeutic optometrist to practice optometry;

(5) incentivize, recommend, encourage, persuade, or attempt to persuade an enrollee to obtain covered or uncovered products or services:

(A) at any particular participating optometrist or therapeutic optometrist instead of another participating optometrist or therapeutic optometrist;

(B) at a retail establishment owned by, partially owned by, contracted with, or otherwise affiliated with the managed care plan instead of a different participating optometrist or therapeutic optometrist; or

(C) at any Internet or virtual provider or retailer owned by, partially owned by, contracted with, or otherwise affiliated with the managed care plan instead of a different participating optometrist or therapeutic optometrist;

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

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

(b) A managed care plan shall:

(1) include optometrists and therapeutic optometrists as participating health care practitioners in the plan;

(2) include the name of a participating optometrist or therapeutic optometrist in any list of participating health care

practitioners and give equal prominence to each name;

(3) provide directly to an optometrist, therapeutic optometrist, or plan enrollee immediate access by electronic means to an enrollee's complete plan coverage information, including in-network and out-of-network coverage details;

(4) publish complete plan information, including in-network and out-of-network coverage details, with any marketing materials that describe the plan benefits, including any summary plan description;

(5) allow an optometrist or a therapeutic optometrist to utilize any third-party claim-filing service, billing service, or electronic data interchange clearinghouse company that uses the standardized claim submission protocol of the National Uniform Claim Committee and that allows the optometrist or therapeutic optometrist to submit details for both services and vision care products to facilitate the authorization, submission, and reimbursement of claims; and

(6) allow an optometrist or a therapeutic optometrist to receive reimbursement through an electronic funds transfer.

(c) For the purposes of Subsection (a)(7), "medical panel" and "vision panel" have the meanings assigned by Section 1451.154(a).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.043, eff. September 1, 2005.

Acts 2011, 82nd Leg., R.S., Ch. 1147 (H.B. 1951), Sec. 12.001, eff. September 1, 2011.

Acts 2023, 88th Leg., R.S., Ch. 898 (H.B. 1696), Sec. 3, eff. September 1, 2023.

Sec. 1451.154. PARTICIPATION OF THERAPEUTIC OPTOMETRIST. (a)

In this section:

(1) "Medical panel" means the health care practitioners who are listed as participating providers in a managed care plan or who a patient seeking diagnosis or treatment of a medical disease, disorder, or condition is encouraged or required to use under a managed care plan.

(2) "Vision panel" means the optometrists and therapeutic

optometrists who are listed as participating providers for routine eye examinations under a managed care plan or who a patient seeking a routine eye examination is encouraged or required to use under a managed care plan.

(b) A managed care plan must allow a therapeutic optometrist who is on one or more of the plan's vision panels to be a fully participating provider on the plan's medical panels to the full extent of the therapeutic optometrist's license to practice therapeutic optometry.

(c) A therapeutic optometrist who is included in a managed care plan's medical panels under Subsection (b) must:

- (1) abide by the terms and conditions of the managed care plan;
- (2) satisfy the managed care plan's credentialing standards for therapeutic optometrists; and
- (3) provide proof that the Texas Optometry Board considers the therapeutic optometrist's license to practice therapeutic optometry to be in good standing.

(d) Repealed by Acts 2023, 88th Leg., R.S., Ch. 898 (H.B. 1696), Sec. 10, eff. September 1, 2023.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.044(a), eff. September 1, 2005.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 898 (H.B. 1696), Sec. 4, eff. September 1, 2023.

Acts 2023, 88th Leg., R.S., Ch. 898 (H.B. 1696), Sec. 5, eff. September 1, 2023.

Acts 2023, 88th Leg., R.S., Ch. 898 (H.B. 1696), Sec. 10, eff. September 1, 2023.

Sec. 1451.155. CONTRACTS WITH OPTOMETRISTS OR THERAPEUTIC OPTOMETRISTS. (a) In this section:

(1) "Chargeback" means a dollar amount, fee, surcharge, or item of value that reduces, modifies, or offsets all or part of the patient responsibility, provider reimbursement, or fee schedule for a covered product or service.

(2) "Covered product or service" means a medical or vision care product or service for which reimbursement is available under an

enrollee's managed care plan contract or for which reimbursement is available subject to a contractual limitation, including:

- (A) a deductible;
- (B) a copayment;
- (C) coinsurance;
- (D) a waiting period;
- (E) an annual or lifetime maximum limit;
- (F) a frequency limitation; or
- (G) an alternative benefit payment.

(3) "Medical or vision care product or service" means a product or service provided within the scope of the practice of optometry or therapeutic optometry under Chapter 351, Occupations Code.

(a-1) For the purposes of this section, a product or service reimbursed to an optometrist or therapeutic optometrist at a nominal or de minimis rate is not a covered product or service.

(a-2) For the purposes of this section, a product or service reimbursed to an optometrist or therapeutic optometrist solely by the enrollee is not a covered product or service.

(b) A contract between a managed care plan and an optometrist or therapeutic optometrist may not limit the fee the optometrist or therapeutic optometrist may charge for a product or service that is not a covered product or service.

(c) A contract between a managed care plan and an optometrist or therapeutic optometrist may not require a discount on a product or service that is not a covered product or service.

(d) A contract between a managed care plan and an optometrist or therapeutic optometrist may not contain a provision authorizing a chargeback to the patient, optometrist, or therapeutic optometrist if the chargeback is for a covered product or service that the managed care plan does not incur the cost to produce, deliver, or provide to the patient, optometrist, or therapeutic optometrist.

(e) A contract between a managed care plan and an optometrist or therapeutic optometrist may not contain a provision authorizing a reimbursement fee schedule for a covered product or service that is different from the fee schedule applicable to another optometrist or therapeutic optometrist because of the optometrist's or therapeutic optometrist's choice of:

- (1) optical laboratory;
- (2) source or supplier of:

- (A) contact lenses;
 - (B) ophthalmic lenses;
 - (C) ophthalmic glasses frames; or
 - (D) covered or uncovered products or services;
- (3) equipment used for patient care;
 - (4) retail optical affiliation;
 - (5) vision support organization;
 - (6) group purchasing organization;
 - (7) doctor alliance;
 - (8) professional trade association membership;
 - (9) affiliation with an arrangement defined as a franchise by 16 C.F.R. Part 436;
 - (10) electronic health record software, electronic medical record software, or practice management software; or
 - (11) third-party claim-filing service, billing service, or electronic data interchange clearinghouse company.

(f) A managed care plan may not change a contract between a managed care plan and an optometrist or therapeutic optometrist, including terms, reimbursements, or fee schedules, unless the managed care plan provides written notice of the change to the optometrist or therapeutic optometrist at least 90 days before the date the proposed change takes effect.

(g) A contract between a managed care plan and an optometrist or therapeutic optometrist may not contain a provision requiring the optometrist or therapeutic optometrist to provide a covered product at a loss.

(h) A contract between a managed care plan and an optometrist or therapeutic optometrist may not contain a provision requiring the optometrist or therapeutic optometrist to accept a reimbursement payment in the form of a virtual credit card or any other payment method where a processing fee, administrative fee, percentage amount, or dollar amount is assessed to receive the reimbursement payment, except in the case of a nominal fee assessed by the optometrist's or therapeutic optometrist's bank to receive an electronic funds transfer.

Added by Acts 2013, 83rd Leg., R.S., Ch. 755 (S.B. [632](#)), Sec. 1, eff. September 1, 2013.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 898 (H.B. [1696](#)), Sec. 6, eff.

September 1, 2023.

Sec. 1451.156. CERTAIN CONDUCT PROHIBITED. (a) A managed care plan, as described by Section 1451.152(a), may not directly or indirectly:

(1) control or attempt to control the professional judgment, manner of practice, or practice of an optometrist or therapeutic optometrist;

(2) employ an optometrist or therapeutic optometrist to provide a vision care product or service as defined by Section 1451.155;

(3) pay an optometrist or therapeutic optometrist for a service not provided;

(4) reimburse an optometrist or therapeutic optometrist a different amount for a covered product or service as defined by Section 1451.155 because of the optometrist's or therapeutic optometrist's choice of:

(A) optical laboratory;

(B) source or supplier of:

(i) contact lenses;

(ii) ophthalmic lenses;

(iii) ophthalmic glasses frames; or

(iv) covered or uncovered products or services;

(C) equipment used for patient care;

(D) retail optical affiliation;

(E) vision support organization;

(F) group purchasing organization;

(G) doctor alliance;

(H) professional trade association membership;

(I) affiliation with an arrangement defined as a

franchise by 16 C.F.R. Part 436;

(J) electronic health record software, electronic medical record software, or practice management software; or

(K) third-party claim-filing service, billing service, or electronic data interchange clearinghouse company;

(5) restrict, limit, or influence an optometrist's or therapeutic optometrist's choice of sources or suppliers of services or materials, including optical laboratories used by the optometrist or therapeutic optometrist to provide services or materials to a

patient;

(6) restrict, limit, or influence an optometrist's or therapeutic optometrist's choice of electronic health record software, electronic medical record software, or practice management software;

(7) restrict, limit, or influence an optometrist's or therapeutic optometrist's choice of third-party claim-filing service, billing service, or electronic data interchange clearinghouse company;

(8) restrict or limit an optometrist's or therapeutic optometrist's access to a patient's complete plan coverage information, including in-network and out-of-network coverage details;

(9) apply a chargeback, as defined by Section 1451.155, to a patient, optometrist, or therapeutic optometrist if the chargeback is for a covered product or service that the managed care plan does not incur the cost to produce, deliver, or provide to the patient, optometrist, or therapeutic optometrist;

(10) require an optometrist or therapeutic optometrist to provide a covered product at a loss;

(11) require an optometrist or therapeutic optometrist to disclose a patient's confidential or protected health information unless the disclosure is authorized by the patient or permitted without authorization under the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. Section 1320d et seq.) or under Section 602.053;

(12) require an optometrist or therapeutic optometrist to disclose or report a medical history or diagnosis as a condition to file a claim, adjudicate a claim, or receive reimbursement for a routine or wellness vision eye exam;

(13) require an optometrist or therapeutic optometrist to disclose or report a patient's glasses prescription, contact lens prescription, ophthalmic device measurements, facial photograph, or unique anatomical measurements as a condition to file a claim, adjudicate a claim, or receive reimbursement for a claim unless the information is needed for the managed care plan to manufacture or cause to be manufactured a covered product that is submitted on the claim;

(14) require an optometrist or therapeutic optometrist to disclose any patient information, other than information identified

on the version of the Health Insurance Claim Form approved by the National Uniform Claim Committee as of March 1, 2023, as a condition to file a claim, adjudicate a claim, or receive reimbursement for a claim unless the information is needed for the managed care plan to manufacture or cause to be manufactured a covered product that is submitted on the claim; or

(15) require an optometrist or therapeutic optometrist to accept a reimbursement payment in the form of a virtual credit card or any other payment method where a processing fee, administrative fee, percentage amount, or dollar amount is assessed to receive the reimbursement payment, except in the case of a nominal fee assessed by the optometrist's or therapeutic optometrist's bank to receive an electronic funds transfer.

(b) Subsection (a)(2) does not prohibit a managed care plan from employing an optometrist or therapeutic optometrist for utilization review or for operations of the managed care plan.

(c) Subsection (a)(3) does not prohibit the use of capitation as a method of payment.

(d) Repealed by Acts 2023, 88th Leg., R.S., Ch. 898 (H.B. 1696), Sec. 10, eff. September 1, 2023.

(e) An optometrist or therapeutic optometrist must disclose to a patient any business interest the optometrist or therapeutic optometrist has in an out-of-network supplier or manufacturer to which the optometrist or therapeutic optometrist refers the patient.

(f) This section shall be liberally construed to prevent managed care plans from controlling or attempting to control the professional judgment, manner of practice, or practice of an optometrist or therapeutic optometrist.

Added by Acts 2015, 84th Leg., R.S., Ch. 1271 (S.B. 684), Sec. 3, eff. September 1, 2015.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 898 (H.B. 1696), Sec. 7, eff. September 1, 2023.

Acts 2023, 88th Leg., R.S., Ch. 898 (H.B. 1696), Sec. 8, eff. September 1, 2023.

Acts 2023, 88th Leg., R.S., Ch. 898 (H.B. 1696), Sec. 10, eff. September 1, 2023.

Sec. 1451.157. EXTRAPOLATION PROHIBITED. (a) In this section:

(1) "Extrapolation" means a mathematical process or technique used by a vision care plan in the audit of an optometrist or therapeutic optometrist to estimate audit results or findings for a larger batch or group of claims not reviewed by the plan.

(2) "Vision care plan" means a limited-scope policy, agreement, contract, or evidence of coverage that provides coverage for eye care expenses but does not provide comprehensive medical coverage.

(b) A vision care plan may not use extrapolation to complete an audit of a participating optometrist or therapeutic optometrist. Any additional payment due to a participating optometrist or therapeutic optometrist or any refund due to the vision care plan must be based on the actual overpayment or underpayment and may not be based on an extrapolation.

Added by Acts 2023, 88th Leg., R.S., Ch. 898 (H.B. 1696), Sec. 9, eff. September 1, 2023.

Sec. 1451.158. ENFORCEMENT OF SUBCHAPTER. (a) A violation of this subchapter by a managed care plan is subject to an administrative penalty under Chapter 84.

(b) The commissioner shall take all reasonable actions to ensure compliance with this subchapter, including issuing orders to enforce this subchapter.

Added by Acts 2023, 88th Leg., R.S., Ch. 898 (H.B. 1696), Sec. 9, eff. September 1, 2023.

**SUBCHAPTER E. DENTAL CARE BENEFITS IN HEALTH INSURANCE POLICIES OR
EMPLOYEE BENEFIT PLANS**

Sec. 1451.201. DEFINITIONS. In this subchapter:

(1) "Dental care service" means a service provided to a person to prevent, alleviate, cure, or heal a human dental illness or injury.

(2) "Employee benefit plan" means a plan, fund, or program established or maintained by an employer or employee organization.

(3) "Health insurance policy" means any individual, group, blanket, or franchise insurance policy, insurance agreement, or group

hospital service contract.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1451.202. APPLICABILITY AND CONSTRUCTION OF SUBCHAPTER.

(a) This subchapter applies only to an employee benefit plan or health insurance policy delivered, issued for delivery, renewed, or contracted for in this state to the extent that:

(1) the employee benefit plan is established or maintained to provide dental care services, through insurance or otherwise, for the plan's participants or the beneficiaries of the plan's participants; or

(2) the health insurance policy provides benefits for dental care services.

(b) This subchapter does not apply to a health maintenance organization governed by Chapter 843.

(c) The exemptions and exceptions of Sections 881.002 and 881.004 and Article 21.41 do not apply to this subchapter.

(d) This subchapter does not require an employee benefit plan or health insurance policy to provide any type of benefits for dental care expenses.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1451.203. CONFLICTING PROVISIONS. A provision of an employee benefit plan or health insurance policy that conflicts with this subchapter is void to the extent of the conflict.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1451.204. CERTAIN CONDUCT PERMITTED. (a) Notwithstanding any other provision of this subchapter, a dentist may contract directly with a patient to provide dental care services to the patient as authorized by law.

(b) Notwithstanding any other provision of this subchapter, a person providing a health insurance policy or employee benefit plan or an employer or an employee organization may:

(1) make information available to its insureds,

beneficiaries, participants, employees, or members regarding dental care services through the distribution of factually accurate information about dental care services and the rates, fees, locations, and hours for the services if the information is distributed on the request of a dentist;

(2) establish an administrative mechanism to facilitate payments for dental care services from an insured, beneficiary, participant, employee, or member to a dentist chosen by the insured, beneficiary, participant, employee, or member; or

(3) nondiscriminatorily pay or reimburse its insured, beneficiary, participant, employee, or member for the cost of dental care services provided by a dentist chosen by the insured, beneficiary, participant, employee, or member.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1451.205. DISCLOSURE OF BENEFIT TERMS. (a) An employee benefit plan or health insurance policy shall:

(1) if applicable, disclose that the benefit for dental care services offered is limited to the least costly treatment; and

(2) specify in dollars and cents the amount of the payment or reimbursement to be provided for dental care services or define and explain the standard on which payment of benefits or reimbursement for the cost of dental care services is based, such as:

(A) "usual and customary" fees;

(B) "reasonable and customary" fees;

(C) "usual, customary, and reasonable" fees; or

(D) words of similar meaning.

(b) A person or entity who provides or issues an employee benefit plan or health insurance policy or the employer or employee organization, if applicable, shall establish an Internet website to provide resources and information to dentists, insureds, participants, employees, and members.

(c) An employee benefit plan or health insurance policy provider or issuer shall make accessible on the Internet website established under Subsection (b) information about the plan or policy sufficient for patients and dentists to determine the type of dental care services covered by the plan or policy, the percentage of the allowed charges for a covered service that will be paid or reimbursed

under the plan or policy, and, for a contracting provider dentist, an estimate of the amount of the payment or reimbursement available for the provider's services under the plan or policy. Access to the Internet website must be at no charge to patients under the plan or policy and dentists providing dental care services to the patients.

(d) An employee benefit plan or health insurance policy provider or issuer is not required to comply with Subsection (b) or (c) for a plan or policy that:

(1) provides for payment of the benefit for dental care services under the plan or policy:

(A) as an indemnity benefit based on a fixed schedule, regardless of the cost of the dental care service;

(B) on a cash-payment-only basis;

(C) directly to the beneficiary of the plan or policy or to the beneficiary's assigns; and

(D) regardless of other coverage; and

(2) does not provide for a copayment, a deductible, a network, or contracting provider dentists.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2019, 86th Leg., R.S., Ch. 1290 (H.B. [2486](#)), Sec. 1, eff. September 1, 2019.

Sec. 1451.206. PAYMENT OR REIMBURSEMENT OF DENTIST. (a) The employee benefit plan or health insurance policy shall:

(1) provide:

(A) that payment or reimbursement for a noncontracting provider dentist shall be the same as payment or reimbursement for a contracting provider dentist;

(B) that the party to or beneficiary of the plan or policy may assign the right to payment or reimbursement to the dentist who provides the dental care services; and

(C) one or more methods of payment or reimbursement that provide the dentist 100 percent of the contracted amount of the payment or reimbursement and that do not require the dentist to incur a fee to access the payment or reimbursement; and

(2) disclose on the Internet website required under Section 1451.205 and on request of a dentist or a party to or beneficiary of

the plan or policy the fees, if any, associated with the methods of payment or reimbursement available under the plan or policy.

(b) Notwithstanding Subsection (a)(1), the employee benefit plan or health insurance policy is not required to make payment or reimbursement in an amount greater than:

- (1) the amount specified in the plan or policy; or
- (2) the fee the providing dentist charges for the dental care services provided.

(c) If the right to payment or reimbursement is assigned as provided by Subsection (a)(2):

- (1) payment or reimbursement shall be made directly to the designated dentist; and
- (2) direct payment to the designated dentist discharges the payor's obligation.

(d) An employee benefit plan or health insurance policy provider or issuer may not recover an overpayment made to a dentist unless:

- (1) not later than the 180th day after the date the dentist receives the payment, the provider or issuer provides written notice of the overpayment to the dentist that includes the basis and specific reasons for the request for recovery of funds; and

(2) the dentist:

(A) fails to provide a written objection to the request for recovery of funds and does not make arrangements for repayment of the requested funds on or before the 45th day after the date the dentist receives the notice; or

(B) objects to the request in accordance with the procedure described by Subsection (e) and exhausts all rights of appeal.

(e) An employee benefit plan or health insurance policy provider or issuer shall provide a dentist with the opportunity to challenge an overpayment recovery request and establish written policies and procedures for a dentist to object to an overpayment recovery request. The procedures must allow the dentist to access the claims information in dispute.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2019, 86th Leg., R.S., Ch. 1290 (H.B. [2486](#)), Sec. 2, eff. September 1, 2019.

Acts 2023, 88th Leg., R.S., Ch. 1002 (H.B. 1527), Sec. 1, eff. September 1, 2023.

Sec. 1451.2065. CONTRACTS WITH DENTISTS. (a) In this section:

(1) "Covered service" means a dental care service for which reimbursement is available under a patient's employee benefit plan or health insurance policy, or for which reimbursement is available subject to a contractual limitation, including:

- (A) a deductible;
- (B) a copayment;
- (C) coinsurance;
- (D) a waiting period;
- (E) an annual or lifetime maximum limit;
- (F) a frequency limitation;
- (G) an alternative benefit payment; or
- (H) any other limitation.

(2) "Insurer" means a provider or issuer of an employee benefit plan or health insurance policy.

(b) A contract between an insurer and a dentist may not:

(1) limit the fee the dentist may charge for a service that is not a covered service; or

(2) include a provision that both:

(A) allows the insurer to disallow a service, resulting in denial of payment to the dentist for a service that ordinarily would have been covered; and

(B) prohibits the dentist from billing for and collecting the amount owed from the patient for that service if there is a dental necessity, as defined by Section 32.054, Human Resources Code, for that service.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1061 (S.B. 554), Sec. 2, eff. September 1, 2011.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 1002 (H.B. 1527), Sec. 2, eff. September 1, 2023.

Sec. 1451.207. PROHIBITED CONDUCT. (a) An employee benefit plan or health insurance policy may not:

(1) interfere with or prevent an individual who is a party to or beneficiary of the plan or policy from selecting a dentist of the individual's choice to provide a dental care service the plan or policy offers if the dentist selected is licensed in this state to provide the service;

(2) deny a dentist the right to participate as a contracting provider under the plan or policy if the dentist is licensed to provide the dental care services the plan or policy offers;

(3) authorize a person to regulate, interfere with, or intervene in the provision of dental care services a dentist provides a patient, including diagnosis, if the dentist practices within the scope of the dentist's license;

(4) require a dentist to make or obtain a dental x-ray or other diagnostic aid in providing dental care services; or

(5) deduct the amount of an overpayment of a claim from a payment or reimbursement for a dental care service provided by a dentist who did not receive the overpayment.

(b) Subsection (a)(4) does not prohibit a request for an existing dental x-ray or other existing diagnostic aid for a determination of benefits payable under an employee benefit plan or health insurance policy.

(c) This section does not prohibit the predetermination of benefits for dental care expenses before the attending dentist provides treatment. In this subsection, "predetermination" means an estimate by the patient's employee benefit plan or health insurance policy provider or issuer of:

(1) the patient's eligibility under the plan or policy for benefits or covered services;

(2) the amount of the patient's deductible, copayment, or coinsurance related to benefits or covered services; and

(3) the maximum benefit limits for benefits or covered services.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2019, 86th Leg., R.S., Ch. 1290 (H.B. [2486](#)), Sec. 3, eff. September 1, 2019.

Sec. 1451.208. PRIOR AUTHORIZATION OF DENTAL CARE SERVICES.

(a) For purposes of this section, "prior authorization" means a written and verifiable determination that one or more specific dental care services are covered under the patient's employee benefit plan or health insurance policy and are payable and reimbursable in a specific stated amount, subject to applicable coinsurance and deductible amounts. The term:

(1) includes preauthorization or similar authorization; and

(2) does not include a predetermination as defined by Section 1451.207(c).

(b) For services for which a prior authorization is required, on request of a patient or treating dentist, an employee benefit plan or health insurance policy provider or issuer shall provide to the dentist a written prior authorization of benefits for a dental care service for the patient. The prior authorization must include a specific benefit payment or reimbursement amount. Except as provided by Subsection (c), the plan or policy provider or issuer may not pay or reimburse the dentist in an amount that is less than the amount stated in the prior authorization.

(c) An employee benefit plan or health insurance policy provider or issuer that preauthorizes a dental care service under Subsection (b) may deny a claim for the dental care service or reduce payment or reimbursement to the dentist for the service only if:

(1) the denial or reduction is in accordance with the patient's employee benefit plan or health insurance policy benefit limitations, including an annual maximum or frequency of treatment limitation, and the patient met the benefit limitation after the date the prior authorization was issued;

(2) the documentation for the claim fails to reasonably support the claim as preauthorized;

(3) the preauthorized dental care service was not medically necessary based on the prevailing standard of care on the date of the service, or is subject to denial under the conditions for coverage under the patient's plan or policy in effect at the time the service was preauthorized, because of a change in the patient's condition or because the patient received additional dental care services after the date the prior authorization was issued;

(4) a payor other than the employee benefit plan or health insurance policy provider or issuer is responsible for payment of the claim;

(5) the dentist received full payment for the preauthorized dental care service on which the claim is based;

(6) the claim is fraudulent;

(7) the prior authorization was based wholly or partly on a material error in information provided to the employee benefit plan or health insurance policy provider or issuer by any person not related to the provider or issuer; or

(8) the patient was otherwise ineligible for the dental care service under the patient's plan or policy, and the plan or policy provider or issuer did not know and could not reasonably have known that the patient was ineligible for the dental care service on the date the plan or policy provider or issuer preauthorized the dental care service.

Added by Acts 2019, 86th Leg., R.S., Ch. 1290 (H.B. [2486](#)), Sec. 4, eff. September 1, 2019.

Sec. 1451.209. REQUIREMENTS FOR THIRD PARTY ACCESS TO PROVIDER NETWORKS. (a) At the time a provider network contract is entered into or when material modifications are made to the contract relevant to granting a third party access to the contract, an employee benefit plan or health insurance policy provider or issuer shall allow any dentist that is part of the provider network to elect not to participate in the third party access to the contract and to elect not to enter into a contract directly with the third party that will obtain access to the provider network. This subsection does not permit the plan or policy provider or issuer to cancel or otherwise end a contractual relationship with a dentist if the dentist elects to not participate in or agree to third party access to the provider network contract.

(b) An employee benefit plan or health insurance policy provider or issuer that enters into a provider network contract with a dentist, or a contracting entity that has leased or acquired the provider network contract, may grant a third party access to the provider network contract or to a dentist's dental care services or contractual discounts provided under the contract only if:

(1) the provider network contract conspicuously states that the provider or issuer or contracting entity may enter into an agreement with a third party that allows the third party to obtain

the provider's, issuer's, or contracting entity's rights and responsibilities as if the third party were the provider, issuer, or contracting entity;

(2) if the contracting entity is an employee benefit plan or health insurance policy provider or issuer, the provider network contract conspicuously states, in addition to the language required by Subdivision (1), that the dentist may elect not to participate in third party access to the provider network contract:

(A) at the time the provider network contract is entered into; or

(B) when there are material modifications to the provider network contract relevant to granting a third party access to the provider network contract;

(3) the third party accessing the provider network contract agrees to comply with all of the original contract's terms, including the contracted fee schedule and obligations concerning patient steerage;

(4) the provider, issuer, or other contracting entity provides in writing to the dentist the names of all third parties with access to the provider network in existence as of the date the contract is entered into;

(5) the provider, issuer, or other contracting entity identifies all current third parties with access to the provider network on its Internet website with a list updated at least once every 90 days;

(6) the provider, issuer, or other contracting entity requires a third party with access to the provider network to identify the source of any discount on all remittance advices or explanations of payment under which a discount is taken, provided that this subsection does not apply to electronic transactions mandated by the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191);

(7) the provider, issuer, or other contracting entity provides written or electronic notice to network dentists that a third party will lease, acquire, or obtain access to the provider network at least 30 days before the lease or access takes effect;

(8) the provider, issuer, or other contracting entity provides written or electronic notice to network dentists of the termination of the provider network contract at least 30 days before the termination date;

(9) a third party's right to a dentist's discounted rate ceases as of the termination date of the provider network contract; and

(10) the provider, issuer, or other contracting entity makes available a copy of the provider network contract relied on in the adjudication of a claim to a network dentist not later than the 30th day after the date the dentist requests a copy of that contract.

(c) Subsections (b)(7) and (8) do not apply to a contracting entity that only organizes and leases networks but does not engage in the business of insurance.

(d) A person may not bind or require a dentist to perform dental care services under a provider network contract that has been sold, leased, or assigned to a third party or for which a third party has otherwise obtained provider network access in violation of this section.

(e) This section does not apply:

(1) if access to a provider network contract is granted to:

(A) a third party operating in accordance with the same brand licensee program as the employee benefit plan provider, health insurance policy issuer, or other contracting entity selling or leasing the provider network contract, provided that the third party accessing the provider network contract agrees to comply with all of the original contract's terms, including the contracted fee schedule and obligations concerning patient steerage; or

(B) an entity that is an affiliate of the employee benefit plan provider, health insurance policy issuer, or other contracting entity selling or leasing the provider network contract, provided that:

(i) the provider, issuer, or entity publicly discloses the names of the affiliates on its Internet website; and

(ii) the affiliate accessing the provider network contract agrees to comply with all of the original contract's terms, including the contracted fee schedule and obligations concerning patient steerage;

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

(3) to a Medicaid managed care program operated under Chapter 533, Government Code, or a Medicaid program operated under Chapter 32, Human Resources Code.

Added by Acts 2023, 88th Leg., R.S., Ch. 1002 (H.B. 1527), Sec. 3, eff. September 1, 2023.

SUBCHAPTER F. ACCESS TO OBSTETRICAL OR GYNECOLOGICAL CARE

Sec. 1451.251. DEFINITION. In this subchapter, "enrollee" means an individual enrolled in a health benefit plan.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1451.252. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a health benefit plan that requires an enrollee to obtain certain specialty health care services through a referral made by a primary care physician or other gatekeeper and that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

- (i) an insurance company;
- (ii) a group hospital service corporation operating under Chapter 842;
- (iii) a fraternal benefit society operating under Chapter 885;
- (iv) a stipulated premium company operating under Chapter 884; or
- (v) a health maintenance organization operating under Chapter 843; and

(B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:

- (i) a multiple employer welfare arrangement as defined by Section 3 of that Act; or
- (ii) another analogous benefit arrangement;

(2) is offered by:

(A) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844; or

(B) an entity that is not authorized under this code or another insurance law of this state that contracts directly for health care services on a risk-sharing basis, including a capitation basis; or

(3) provides health and accident coverage through a risk pool created under Chapter 172, Local Government Code, notwithstanding Section 172.014, Local Government Code, or any other law.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1451.253. EXCEPTION. This subchapter does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease;

(B) only for accidental death or dismemberment;

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

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

(2) a small employer health benefit plan written under Chapter 1501;

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

(4) a workers' compensation insurance policy;

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

(6) 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 as described by Section 1451.252; or

(7) any health benefit plan that does not provide:

(A) benefits related to pregnancy; or

(B) well-woman care benefits.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1451.254. RULES. The commissioner shall adopt rules necessary to implement this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1451.255. RIGHT OF FEMALE ENROLLEE TO SELECT OBSTETRICIAN OR GYNECOLOGIST. (a) Except as provided by Subsection (b), a health benefit plan shall permit a female enrollee to select, in addition to a primary care physician, an obstetrician or gynecologist to provide the enrollee with health care services that are within the scope of the professional specialty practice of a properly credentialed obstetrician or gynecologist.

(b) A health benefit plan may limit an enrollee's self-referral under Subsection (a) to only one participating obstetrician or gynecologist to provide both gynecological and obstetrical care to the enrollee. This subsection does not affect the right of an enrollee to select the physician who provides that care.

(c) This section does not preclude an enrollee from selecting a qualified physician, including a family physician or internal medicine physician, to provide the enrollee with health care services described by Subsection (a).

(d) This section does not affect the authority of a health benefit plan issuer to establish selection criteria regarding other physicians who provide services under the plan.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1451.256. DIRECT ACCESS TO SERVICES OF OBSTETRICIAN OR GYNECOLOGIST. (a) In this section, "health care services" includes:

- (1) one well-woman examination each year;
- (2) care related to pregnancy;
- (3) care for any active gynecological condition; and
- (4) diagnosis, treatment, and referral for any disease or condition that is within the scope of the professional specialty practice of a properly credentialed obstetrician or gynecologist.

(b) In addition to other benefits authorized under the health benefit plan, a health benefit plan shall permit an enrollee who selects an obstetrician or gynecologist under Section 1451.255 to have direct access to the health care services of that selected physician without:

- (1) a referral from the enrollee's primary care physician;

or

(2) prior authorization or precertification from the plan issuer.

(c) A health benefit plan may not impose a copayment or deductible for direct access to health care services as required by this section unless the same copayment or deductible is imposed for access to other health care services provided under the plan.

(d) This section does not affect the authority of a health benefit plan issuer to require an obstetrician or gynecologist selected by an enrollee under Section 1451.255 to forward information concerning the medical care of the enrollee to the enrollee's primary care physician.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1451.257. AVAILABILITY OF PROVIDERS. To ensure access to services that are within the scope of the professional specialty practice of a properly credentialed obstetrician or gynecologist, a health benefit plan shall include in the classification of persons authorized to provide medical services under the plan a sufficient number of properly credentialed obstetricians and gynecologists.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1451.258. NOTICE OF AVAILABLE PROVIDERS. (a) A health benefit plan issuer shall provide to each person covered under the plan a timely written notice of the choices of the types of physician providers available for the direct access required under this subchapter.

(b) The notice must be stated in clear and accurate language.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1451.259. LIMITS ON PHYSICIAN SANCTIONS. (a) A health benefit plan may not sanction or terminate a primary care physician because of female enrollees' access to participating obstetricians and gynecologists under this subchapter.

(b) A health benefit plan may not impose a financial or other

penalty on an obstetrician or gynecologist selected under Section 1451.255, or on the enrollee who selected the physician, because the selected physician failed to provide to the enrollee's primary care physician information concerning the medical care of the enrollee if the selected physician made a reasonable good faith effort to forward the information.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1451.260. ADMINISTRATIVE PENALTY. An entity that operates a health benefit plan in violation of this subchapter is subject to an administrative penalty as provided by Chapter 84.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

SUBCHAPTER G. ACCESS TO DIETITIAN SERVICES

Sec. 1451.301. APPLICABILITY OF GENERAL PROVISIONS OF OTHER LAW. The provisions of Chapter 1201, including provisions relating to the applicability, purpose, and enforcement of that chapter, the construction of policies under that chapter, rulemaking under that chapter, and definitions of terms applicable in that chapter, apply to this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1451.302. DIETITIAN SERVICES. An individual or group accident and health insurance policy delivered or issued for delivery in this state may not:

- (1) exclude or deny coverage for services performed by:
 - (A) a dietitian; or
 - (B) a provisionally licensed dietitian acting under the supervision of a dietitian; or
- (2) refuse payment or reimbursement for charges for services described by Subdivision (1) if the services:
 - (A) are in the scope of the dietitian's license;
 - (B) are related to an injury or illness the policy covers if the services are scheduled in the policy; and
 - (C) are provided under a professional recommendation of

a physician whose treatment or examination for the injury or illness would be covered by the policy and would be payable or reimbursable under the policy.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

SUBCHAPTER H. DISABILITY CERTIFIED BY PODIATRIST

Sec. 1451.351. LOSS OF INCOME BENEFITS FOR DISABILITY TREATABLE BY PODIATRIST. (a) This section applies only to an insurance policy delivered, issued for delivery, or renewed in this state that provides benefits covering loss of income as a result of an acute temporary disability caused by sickness or injury.

(b) An insurance policy may not deny payment of benefits described by Subsection (a) solely because the disability is certified or attested to by a podiatrist if the disability is caused by a sickness or injury that may be treated within the scope of the podiatrist's license.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

SUBCHAPTER I. USE OF OSTEOPATHIC HOSPITAL

Sec. 1451.401. CONTRACT WITH OSTEOPATHIC HOSPITAL. A health maintenance organization or preferred provider benefit plan issuer that contracts with a hospital to provide services to covered individuals may not refuse to contract with an osteopathic hospital solely because the hospital is an osteopathic hospital.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1451.402. SERVICES AT OSTEOPATHIC HOSPITAL. A health maintenance organization or preferred provider benefit plan issuer that provides benefits for inpatient or outpatient services provided by an allopathic hospital shall seek to provide benefits for similar services provided by an osteopathic hospital if there is an osteopathic hospital within the service area of the health maintenance organization or preferred provider benefit plan issuer that will provide the services at a substantially similar cost.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1451.403. REQUEST FOR ACTION OF COMMISSIONER. An aggrieved party may request that the commissioner conduct an investigation, review, hearing, or other proceeding to determine compliance with this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1451.404. ENFORCEMENT. The commissioner shall take all reasonable actions to ensure compliance with this subchapter, including issuing orders and assessing penalties.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

SUBCHAPTER J. REIMBURSEMENT OF HEALTH CARE PROVIDERS

Sec. 1451.451. REIMBURSEMENT UNDER MEDICAID-BASED FEE SCHEDULE.

Text of subsection effective until April 1, 2025

(a) An insurance company, health maintenance organization, or preferred provider organization that contracts with a health care provider to provide services in connection with Chapter 533, Government Code, or Chapter 62, Health and Safety Code, may not require the health care provider to provide access to or transfer the provider's name and contracted discounted fee for use with health benefit plans issued to individuals and groups under Chapter 1271 or 1301.

Text of subsection effective on April 1, 2025

(a) An insurance company, health maintenance organization, or preferred provider organization that contracts with a health care provider to provide services in connection with Chapter 540 or 540A, Government Code, as applicable, or Chapter 62, Health and Safety Code, may not require the health care provider to provide access to or transfer the provider's name and contracted discounted fee for use with health benefit plans issued to individuals and groups under Chapter 1271 or 1301.

(b) An insurance company, health maintenance organization, or

preferred provider organization may provide access to or transfer a provider's name and discounted fee described by Subsection (a) only if:

(1) the insurance company, health maintenance organization, or preferred provider organization provides written notice to the provider that is printed in conspicuous boldface type near a separate signature line and includes a statement substantially similar to the following: "By signing on this line, you may be agreeing to apply this company's Medicaid or CHIP fee schedule to services you provide to commercial insurance or HMO enrollees."; and

(2) the provider authorizes the access or transfer and agrees to accept the contracted discounted fee by signing the notice described in Subdivision (1).

Added by Acts 2013, 83rd Leg., R.S., Ch. 778 (S.B. 1221), Sec. 1, eff. June 14, 2013.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 2.132, eff. April 1, 2025.

SUBCHAPTER K. HEALTH CARE PROVIDER DIRECTORIES

Sec. 1451.501. DEFINITIONS. In this subchapter:

(1) "Facility" has the meaning assigned by Section 324.001, Health and Safety Code.

(1-a) "Facility-based physician or provider" means a physician or health care provider:

(A) to whom a facility has granted clinical privileges; and

(B) who provides services to patients of the facility under those clinical privileges.

(1-b) "Health care provider" means a practitioner, institutional provider, or other person or organization that furnishes health care services and that is licensed or otherwise authorized to practice in this state. The term includes a pharmacist, pharmacy, hospital, nursing home, or other medical or health-related service facility that provides care for the sick or injured or other care. The term does not include a physician.

(2) "Physician" means an individual licensed to practice medicine in this state.

Added by Acts 2015, 84th Leg., R.S., Ch. 1038 (H.B. 1624), Sec. 2, eff. September 1, 2015.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 1218 (S.B. 1742), Sec. 1.01, eff. September 1, 2019.

Acts 2023, 88th Leg., R.S., Ch. 18 (S.B. 1003), Sec. 1, eff. September 1, 2023.

Sec. 1451.502. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a health benefit plan 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 a small or large employer group contract or similar coverage document that is offered by:

- (1) an insurance company;
- (2) a group hospital service corporation operating under Chapter 842;
- (3) a fraternal benefit society operating under Chapter 885;
- (4) a stipulated premium company operating under Chapter 884;
- (5) a reciprocal exchange operating under Chapter 942;
- (6) a health maintenance organization operating under Chapter 843;
- (7) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; or
- (8) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844.

Added by Acts 2015, 84th Leg., R.S., Ch. 1038 (H.B. 1624), Sec. 2, eff. September 1, 2015.

Text of section effective until April 1, 2025

Sec. 1451.503. EXCEPTION. This subchapter does not apply to:

- (1) a health benefit plan that provides coverage:
 - (A) only for a specified disease or for another single benefit;

- (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 as described by Section 1451.502;
- (6) the child health plan program under Chapter 62, Health and Safety Code, or the health benefits plan for children under Chapter 63, Health and Safety Code; or
- (7) a Medicaid managed care program operated under Chapter 533, Government Code, or a Medicaid program operated under Chapter 32, Human Resources Code.

Added by Acts 2015, 84th Leg., R.S., Ch. 1038 (H.B. 1624), Sec. 2, eff. September 1, 2015.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 2.133, eff. April 1, 2025.

Text of section effective on April 1, 2025

Sec. 1451.503. EXCEPTION. This subchapter does not apply to:

- (1) a health benefit plan that provides coverage:
 - (A) only for a specified disease or for another single benefit;
 - (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 as described by Section 1451.502;

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

(7) a Medicaid managed care program operated under Chapter 540 or 540A, Government Code, as applicable, or a Medicaid program operated under Chapter 32, Human Resources Code.

Added by Acts 2015, 84th Leg., R.S., Ch. 1038 (H.B. [1624](#)), Sec. 2, eff. September 1, 2015.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. [4611](#)), Sec. 2.133, eff. April 1, 2025.

Sec. 1451.504. PHYSICIAN AND HEALTH CARE PROVIDER DIRECTORIES.

(a) A health benefit plan issuer that offers coverage for health care services through preferred providers, exclusive providers, or a network of physicians or health care providers shall develop and maintain a physician and health care provider directory in accordance with this subchapter.

(b) The directory must include the name, street address, specialty, if any, and telephone number of each physician and health care provider described by Subsection (a) and indicate whether the

physician or provider is accepting new patients.

(c) Except as provided by Subsection (e), for each health care provider that is a facility included in the directory under this section, the directory must:

(1) list under the facility name separate headings for specialties, including radiologists, anesthesiologists, nurse anesthetists, anesthesiologist assistants, pathologists, emergency department physicians, neonatologists, nurse midwives, surgical assistants, physical therapists, occupational therapists, speech-language pathologists, and any other specialty identified by commissioner rule;

(2) list under each heading described by Subdivision (1) each facility-based physician or provider described by Subsection (a) practicing in the specialty corresponding with that heading that is a preferred provider, exclusive provider, or network physician or provider;

(3) for the facility and each facility-based physician or provider described by Subdivision (2), clearly indicate each health benefit plan issued by the issuer that may provide coverage for the services provided by that facility or facility-based physician or provider; and

(4) include the facility in a listing of all facilities included in the directory indicating:

(A) the name of the facility;

(B) the municipality in which the facility is located or county in which the facility is located if the facility is in the unincorporated area of the county;

(C) for each specialty of facility-based physician or provider practicing at the facility, the name, street address, and telephone number of any facility-based physician or provider that is a preferred provider, exclusive provider, or network physician or provider or of the physician or provider group in which the facility-based physician or provider practices;

(D) each health benefit plan issued by the issuer that may provide coverage for the services provided by the facility; and

(E) each health benefit plan issued by the issuer that may provide coverage for the services provided by each facility-based physician or provider group.

(d) The directory must list a facility-based physician or provider individually and, if the physician or provider belongs to a

physician or provider group, as part of the physician or provider group.

(e) The directory is not required to list a physician or health care provider who is employed by the facility.

Added by Acts 2015, 84th Leg., R.S., Ch. 1038 (H.B. 1624), Sec. 2, eff. September 1, 2015.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 1218 (S.B. 1742), Sec. 1.02, eff. September 1, 2019.

Acts 2023, 88th Leg., R.S., Ch. 18 (S.B. 1003), Sec. 2, eff. September 1, 2023.

Sec. 1451.505. PHYSICIAN AND HEALTH CARE PROVIDER DIRECTORY ON INTERNET WEBSITE. (a) A health benefit plan issuer shall display on a public Internet website maintained by the issuer the directory required by Section 1451.504. A direct electronic link to the directory must be displayed in a conspicuous manner in the electronic summary of benefits and coverage of each health benefit plan issued by the health benefit plan issuer on the Internet website.

(b) The health benefit plan issuer shall clearly indicate in the directory each health benefit plan issued by the issuer that may provide coverage for services provided by each physician or health care provider included in the directory.

(c) The directory must be:

(1) electronically searchable by physician or health care provider name, specialty, if any, facility, and location; and

(2) publicly accessible without necessity of providing a password, a user name, or personally identifiable information.

(d) The health benefit plan issuer shall conduct an ongoing review of the directory and correct or update the information as necessary. Except as provided by Subsection (e), corrections and updates, if any, must be made not less than once each month.

(e) The health benefit plan issuer shall conspicuously display in the directory required by Section 1451.504 an e-mail address and a toll-free telephone number to which any individual may report any inaccuracy in the directory. If the issuer receives a report from any person that specifically identified directory information may be inaccurate, the issuer shall investigate the report and correct the

information, as necessary, not later than the seventh day after the date the report is received.

Added by Acts 2015, 84th Leg., R.S., Ch. 1038 (H.B. 1624), Sec. 2, eff. September 1, 2015.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 1218 (S.B. 1742), Sec. 1.03, eff. September 1, 2019.

CHAPTER 1452. PHYSICIAN AND PROVIDER CREDENTIALS
SUBCHAPTER A. CREDENTIALING OF PHYSICIANS AND PROVIDERS BY HEALTH
MAINTENANCE ORGANIZATION

Sec. 1452.001. APPLICABILITY OF CERTAIN DEFINITIONS. In this subchapter, a term defined by Section 843.002 has the meaning assigned by that section.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1452.002. VERIFICATION OF PHYSICIAN'S LICENSE OR CERTIFICATE. The commissioner shall require a health maintenance organization to verify that a physician's license to practice medicine and any other certificate the physician is required to hold, including a certificate issued by the Department of Public Safety or the federal Drug Enforcement Administration or a certificate issued under the Medicare program, is valid as of the date of:

- (1) initial credentialing of the physician; and
- (2) each recredentialing.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1452.003. SITE VISIT FOR INITIAL CREDENTIALING. (a) The commissioner shall require a health maintenance organization that conducts a site visit for the purpose of initial credentialing of a physician or provider to evaluate during the visit a site's accessibility, appearance, space, medical or dental recordkeeping practices, availability of appointments, and confidentiality procedures.

(b) The commissioner may not require the health maintenance

organization to evaluate the appropriateness of equipment during the site visit.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1452.004. LIMITATION ON COMMISSIONER'S AUTHORITY. The commissioner may not require a health maintenance organization to:

- (1) formally recredential a physician or provider more frequently than once in any three-year period;
- (2) verify the validity of a license or certificate held by a physician as of a date other than the date of initial credentialing or recredentialing of the physician;
- (3) use clinical personnel to perform a site visit for initial credentialing of a physician or provider unless clinical review is needed during the site visit; or
- (4) require a site visit be performed for the purpose of recredentialing of a physician or provider.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1452.005. SITE VISIT FOR CAUSE NOT PRECLUDED. This subchapter does not preclude a health maintenance organization from conducting a site visit of a physician or provider at any time for cause, including a complaint made by a member or another external complaint made to the health maintenance organization.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1452.006. RULES RELATED TO SELECTION OF PHYSICIANS AND PROVIDERS BY HEALTH MAINTENANCE ORGANIZATION. A rule adopted by the commissioner under Section 843.102 that relates to implementation and maintenance by a health maintenance organization of a process for selecting and retaining affiliated physicians and providers must comply with:

- (1) this subchapter; and
- (2) standards adopted by the National Committee for Quality Assurance, to the extent those standards do not conflict with other laws of this state.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

SUBCHAPTER B. STANDARDIZED FORMS

Sec. 1452.051. DEFINITIONS. In this subchapter:

(1) "Advanced practice nurse" has the meaning assigned by Section 301.152, Occupations Code.

(2) "Physician" means an individual licensed to practice medicine in this state.

(3) "Physician assistant" means an individual who holds a license issued under Chapter 204, Occupations Code.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.045(a), eff. September 1, 2005.

Sec. 1452.052. STANDARDIZED FORM FOR VERIFICATION OF CREDENTIALS. (a) The commissioner by rule shall:

(1) prescribe a standardized form for the verification of the credentials of a physician, advanced practice nurse, or physician assistant; and

(2) require a public or private hospital, a health maintenance organization operating under Chapter 843, or the issuer of a preferred provider benefit plan under Chapter 1301 to use the form for verification of credentials.

(b) In prescribing a form under this section, the commissioner shall consider any credentialing application form that is widely used in this state or any form currently used by the department.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.045(a), eff. September 1, 2005.

SUBCHAPTER C. EXPEDITED CREDENTIALING PROCESS FOR CERTAIN PHYSICIANS

Sec. 1452.101. DEFINITIONS. In this subchapter:

(1) "Applicant physician" means a physician applying for

expedited credentialing under this subchapter.

(2) "Enrollee" means an individual who is eligible to receive health care services under a managed care plan.

(3) "Health care provider" means:

(A) an individual who is licensed, certified, or otherwise authorized to provide health care services in this state; or

(B) a hospital, emergency clinic, outpatient clinic, or other facility providing health care services.

(4) "Managed care plan" means a health benefit plan under which health care services are provided to enrollees through contracts with health care providers and that requires enrollees to use participating providers or that provides a different level of coverage for enrollees who use participating providers. The term includes a health benefit plan issued by:

(A) a health maintenance organization;

(B) a preferred provider benefit plan issuer; or

(C) any other entity that issues a health benefit plan, including an insurance company.

(5) "Medical group" means:

(A) a single legal entity owned by two or more physicians;

(B) a professional association composed of licensed physicians;

(C) any other business entity composed of licensed physicians as permitted under Subchapter B, Chapter 162, Occupations Code; or

(D) two or more physicians on the medical staff of, or teaching at, a medical school or medical and dental unit, as defined or described by Section 61.003, 61.501, or 74.601, Education Code.

(6) "Participating provider" means a health care provider who has contracted with a health benefit plan issuer to provide services to enrollees.

Added by Acts 2007, 80th Leg., R.S., Ch. 1203 (H.B. 1594), Sec. 1, eff. September 1, 2007.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 296 (H.B. 389), Sec. 1, eff. September 1, 2009.

Acts 2011, 82nd Leg., R.S., Ch. 414 (S.B. 822), Sec. 1, eff.

September 1, 2011.

Sec. 1452.102. APPLICABILITY. This subchapter applies only to a physician who joins an established medical group that has a current contract in force with a managed care plan.

Added by Acts 2007, 80th Leg., R.S., Ch. 1203 (H.B. 1594), Sec. 1, eff. September 1, 2007.

Sec. 1452.103. ELIGIBILITY REQUIREMENTS. To qualify for expedited credentialing under this subchapter and payment under Section 1452.104, an applicant physician must:

- (1) be licensed in this state by, and in good standing with, the Texas Medical Board;
- (2) submit all documentation and other information required by the issuer of the managed care plan as necessary to enable the issuer to begin the credentialing process required by the issuer to include a physician in the issuer's health benefit plan network; and
- (3) agree to comply with the terms of the managed care plan's participating provider contract currently in force with the applicant physician's established medical group.

Added by Acts 2007, 80th Leg., R.S., Ch. 1203 (H.B. 1594), Sec. 1, eff. September 1, 2007.

Sec. 1452.104. PAYMENT OF APPLICANT PHYSICIAN DURING CREDENTIALING PROCESS. On submission by the applicant physician of the information required by the managed care plan issuer under Section 1452.103(2), and for payment purposes only, the issuer shall treat the applicant physician as if the physician were a participating provider in the health benefit plan network when the applicant physician provides services to the managed care plan's enrollees, including:

- (1) authorizing the applicant physician to collect copayments from the enrollees; and
- (2) making payments to the applicant physician.

Added by Acts 2007, 80th Leg., R.S., Ch. 1203 (H.B. 1594), Sec. 1,

eff. September 1, 2007.

Sec. 1452.105. DIRECTORY ENTRIES. Pending the approval of an application submitted under Section 1452.104, the managed care plan may exclude the applicant physician from the managed care plan's directory of participating physicians, the managed care plan's website listing of participating physicians, or any other listing of participating physicians.

Added by Acts 2007, 80th Leg., R.S., Ch. 1203 (H.B. 1594), Sec. 1, eff. September 1, 2007.

Sec. 1452.106. EFFECT OF FAILURE TO MEET CREDENTIALING REQUIREMENTS. If, on completion of the credentialing process, the managed care plan issuer determines that the applicant physician does not meet the issuer's credentialing requirements:

(1) the managed care plan issuer may recover from the applicant physician or the physician's medical group an amount equal to the difference between payments for in-network benefits and out-of-network benefits; and

(2) the applicant physician or the physician's medical group may retain any copayments collected or in the process of being collected as of the date of the issuer's determination.

Added by Acts 2007, 80th Leg., R.S., Ch. 1203 (H.B. 1594), Sec. 1, eff. September 1, 2007.

Sec. 1452.107. ENROLLEE HELD HARMLESS. An enrollee in the managed care plan is not responsible and shall be held harmless for the difference between in-network copayments paid by the enrollee to a physician who is determined to be ineligible under Section 1452.106 and the managed care plan's charges for out-of-network services. The physician and the physician's medical group may not charge the enrollee for any portion of the physician's fee that is not paid or reimbursed by the enrollee's managed care plan.

Added by Acts 2007, 80th Leg., R.S., Ch. 1203 (H.B. 1594), Sec. 1, eff. September 1, 2007.

Sec. 1452.108. LIMITATION ON MANAGED CARE ISSUER LIABILITY. A managed care plan issuer that complies with this subchapter is not subject to liability for damages arising out of or in connection with, directly or indirectly, the payment by the issuer of an applicant physician as if the physician were a participating provider in the health benefit plan network.

Added by Acts 2007, 80th Leg., R.S., Ch. 1203 (H.B. 1594), Sec. 1, eff. September 1, 2007.

**SUBCHAPTER D. EXPEDITED CREDENTIALING PROCESS
FOR CERTAIN PODIATRISTS**

Sec. 1452.151. DEFINITIONS. In this subchapter:

- (1) "Applicant podiatrist" means a podiatrist applying for expedited credentialing under this subchapter.
- (2) "Enrollee" means an individual who is eligible to receive health care services under a managed care plan.
- (3) "Health care provider" means:
 - (A) an individual who is licensed, certified, or otherwise authorized to provide health care services in this state; or
 - (B) a hospital, emergency clinic, outpatient clinic, or other facility providing health care services.
- (4) "Managed care plan" means a health benefit plan under which health care services are provided to enrollees through contracts with health care providers and that requires enrollees to use participating providers or that provides a different level of coverage for enrollees who use participating providers. The term includes a health benefit plan issued by:
 - (A) a health maintenance organization;
 - (B) a preferred provider benefit plan issuer; or
 - (C) any other entity that issues a health benefit plan, including an insurance company.
- (5) "Participating provider" means a health care provider who has contracted with a health benefit plan issuer to provide services to enrollees.
- (6) "Professional practice" means a business entity that is

owned by one or more podiatrists or physicians.

Added by Acts 2013, 83rd Leg., R.S., Ch. 79 (S.B. 365), Sec. 1, eff. September 1, 2013.

Sec. 1452.152. APPLICABILITY. This subchapter applies only to a podiatrist who joins an established professional practice that has a current contract in force with a managed care plan.

Added by Acts 2013, 83rd Leg., R.S., Ch. 79 (S.B. 365), Sec. 1, eff. September 1, 2013.

Sec. 1452.153. ELIGIBILITY REQUIREMENTS. To qualify for expedited credentialing under this subchapter and payment under Section 1452.154, an applicant podiatrist must:

- (1) be licensed as a podiatrist in this state by, and be in good standing with, the Texas Department of Licensing and Regulation;
- (2) submit all documentation and other information required by the issuer of the managed care plan as necessary to enable the issuer to begin the credentialing process required by the issuer to include a podiatrist in the issuer's health benefit plan network; and
- (3) agree to comply with the terms of the managed care plan's participating provider contract currently in force with the applicant podiatrist's established professional practice.

Added by Acts 2013, 83rd Leg., R.S., Ch. 79 (S.B. 365), Sec. 1, eff. September 1, 2013.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 467 (H.B. 4170), Sec. 19.016, eff. September 1, 2019.

Sec. 1452.154. PAYMENT OF APPLICANT PODIATRIST DURING CREDENTIALING PROCESS. On submission by the applicant podiatrist of the information required by the managed care plan issuer under Section 1452.153(2), and for payment purposes only, the issuer shall treat the applicant podiatrist as if the podiatrist were a participating provider in the health benefit plan network when the applicant podiatrist provides services to the managed care plan's

enrollees, including:

- (1) authorizing the applicant podiatrist to collect copayments from the enrollees; and
- (2) making payments to the applicant podiatrist.

Added by Acts 2013, 83rd Leg., R.S., Ch. 79 (S.B. 365), Sec. 1, eff. September 1, 2013.

Sec. 1452.155. DIRECTORY ENTRIES. Pending the approval of an application submitted under Section 1452.154, the managed care plan may exclude the applicant podiatrist from the managed care plan's directory of participating podiatrists, the managed care plan's website listing of participating podiatrists, or any other listing of participating podiatrists.

Added by Acts 2013, 83rd Leg., R.S., Ch. 79 (S.B. 365), Sec. 1, eff. September 1, 2013.

Sec. 1452.156. EFFECT OF FAILURE TO MEET CREDENTIALING REQUIREMENTS. If, on completion of the credentialing process, the managed care plan issuer determines that the applicant podiatrist does not meet the issuer's credentialing requirements:

- (1) the managed care plan issuer may recover from the applicant podiatrist or the podiatrist's professional practice an amount equal to the difference between payments for in-network benefits and out-of-network benefits; and
- (2) the applicant podiatrist or the podiatrist's professional practice may retain any copayments collected or in the process of being collected as of the date of the issuer's determination.

Added by Acts 2013, 83rd Leg., R.S., Ch. 79 (S.B. 365), Sec. 1, eff. September 1, 2013.

Sec. 1452.157. ENROLLEE HELD HARMLESS. An enrollee in the managed care plan is not responsible and shall be held harmless for the difference between in-network copayments paid by the enrollee to a podiatrist who is determined to be ineligible under Section

1452.156 and the managed care plan's charges for out-of-network services. The podiatrist and the podiatrist's professional practice may not charge the enrollee for any portion of the podiatrist's fee that is not paid or reimbursed by the enrollee's managed care plan.

Added by Acts 2013, 83rd Leg., R.S., Ch. 79 (S.B. 365), Sec. 1, eff. September 1, 2013.

Sec. 1452.158. LIMITATION ON MANAGED CARE ISSUER LIABILITY. A managed care plan issuer that complies with this subchapter is not subject to liability for damages arising out of or in connection with, directly or indirectly, the payment by the issuer of an applicant podiatrist as if the podiatrist were a participating provider in the health benefit plan network.

Added by Acts 2013, 83rd Leg., R.S., Ch. 79 (S.B. 365), Sec. 1, eff. September 1, 2013.

**SUBCHAPTER E. EXPEDITED CREDENTIALING PROCESS
FOR CERTAIN THERAPEUTIC OPTOMETRISTS**

Sec. 1452.201. DEFINITIONS. In this subchapter:

- (1) "Applicant therapeutic optometrist" means a therapeutic optometrist applying for expedited credentialing under this subchapter.
- (2) "Enrollee" means an individual who is eligible to receive health care services under a managed care plan.
- (3) "Health care provider" has the meaning assigned by Section 1452.151.
- (4) "Managed care plan" has the meaning assigned by Section 1452.151.
- (5) "Participating provider" means a health care provider who has contracted with a health benefit plan issuer to provide services to enrollees.
- (6) "Professional practice" means a business entity that is owned by one or more therapeutic optometrists or physicians.

Added by Acts 2013, 83rd Leg., R.S., Ch. 79 (S.B. 365), Sec. 1, eff. September 1, 2013.

Sec. 1452.202. APPLICABILITY. This subchapter applies only to a therapeutic optometrist who joins an established professional practice that has a current contract in force with a managed care plan.

Added by Acts 2013, 83rd Leg., R.S., Ch. 79 (S.B. 365), Sec. 1, eff. September 1, 2013.

Sec. 1452.203. ELIGIBILITY REQUIREMENTS. To qualify for expedited credentialing under this subchapter and payment under Section 1452.204, an applicant therapeutic optometrist must:

- (1) be licensed in this state by, and in good standing with, the Texas Optometry Board;
- (2) submit all documentation and other information required by the issuer of the managed care plan as necessary to enable the issuer to begin the credentialing process required by the issuer to include a therapeutic optometrist in the issuer's health benefit plan network; and
- (3) agree to comply with the terms of the managed care plan's participating provider contract currently in force with the applicant therapeutic optometrist's established professional practice.

Added by Acts 2013, 83rd Leg., R.S., Ch. 79 (S.B. 365), Sec. 1, eff. September 1, 2013.

Sec. 1452.204. PAYMENT OF APPLICANT THERAPEUTIC OPTOMETRIST DURING CREDENTIALING PROCESS. On submission by the applicant therapeutic optometrist of the information required by the managed care plan issuer under Section 1452.203(2), and for payment purposes only, the issuer shall treat the applicant therapeutic optometrist as if the therapeutic optometrist were a participating provider in the health benefit plan network when the applicant therapeutic optometrist provides services to the managed care plan's enrollees, including:

- (1) authorizing the applicant therapeutic optometrist to collect copayments from the enrollees; and
- (2) making payments to the applicant therapeutic optometrist.

Added by Acts 2013, 83rd Leg., R.S., Ch. 79 (S.B. 365), Sec. 1, eff. September 1, 2013.

Sec. 1452.205. DIRECTORY ENTRIES. Pending the approval of an application submitted under Section 1452.204, the managed care plan may exclude the applicant therapeutic optometrist from the managed care plan's directory of participating therapeutic optometrists, the managed care plan's website listing of participating therapeutic optometrists, or any other listing of participating therapeutic optometrists.

Added by Acts 2013, 83rd Leg., R.S., Ch. 79 (S.B. 365), Sec. 1, eff. September 1, 2013.

Sec. 1452.206. EFFECT OF FAILURE TO MEET CREDENTIALING REQUIREMENTS. If, on completion of the credentialing process, the managed care plan issuer determines that the applicant therapeutic optometrist does not meet the issuer's credentialing requirements:

(1) the managed care plan issuer may recover from the applicant therapeutic optometrist or the therapeutic optometrist's professional practice an amount equal to the difference between payments for in-network benefits and out-of-network benefits; and

(2) the applicant therapeutic optometrist or the therapeutic optometrist's professional practice may retain any copayments collected or in the process of being collected as of the date of the issuer's determination.

Added by Acts 2013, 83rd Leg., R.S., Ch. 79 (S.B. 365), Sec. 1, eff. September 1, 2013.

Sec. 1452.207. ENROLLEE HELD HARMLESS. An enrollee in the managed care plan is not responsible and shall be held harmless for the difference between in-network copayments paid by the enrollee to a therapeutic optometrist who is determined to be ineligible under Section 1452.206 and the managed care plan's charges for out-of-network services. The therapeutic optometrist and the therapeutic optometrist's professional practice may not charge the enrollee for any portion of the therapeutic optometrist's fee that is not paid or

reimbursed by the enrollee's managed care plan.

Added by Acts 2013, 83rd Leg., R.S., Ch. 79 (S.B. 365), Sec. 1, eff. September 1, 2013.

Sec. 1452.208. LIMITATION ON MANAGED CARE ISSUER LIABILITY. A managed care plan issuer that complies with this subchapter is not subject to liability for damages arising out of or in connection with, directly or indirectly, the payment by the issuer of an applicant therapeutic optometrist as if the therapeutic optometrist were a participating provider in the health benefit plan network.

Added by Acts 2013, 83rd Leg., R.S., Ch. 79 (S.B. 365), Sec. 1, eff. September 1, 2013.

CHAPTER 1453. DISCLOSURE OF REIMBURSEMENT GUIDELINES UNDER MANAGED CARE PLAN

Sec. 1453.001. DEFINITIONS. In this chapter:

(1) "Health care provider" means:

(A) a hospital, emergency clinic, outpatient clinic, or other facility providing health care services; or

(B) an individual who is licensed in this state to provide health care services.

(2) "Managed care entity" means:

(A) a health maintenance organization;

(B) a preferred provider benefit plan issuer;

(C) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844; or

(D) another entity that offers a managed care plan, including:

(i) an insurance company;

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

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

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

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

(vi) an entity not authorized under this code or another insurance law of this state that contracts directly for health care services on a risk-sharing basis, including a capitation basis.

(3) "Managed care plan" means a health benefit plan:

(A) under which health care services are provided through contracts with health care providers to individuals enrolled in or insured under the plan; and

(B) that provides financial incentives to individuals enrolled in or insured under the plan to use health care providers participating in the plan and procedures covered by the plan.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1453.002. PROVISION OF INFORMATION REGARDING REIMBURSEMENT GUIDELINES. (a) On the written request of an out-of-network health care provider, a managed care entity shall furnish to the provider a written description of the factors considered by the entity in determining the amount of reimbursement the provider may receive for goods or services provided to an individual enrolled in or insured under the entity's managed care plan.

(b) This section does not require a managed care entity to disclose proprietary information that is prohibited from disclosure by a contract between the entity and a vendor that supplies payment or statistical data to the entity.

(c) A contract between a managed care entity and a vendor that supplies payment or statistical data to the entity may not prohibit the entity from disclosing under this section:

(1) the name of the vendor; or

(2) the methodology and origin of information used to determine the amount of reimbursement.

(d) A managed care entity that denies a request for information described by Subsection (b) shall send a copy of the request and the information requested to the department for review.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1453.003. RULES. The commissioner shall adopt rules as necessary to implement this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

CHAPTER 1454. EQUAL HEALTH CARE FOR WOMEN

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1454.001. DEFINITIONS. In this chapter:

(1) "Health care provider" means a home health aide, hospital, nurse practitioner, nurse midwife, outpatient care center, physician assistant, registered nurse, or surgery center.

(2) "Physician" has the meaning assigned by Section 151.002, Occupations Code.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1454.002. APPLICABILITY OF CHAPTER. This chapter applies only to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is offered by:

(1) an insurance company;

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

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

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

(5) a reciprocal exchange operating under Chapter 942;

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

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

(8) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844; or

(9) a small employer health benefit plan written under Chapter 1501.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

SUBCHAPTER B. REIMBURSEMENT FOR HEALTH CARE SERVICES

Sec. 1454.051. EQUAL REIMBURSEMENT REQUIRED. A health benefit plan issuer that reimburses a physician or health care provider for reproductive health or oncology services provided to women must reimburse the physician or provider in an amount at least equal to the annual average compensation per hour or unit that would be paid in the service area to a physician or provider for the same medical, surgical, hospital, pharmaceutical, nursing, or other similar resources used to provide the services if the resources would be used to provide health services exclusively to men or to the general population.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1454.052. REIMBURSEMENT FOR ABORTION NOT REQUIRED. This chapter does not require a health benefit plan issuer to provide reimbursement for an abortion, as defined by the Family Code, or for a service related to an abortion.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

SUBCHAPTER C. ENFORCEMENT

Sec. 1454.101. SANCTIONS AUTHORIZED. The sanctions authorized by Chapter 82 apply to a health benefit plan issuer that violates this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1454.102. CEASE AND DESIST PROCEDURES AND RESTITUTION FOR ATTORNEY'S FEES AUTHORIZED. The commissioner may use the cease and desist procedures authorized by Chapter 83 against a health benefit plan issuer that violates this chapter. In accordance with Chapter 83, the commissioner may order the health benefit plan issuer to make complete restitution for the violation, which may include restitution for the reasonable attorney's fees incurred by a person making a complaint under this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1454.103. ADMINISTRATIVE PENALTIES AUTHORIZED. (a) In addition to any sanctions authorized by this subchapter, the commissioner may impose an administrative penalty in accordance with Chapter 84 on a health benefit plan issuer that violates this chapter.

(b) On a finding that a health benefit plan issuer knowingly violated this chapter, the commissioner may impose in addition to the administrative penalty authorized by Section 84.022 an administrative penalty that does not exceed \$25,000.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1454.104. AMOUNT OF DAMAGES. Notwithstanding this subchapter, in imposing a sanction or penalty for a violation of this chapter, the commissioner may order a health benefit plan issuer to pay the greater of complete or economic damages.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1454.105. APPLICABILITY OF CERTAIN PROCEDURAL REQUIREMENTS TO SANCTIONS OR ADMINISTRATIVE PENALTIES. Subchapter C, Chapter 84, applies to the imposition of a sanction or administrative penalty under this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1454.106. INTERVENTION IN PROCEEDING. (a) In a proceeding relating to the imposition by the commissioner of a sanction or administrative penalty under this chapter, a person affected by an order of the commissioner, including a physician or health care provider, may intervene in the proceeding by filing a notice of intervention with the commissioner. The commissioner shall provide an affected person a reasonable period to intervene.

(b) At the time the commissioner notifies a health benefit plan issuer of the issuer's opportunity for a hearing regarding an alleged violation, the commissioner shall notify each affected person of all

relevant information regarding the hearing.

(c) A person who intervenes under this section has the rights and powers of a party under Chapter 2001, Government Code.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1454.107. TIME FOR COMMISSIONER'S DETERMINATION. Not later than the 120th day after the date a complaint alleging a violation of this chapter is filed with the department, the commissioner shall determine whether the alleged violation occurred and impose appropriate sanctions.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1454.108. FAILURE OF COMMISSIONER TO MAKE DETERMINATION BY ORDER; ACTION IN DISTRICT COURT. (a) If the commissioner fails to determine by order in the time prescribed by Section 1454.107 whether a violation alleged in a complaint filed under this chapter occurred, the person who filed the complaint may bring an action in district court for the violation.

(b) The action must be commenced not later than the first anniversary of the date by which the commissioner is required to make a determination under Section 1454.107.

(c) In an action filed under this section, a court may:

(1) impose the sanctions authorized by this subchapter or similar sanctions;

(2) assess an additional civil penalty of \$25,000 if the trier of fact finds the defendant knowingly violated this chapter; and

(3) award a claimant who prevails in an action filed under this section reasonable attorney's fees and court costs, including reasonable and necessary expert witness fees.

(d) On a finding by the court that an action filed under this section was groundless and brought in bad faith or brought for the purpose of harassment, the court shall award the defendant reasonable and necessary attorney's fees.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1454.109. APPEAL OF COMMISSIONER'S ORDER. (a) A person affected by an order of the commissioner regarding a violation of this chapter, including a person who intervenes under Section 1454.106, may file an appeal in district court.

(b) The standard of review for an appeal filed under this section is substantial evidence.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

CHAPTER 1455. TELEMEDICINE, TELEDENTISTRY, AND TELEHEALTH

Sec. 1455.001. DEFINITIONS. In this chapter:

(1) "Dentist" means a person licensed to practice dentistry in this state under Subtitle D, Title 3, Occupations Code.

(1-a) "Health professional" means:

(A) a physician;

(B) an individual who is:

(i) licensed or certified in this state to perform health care services; and

(ii) authorized to assist:

(a) a physician in providing telemedicine medical services that are delegated and supervised by the physician; or

(b) a dentist in providing teledentistry dental services that are delegated and supervised by the dentist;

(C) a licensed or certified health professional acting within the scope of the license or certification who does not perform a telemedicine medical service or a teledentistry dental service; or

(D) a dentist.

(2) "Physician" means a person licensed to practice medicine in this state under Subtitle B, Title 3, Occupations Code.

(2-a) "Platform" means the technology, system, software, application, modality, or other method through which a health professional remotely interfaces with a patient when providing a health care service or procedure as a telemedicine medical service or telehealth service.

(3) "Teledentistry dental service," "telehealth service," and "telemedicine medical service" have the meanings assigned by Section 111.001, Occupations Code.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 205 (S.B. 1107), Sec. 5, eff. January 1, 2018.

Acts 2019, 86th Leg., R.S., Ch. 1174 (H.B. 3345), Sec. 1, eff. September 1, 2019.

Acts 2021, 87th Leg., R.S., Ch. 811 (H.B. 2056), Sec. 26, eff. September 1, 2021.

Sec. 1455.002. APPLICABILITY OF CHAPTER. This chapter applies only to a health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(i) an insurance company;

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

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

(iv) a stipulated premium company operating under Chapter 884; or

(v) a health maintenance organization operating under Chapter 843; and

(B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:

(i) a multiple employer welfare arrangement as defined by Section 3 of that Act; or

(ii) another analogous benefit arrangement; or

(2) is offered by an approved nonprofit health corporation that holds a certificate of authority under Chapter 844.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1455.003. EXCEPTION. This chapter does not apply to:

- (1) a plan that provides coverage:
 - (A) only for a specified disease;
 - (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; or
 - (D) as a supplement to a liability insurance policy;
- (2) a small employer health benefit plan written under Chapter 1501;
- (3) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);
- (4) a workers' compensation insurance policy;
- (5) medical payment insurance coverage provided under a motor vehicle insurance policy; or
- (6) 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 as described by Section 1455.002.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1455.004. COVERAGE FOR TELEMEDICINE MEDICAL SERVICES, TELEDENTISTRY DENTAL SERVICES, AND TELEHEALTH SERVICES. (a) A health benefit plan:

- (1) must provide coverage for a covered health care service or procedure delivered by a preferred or contracted health professional to a covered patient as a telemedicine medical service, teledentistry dental service, or telehealth service on the same basis and to the same extent that the plan provides coverage for the service or procedure in an in-person setting; and
- (2) may not:
 - (A) exclude from coverage a covered health care service or procedure delivered by a preferred or contracted health professional to a covered patient as a telemedicine medical service, a teledentistry dental service, or a telehealth service solely because the covered health care service or procedure is not provided through an in-person consultation; and
 - (B) subject to Subsection (c), limit, deny, or reduce coverage for a covered health care service or procedure delivered as

a telemedicine medical service, teledentistry dental service, or telehealth service based on the health professional's choice of platform for delivering the service or procedure.

(b) A health benefit plan may require a deductible, a copayment, or coinsurance for a covered health care service or procedure delivered by a preferred or contracted health professional to a covered patient as a telemedicine medical service, a teledentistry dental service, or a telehealth service. The amount of the deductible, copayment, or coinsurance may not exceed the amount of the deductible, copayment, or coinsurance required for the covered health care service or procedure provided through an in-person consultation.

(b-1) Subsection (b) does not authorize a health benefit plan to charge a separate deductible that applies only to a covered health care service or procedure delivered as a telemedicine medical service, teledentistry dental service, or telehealth service.

(c) Notwithstanding Subsection (a), a health benefit plan is not required to provide coverage for a telemedicine medical service, a teledentistry dental service, or a telehealth service provided by only synchronous or asynchronous audio interaction, including:

- (1) an audio-only telephone consultation;
- (2) a text-only e-mail message; or
- (3) a facsimile transmission.

(d) A health benefit plan may not impose an annual or lifetime maximum on coverage for covered health care services or procedures delivered as telemedicine medical services, teledentistry dental services, or telehealth services other than the annual or lifetime maximum, if any, that applies in the aggregate to all items and services and procedures covered under the plan.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2017, 85th Leg., R.S., Ch. 205 (S.B. [1107](#)), Sec. 6, eff. January 1, 2018.

Acts 2019, 86th Leg., R.S., Ch. 1174 (H.B. [3345](#)), Sec. 2, eff. September 1, 2019.

Acts 2021, 87th Leg., R.S., Ch. 811 (H.B. [2056](#)), Sec. 27, eff. January 1, 2022.

Sec. 1455.005. RULES. Subject to Section 111.004, Occupations Code, the commissioner may adopt rules necessary to implement this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 23.002(10), eff. September 1, 2005.

Sec. 1455.006. TELEMEDICINE MEDICAL SERVICES, TELEDENTISTRY DENTAL SERVICES, AND TELEHEALTH SERVICES STATEMENT. (a) Each issuer of a health benefit plan shall adopt and display in a conspicuous manner on the health benefit plan issuer's Internet website the issuer's policies and payment practices for telemedicine medical services, teledentistry dental services, and telehealth services.

(b) This section does not require an issuer of a health benefit plan to display negotiated contract payment rates for health professionals who contract with the issuer to provide telemedicine medical services, teledentistry dental services, or telehealth services.

Added by Acts 2017, 85th Leg., R.S., Ch. 205 (S.B. 1107), Sec. 7, eff. January 1, 2018.

Amended by:

Acts 2021, 87th Leg., R.S., Ch. 811 (H.B. 2056), Sec. 28, eff. January 1, 2022.

CHAPTER 1456. DISCLOSURE OF PROVIDER STATUS

Sec. 1456.001. DEFINITIONS. In this chapter:

(1) "Balance billing" means the practice of charging an enrollee in a health benefit plan that uses a provider network to recover from the enrollee the balance of a non-network health care provider's fee for service received by the enrollee from the health care provider that is not fully reimbursed by the enrollee's health benefit plan.

(2) "Enrollee" means an individual who is eligible to receive health care services through a health benefit plan.

(3) "Facility-based physician" means a radiologist, an anesthesiologist, a pathologist, an emergency department physician, a

neonatologist, or an assistant surgeon:

(A) to whom the facility has granted clinical privileges; and

(B) who provides services to patients of the facility under those clinical privileges.

(4) "Health care facility" means a hospital, emergency clinic, outpatient clinic, birthing center, ambulatory surgical center, or other facility providing health care services.

(5) "Health care practitioner" means an individual who is licensed to provide and provides health care services.

(6) "Provider network" means a health benefit plan under which health care services are provided to enrollees through contracts with health care providers and that requires those enrollees to use health care providers participating in the plan and procedures covered by the plan. The term includes a network operated by:

(A) a health maintenance organization;

(B) a preferred provider benefit plan issuer; or

(C) another entity that issues a health benefit plan, including an insurance company.

Added by Acts 2007, 80th Leg., R.S., Ch. 997 (S.B. [1731](#)), Sec. 11, eff. September 1, 2007.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 467 (S.B. [481](#)), Sec. 2, eff. September 1, 2015.

Sec. 1456.002. APPLICABILITY OF CHAPTER. (a) This chapter applies to any health benefit plan that:

(1) 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 that is offered by:

(A) an insurance company;

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

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

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

(E) a health maintenance organization operating under Chapter 843;

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

(G) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844; or

(H) an entity not authorized under this code or another insurance law of this state that contracts directly for health care services on a risk-sharing basis, including a capitation basis; or

(2) provides health and accident coverage through a risk pool created under Chapter 172, Local Government Code, notwithstanding Section 172.014, Local Government Code, or any other law.

(b) This chapter applies to a person to whom a health benefit plan contracts to:

(1) process or pay claims;

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

(3) issue verifications or preauthorizations.

Text of subsection effective until April 1, 2025

(c) This chapter does not apply to:

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

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

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

Text of subsection effective on April 1, 2025

(c) This chapter does not apply to:

(1) Medicaid managed care programs operated under Chapter 540 or 540A, Government Code, as applicable;

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

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

Added by Acts 2007, 80th Leg., R.S., Ch. 997 (S.B. [1731](#)), Sec. 11, eff. September 1, 2007.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 2.134, eff. April 1, 2025.

Sec. 1456.003. REQUIRED DISCLOSURE: HEALTH BENEFIT PLAN. (a) Each health benefit plan that provides health care through a provider network shall provide notice to its enrollees that:

(1) a facility-based physician or other health care practitioner may not be included in the health benefit plan's provider network; and

(2) a health care practitioner described by Subdivision (1) may balance bill the enrollee for amounts not paid by the health benefit plan unless the health care or medical service or supply provided to the enrollee is subject to a law prohibiting balance billing.

(b) The health benefit plan shall provide the disclosure in writing to each enrollee:

(1) in any materials sent to the enrollee in conjunction with issuance or renewal of the plan's insurance policy or evidence of coverage;

(2) in an explanation of payment summary provided to the enrollee or in any other analogous document that describes the enrollee's benefits under the plan; and

(3) conspicuously displayed, on any health benefit plan website that an enrollee is reasonably expected to access.

(c) A health benefit plan must clearly identify any health care facilities within the provider network in which facility-based physicians do not participate in the health benefit plan's provider network. Health care facilities identified under this subsection must be identified in a separate and conspicuous manner in any provider network directory or website directory.

(d) Along with any explanation of benefits sent to an enrollee that contains a remark code indicating a payment made to a non-network physician has been paid at the health benefit plan's allowable or usual and customary amount, a health benefit plan must also include the number for the department's consumer protection division for complaints regarding payment.

Added by Acts 2007, 80th Leg., R.S., Ch. 997 (S.B. 1731), Sec. 11,

eff. September 1, 2007.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 3.01, eff. September 1, 2019.

Sec. 1456.004. REQUIRED DISCLOSURE: FACILITY-BASED PHYSICIANS.

(a) If a facility-based physician bills a patient who is covered by a health benefit plan described in Section 1456.002 that does not have a contract with the facility-based physician, the facility-based physician shall send a billing statement that:

(1) contains an itemized listing of the services and supplies provided along with the dates the services and supplies were provided;

(2) contains a conspicuous, plain-language explanation that:

(A) the facility-based physician is not within the health plan provider network; and

(B) the health benefit plan has paid a rate, as determined by the health benefit plan, which is below the facility-based physician billed amount;

(3) contains a telephone number to call to discuss the statement, provide an explanation of any acronyms, abbreviations, and numbers used on the statement, or discuss any payment issues;

(4) contains a statement that the patient may call to discuss alternative payment arrangements;

(5) contains a notice that the patient may file complaints with the Texas Medical Board and includes the Texas Medical Board mailing address and complaint telephone number; and

(6) for billing statements that total an amount greater than \$200, over any applicable copayments or deductibles, states, in plain language, that if the patient finalizes a payment plan agreement within 45 days of receiving the first billing statement and substantially complies with the agreement, the facility-based physician may not furnish adverse information to a consumer reporting agency regarding an amount owed by the patient for the receipt of medical treatment.

(b) A patient may be considered by the facility-based physician to be out of substantial compliance with the payment plan agreement if payments are not made in compliance with the agreement for a

period of 90 days.

(c) Repealed by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 3.03(1), eff. September 1, 2019.

Added by Acts 2007, 80th Leg., R.S., Ch. 997 (S.B. 1731), Sec. 11, eff. September 1, 2007.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1290 (H.B. 2256), Sec. 3, eff. June 19, 2009.

Acts 2015, 84th Leg., R.S., Ch. 467 (S.B. 481), Sec. 3, eff. September 1, 2015.

Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 3.03(1), eff. September 1, 2019.

Sec. 1456.005. DISCIPLINARY ACTION AND ADMINISTRATIVE PENALTY.

(a) The commissioner may take disciplinary action against a licensee that violates this chapter, in accordance with Chapter 84.

(b) A violation of this chapter by a facility-based physician is grounds for disciplinary action and imposition of an administrative penalty by the Texas Medical Board.

(c) The Texas Medical Board shall:

(1) notify a facility-based physician of a finding by the Texas Medical Board that the facility-based physician is violating or has violated this chapter or a rule adopted under this chapter; and

(2) provide the facility-based physician with an opportunity to correct the violation without penalty or reprimand.

Added by Acts 2007, 80th Leg., R.S., Ch. 997 (S.B. 1731), Sec. 11, eff. September 1, 2007.

Sec. 1456.006. COMMISSIONER RULES; FORM OF DISCLOSURE. The commissioner by rule may prescribe specific requirements for the disclosure required under Section 1456.003. The form of the disclosure must be substantially as follows:

NOTICE: "ALTHOUGH HEALTH CARE SERVICES MAY BE OR HAVE BEEN PROVIDED TO YOU AT A HEALTH CARE FACILITY THAT IS A MEMBER OF THE PROVIDER NETWORK USED BY YOUR HEALTH BENEFIT PLAN, OTHER PROFESSIONAL SERVICES MAY BE OR HAVE BEEN PROVIDED AT OR THROUGH THE FACILITY BY PHYSICIANS AND OTHER HEALTH CARE PRACTITIONERS WHO ARE NOT MEMBERS OF

THAT NETWORK. YOU MAY BE RESPONSIBLE FOR PAYMENT OF ALL OR PART OF THE FEES FOR THOSE PROFESSIONAL SERVICES THAT ARE NOT PAID OR COVERED BY YOUR HEALTH BENEFIT PLAN UNLESS BALANCE BILLING FOR THOSE SERVICES IS PROHIBITED."

Added by Acts 2007, 80th Leg., R.S., Ch. 997 (S.B. 1731), Sec. 11, eff. September 1, 2007.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 3.02, eff. September 1, 2019.

Sec. 1456.007. HEALTH BENEFIT PLAN ESTIMATE OF CHARGES. A health benefit plan that must comply with this chapter under Section 1456.002 shall, on the request of an enrollee, provide an estimate of payments that will be made for any health care service or supply and shall also specify any deductibles, copayments, coinsurance, or other amounts for which the enrollee is responsible. The estimate must be provided not later than the 10th business day after the date on which the estimate was requested. A health benefit plan must advise the enrollee that:

(1) the actual payment and charges for the services or supplies will vary based upon the enrollee's actual medical condition and other factors associated with performance of medical services; and

(2) the enrollee may be personally liable for the payment of services or supplies based upon the enrollee's health benefit plan coverage.

Added by Acts 2007, 80th Leg., R.S., Ch. 997 (S.B. 1731), Sec. 11, eff. September 1, 2007.

CHAPTER 1457. PROVISIONAL CREDENTIALING STATUS

Sec. 1457.001. DEFINITIONS. In this chapter:

(1) "Enrollee" means an individual who is eligible to receive health care services through a health benefit plan.

(2) "Physician" means an individual licensed to practice medicine in this state under the authority of Subtitle B, Title 3, Occupations Code.

(3) "Provider network" means a health benefit plan under

which health care services are provided to enrollees through contracts with physicians and that requires those enrollees to use physicians participating in the plan and procedures covered by the plan. The term includes a network operated by:

- (A) a health maintenance organization;
- (B) a preferred provider organization; or
- (C) another entity that issues a health benefit plan, including an insurance company.

Added by Acts 2005, 79th Leg., Ch. 789 (S.B. 155), Sec. 2, eff. June 17, 2005.

Sec. 1457.002. PROVISIONAL CREDENTIALING STATUS. (a) A health benefit plan shall have a process for provisional credentialing status in compliance with the requirements of the National Committee for Quality Assurance.

(b) A health benefit plan may grant provisional credentialing status to a physician who:

- (1) submits a completed standard credentialing application to the health benefit plan;
- (2) meets the health plan's requirements for provisional credentialing; and
- (3) joins as a partner, shareholder, or employee of another physician who is contracted with a health benefit plan to provide medical or health care services to enrollees.

(c) A health benefit plan must complete the credentialing process within 60 calendar days of the date a physician is granted provisional status. In the event the physician does not meet the health plan's credentialing standards, the physician must be provided the same appeal process as any other physician applying for participation with the health benefit plan.

Added by Acts 2005, 79th Leg., Ch. 789 (S.B. 155), Sec. 2, eff. June 17, 2005.

CHAPTER 1458. PROVIDER NETWORK CONTRACT ARRANGEMENTS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1458.001. GENERAL DEFINITIONS. In this chapter:

- (1) "Affiliate" means a person who, directly or indirectly

through one or more intermediaries, controls, is controlled by, or is under common control with another person.

(1-a) "Anti-steering clause" means a provision in a provider network contract that restricts the ability of a general contracting entity to encourage an enrollee to obtain a health care service from a competitor of the provider, including offering incentives to encourage enrollees to use specific providers.

(1-b) "Anti-tiering clause" means a provision in a provider network contract that:

(A) restricts the ability of a general contracting entity to introduce or modify a tiered network plan or assign providers into tiers; or

(B) requires a general contracting entity to place all members of a provider in the same tier of a tiered network plan.

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

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

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

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

(4) "Express authority" means a provider's consent that is obtained through separate signature lines for each line of business.

(4-a) "Gag clause" means a provision in a provider network contract that restricts the ability of a general contracting entity or provider to disclose:

(A) price or quality information, including the allowed amount, negotiated rates or discounts, fees for services, or other claim-related financial obligations included in the contract, to a governmental entity as authorized by law or its contractors or agents, an enrollee, a treating provider of an enrollee, a plan sponsor, or potential eligible enrollees and plan sponsors; or

(B) out-of-pocket costs to an enrollee.

(4-b) "General contracting entity" means a person who enters into a direct contract with a provider for the delivery of health care services to covered individuals regardless of whether the person, in the ordinary course of business, establishes a provider network for access by another party. The term does not include a health care provider or facility unless the provider or facility is entering into the contract in the provider's or facility's role as a

health benefit plan.

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

(5-a) "Most favored nation clause" means a provision in a provider network contract that:

(A) prohibits or grants an option to prohibit:

(i) a provider from contracting with another general contracting entity to provide health care services at a lower rate; or

(ii) a general contracting entity from contracting with another provider to provide health care services at a higher rate;

(B) requires or grants an option to require:

(i) a provider to accept a lower rate for health care services if the provider agrees with another general contracting entity to accept a lower rate for the services; or

(ii) a general contracting entity to pay a higher rate for health care services if the entity agrees with another provider to pay a higher rate for the services;

(C) requires or grants an option to require termination or renegotiation of an existing provider network contract if:

(i) a provider agrees with another general contracting entity to accept a lower rate for providing health care services; or

(ii) a general contracting entity agrees with a provider to pay a higher rate for health care services; or

(D) requires:

(i) a provider to disclose the provider's contractual reimbursement rates with other general contracting entities; or

(ii) a general contracting entity to disclose the general contracting entity's contractual reimbursement rates with other providers.

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

(7)(A) "Provider" means:

(i) an advanced practice nurse;

(ii) an optometrist;

(iii) a therapeutic optometrist;

(iv) a physician;

- (v) a physician assistant;
- (vi) a professional association composed solely of physicians, optometrists, or therapeutic optometrists;
- (vii) a single legal entity authorized to practice medicine owned by two or more physicians;
- (viii) a nonprofit health corporation certified by the Texas Medical Board under Chapter 162, Occupations Code;
- (ix) a partnership composed solely of physicians, optometrists, or therapeutic optometrists;
- (x) a physician-hospital organization that acts exclusively as an administrator for a provider to facilitate the provider's participation in health care contracts; or
- (xi) an institution that is licensed under Chapter 241, Health and Safety Code.

(B) "Provider" does not include a physician-hospital organization that leases or rents the physician-hospital organization's network to another party.

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

Added by Acts 2013, 83rd Leg., R.S., Ch. 197 (S.B. 822), Sec. 1, eff. September 1, 2013.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 639 (H.B. 711), Sec. 1, eff. June 12, 2023.

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

- (1) a hospital and medical expense incurred policy;
- (2) a nonprofit health care service plan contract;
- (3) a health maintenance organization subscriber contract;

or

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

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

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

- (2) credit-only insurance;
- (3) coverage issued as a supplement to liability insurance;
- (4) liability insurance, including general liability insurance and automobile liability insurance;
- (5) workers' compensation or similar insurance;
- (6) a discount health care program, as defined by Section 7001.001;
- (7) coverage for on-site medical clinics;
- (8) automobile medical payment insurance;
- (9) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; or
- (10) other similar insurance coverage, as specified by federal regulations issued under the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191), under which benefits for medical care are secondary or incidental to other insurance benefits.

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

- (1) dental or vision benefits;
- (2) benefits for long-term care, nursing home care, home health care, community-based care, or any combination of these benefits;
- (3) other similar, limited benefits, including benefits specified by federal regulations issued under the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191); or
- (4) a Medicare supplement benefit plan described by Section 1652.002.

(d) "Health benefit plan" does not include coverage limited to a specified disease or illness or hospital indemnity coverage or other fixed indemnity insurance coverage if:

- (1) the coverage is provided under a separate policy, certificate, or contract of insurance;
- (2) there is no coordination between the provision of the coverage and any exclusion of benefits under any group health benefit plan maintained by the same plan sponsor; and
- (3) the coverage is paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health benefit plan maintained by the same plan

sponsor.

Added by Acts 2013, 83rd Leg., R.S., Ch. 197 (S.B. 822), Sec. 1, eff. September 1, 2013.

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

(1) 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

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

Added by Acts 2013, 83rd Leg., R.S., Ch. 197 (S.B. 822), Sec. 1, eff. September 1, 2013.

Sec. 1458.004. RULEMAKING AUTHORITY. The commissioner may adopt rules to implement this chapter.

Added by Acts 2013, 83rd Leg., R.S., Ch. 197 (S.B. 822), Sec. 1, eff. September 1, 2013.

SUBCHAPTER B. REGISTRATION REQUIREMENTS

Sec. 1458.051. REGISTRATION REQUIRED. (a) Unless the person holds a certificate of authority issued by the department to engage in the business of insurance in this state or operates a health maintenance organization under Chapter 843, a person must register with the department not later than the 30th day after the date on which the person begins acting as a contracting entity in this state.

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

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

an annual basis.

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

Added by Acts 2013, 83rd Leg., R.S., Ch. 197 (S.B. 822), Sec. 1, eff. September 1, 2013.

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

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

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

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

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

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

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

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

Added by Acts 2013, 83rd Leg., R.S., Ch. 197 (S.B. 822), Sec. 1, eff. September 1, 2013.

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

Added by Acts 2013, 83rd Leg., R.S., Ch. 197 (S.B. 822), Sec. 1, eff. September 1, 2013.

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

Added by Acts 2013, 83rd Leg., R.S., Ch. 197 (S.B. 822), Sec. 1, eff. September 1, 2013.

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

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

(2) the relationships between the person who holds a certificate of authority and all affiliates of the person, including subsidiary networks or other networks, are disclosed and clearly defined.

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

Added by Acts 2013, 83rd Leg., R.S., Ch. 197 (S.B. 822), Sec. 1, eff. September 1, 2013.

SUBCHAPTER C. RIGHTS AND RESPONSIBILITIES OF A CONTRACTING ENTITY

Sec. 1458.101. CONTRACT REQUIREMENTS. (a) In this section, the following are each considered a single separate line of business:

(1) preferred provider benefit plans covering individuals and groups;

(2) exclusive provider benefit plans covering individuals and groups;

(3) health maintenance organization plans covering individuals and groups;

(4) Medicare Advantage or similar plans issued in connection with a contract with the Centers for Medicare and Medicaid Services;

(5) Medicaid managed care; and

(6) the state child health plan established under Chapter 62, Health and Safety Code, or the comparable plan under Chapter 63, Health and Safety Code.

(b) A contracting entity may not sell, lease, or otherwise transfer information regarding the payment or reimbursement terms of the provider network contract without the express authority of and prior adequate notification to the provider. The prior adequate notification may be provided in the written format specified by a provider network contract subject to this chapter.

(c) A contracting entity may not provide a person access to health care services or contractual discounts under a provider network contract unless the provider network contract specifically states that the contracting entity may contract with a person to provide access to the contracting entity's rights and responsibilities under the provider network contract.

(d) The provider network contract must require that on the request of the provider, the contracting entity will provide information necessary to determine whether a particular person has been authorized to access the provider's health care services and contractual discounts.

(e) To be enforceable against a provider, a provider network contract, including the lines of business described by Subsections (a) and (f), must also specify or reference a separate fee schedule for each such line of business. The separate fee schedule may describe specific services or procedures that the provider will deliver along with a corresponding payment, may describe a methodology for calculating payment based on a published fee schedule, or may describe payment in any other reasonable manner that specifies a definite payment for services. The fee information may be provided by any reasonable method, including electronically.

(f) The commissioner may, by rule, add additional lines of business for which express authority is required.

(g) A provider may not:

(1) offer to a general contracting entity a written provider network contract that includes an anti-steering, anti-tiering, gag, or most favored nation clause;

(2) enter into a provider network contract that includes an anti-steering, anti-tiering, gag, or most favored nation clause; or

(3) amend or renew an existing provider network contract

previously entered into with a general contracting entity so that the contract as amended or renewed adds or retains an anti-steering, anti-tiering, gag, or most favored nation clause.

(h) Any provision in a provider network contract that is an anti-steering, anti-tiering, gag, or most favored nation clause is void and unenforceable. The remaining provisions in the provider network contract remain in effect and are enforceable.

(i) A health benefit plan issuer that encourages an enrollee to obtain a health care service from a particular provider, including offering incentives to encourage enrollees to use specific providers, or that introduces or modifies a tiered network plan or assigns providers into tiers has a fiduciary duty to the enrollee or policyholder to engage in that conduct only for the primary benefit of the enrollee or policyholder.

Added by Acts 2013, 83rd Leg., R.S., Ch. 197 (S.B. 822), Sec. 1, eff. September 1, 2013.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 639 (H.B. 711), Sec. 2, eff. June 12, 2023.

Sec. 1458.102. CONTRACT ACCESS. (a) A contracting entity may not provide a person access to health care services or contractual discounts under a provider network contract unless the provider network contract specifically states that the person must comply with all applicable terms, limitations, and conditions of the provider network contract.

(b) For the purposes of this section, a contracting entity shall permit reasonable access, including electronic access, during business hours for the review of the provider network contract. The information may be used or disclosed only for the purposes of complying with the terms of the contract or state law.

Added by Acts 2013, 83rd Leg., R.S., Ch. 197 (S.B. 822), Sec. 1, eff. September 1, 2013.

Sec. 1458.103. ENFORCEMENT. The commissioner may impose a sanction under Chapter 82 or assess an administrative penalty under Chapter 84 on a contracting entity that violates this chapter or a

rule adopted to implement this chapter.

Added by Acts 2013, 83rd Leg., R.S., Ch. 197 (S.B. 822), Sec. 1, eff. September 1, 2013.

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

Sec. 1460.001. DEFINITIONS. In this chapter:

(1) "Health benefit plan issuer" means an entity authorized under this code or another insurance law of this state that provides health insurance or health benefits in this state, including:

(A) an insurance company;

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

(C) a health maintenance organization operating under Chapter 843; and

(D) a stipulated premium company operating under Chapter 884.

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

Added by Acts 2009, 81st Leg., R.S., Ch. 652 (H.B. 1888), Sec. 1, eff. September 1, 2009.

Text of section effective until April 1, 2025

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

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

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

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

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

Added by Acts 2009, 81st Leg., R.S., Ch. 652 (H.B. 1888), Sec. 1, eff. September 1, 2009.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 2.135, eff. April 1, 2025.

Text of section effective on April 1, 2025

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

(1) a Medicaid managed care program operated under Chapter 540 or 540A, Government Code, as applicable;

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

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

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

Added by Acts 2009, 81st Leg., R.S., Ch. 652 (H.B. 1888), Sec. 1, eff. September 1, 2009.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 2.135, eff. April 1, 2025.

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

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

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

(3) each affected physician is afforded, before any publication or other public dissemination, an opportunity to dispute the ranking or classification through a process that, at a minimum, includes due process protections that conform to the following protections:

(A) the health benefit plan issuer provides at least 45 days' written notice to the physician of the proposed rating, ranking, tiering, or comparison, including the methodologies, data, and all other information utilized by the health benefit plan issuer in its rating, tiering, ranking, or comparison decision;

(B) in addition to any written fair reconsideration process, the health benefit plan issuer, upon a request for review that is made within 30 days of receiving the notice under Paragraph (A), provides a fair reconsideration proceeding, at the physician's option:

(i) by teleconference, at an agreed upon time; or

(ii) in person, at an agreed upon time or between the hours of 8:00 a.m. and 5:00 p.m. Monday through Friday;

(C) the physician has the right to provide information at a requested fair reconsideration proceeding for determination by a decision-maker, have a representative participate in the fair reconsideration proceeding, and submit a written statement at the conclusion of the fair reconsideration proceeding; and

(D) the health benefit plan issuer provides a written communication of the outcome of a fair reconsideration proceeding prior to any publication or dissemination of the rating, ranking, tiering, or comparison. The written communication must include the specific reasons for the final decision.

(b) This section does not apply to the publication of a list of network physicians and providers if ratings or comparisons are not made and the list is not a product of nor reflects the tiering or classification of physicians or providers.

Added by Acts 2009, 81st Leg., R.S., Ch. 652 (H.B. 1888), Sec. 1, eff. September 1, 2009.

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

(1) rank or otherwise evaluate the physician;

(2) participate in surveys regarding the physician; or

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

Added by Acts 2009, 81st Leg., R.S., Ch. 652 (H.B. 1888), Sec. 1, eff.

September 1, 2009.

Sec. 1460.005. RULES; STANDARDS. (a) The commissioner shall adopt rules as necessary to implement this chapter.

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

(c) In adopting rules under this section, the commissioner shall consider the standards, guidelines, and measures prescribed by nationally recognized organizations that establish or promote guidelines and performance measures emphasizing quality of health care, including the National Quality Forum and the AQA Alliance. If neither the National Quality Forum nor the AQA Alliance has established standards or guidelines regarding an issue, the commissioner shall consider the standards, guidelines, and measures prescribed by the National Committee on Quality Assurance and other similar national organizations. If neither the National Quality Forum, nor the AQA Alliance, nor other national organizations have established standards or guidelines regarding an issue, the commissioner shall consider standards, guidelines, and measures based on other bona fide nationally recognized guidelines, expert-based physician consensus quality standards, or leading objective clinical evidence and scholarship.

Added by Acts 2009, 81st Leg., R.S., Ch. 652 (H.B. 1888), Sec. 1, eff. September 1, 2009.

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

(1) physicians currently in clinical practice are actively involved in the development of the standards used under this chapter; and

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

Added by Acts 2009, 81st Leg., R.S., Ch. 652 (H.B. 1888), Sec. 1, eff. September 1, 2009.

Sec. 1460.007. SANCTIONS; DISCIPLINARY ACTIONS. (a) A health benefit plan issuer that violates this chapter or a rule adopted under this chapter is subject to sanctions and disciplinary actions under Chapters 82 and 84.

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

Added by Acts 2009, 81st Leg., R.S., Ch. 652 (H.B. 1888), Sec. 1, eff. September 1, 2009.

CHAPTER 1461. DISCRIMINATION AGAINST PHYSICIAN BASED ON MAINTENANCE OF CERTIFICATION

Sec. 1461.001. DEFINITIONS. In this chapter:

(1) "Enrollee" means an individual who is eligible to receive health care services under a managed care plan.

(2) "Maintenance of certification" has the meaning assigned by Section 151.002, Occupations Code.

(3) "Managed care plan" means a health benefit plan under which health care services are provided to enrollees through contracts with physicians and that requires enrollees to use participating physicians or that provides a different level of coverage for enrollees who use participating physicians. The term includes a health benefit plan issued by:

(A) a health maintenance organization;

(B) a preferred provider benefit plan issuer; or

(C) any other entity that issues a health benefit plan, including an insurance company.

(4) "Participating physician" means a physician who has directly or indirectly contracted with a health benefit plan issuer to provide services to enrollees.

(5) "Physician" means an individual licensed to practice medicine in this state.

Added by Acts 2017, 85th Leg., R.S., Ch. 1121 (S.B. 1148), Sec. 1, eff. January 1, 2018.

Sec. 1461.002. APPLICABILITY. (a) This chapter applies to a physician regardless of whether the physician is a participating

physician.

(b) This chapter applies to a person with whom a managed care plan issuer contracts to:

- (1) process or pay claims;
- (2) obtain the services of physicians to provide health care services to enrollees; or
- (3) issue verifications or preauthorizations.

Added by Acts 2017, 85th Leg., R.S., Ch. 1121 (S.B. 1148), Sec. 1, eff. January 1, 2018.

Sec. 1461.003. DISCRIMINATION BASED ON MAINTENANCE OF CERTIFICATION. (a) Except as provided by Subsection (b), a managed care plan issuer may not differentiate between physicians based on a physician's maintenance of certification in regard to:

- (1) paying the physician;
- (2) reimbursing the physician; or
- (3) directly or indirectly contracting with the physician to provide services to enrollees.

(b) A managed care plan issuer may differentiate between physicians based on a physician's maintenance of certification only if the designation under law or certification or accreditation by a national certifying or accrediting organization of an entity described by Section 151.0515(a), Occupations Code, is contingent on the entity requiring a specific maintenance of certification by physicians seeking staff privileges or credentialing at the entity.

Added by Acts 2017, 85th Leg., R.S., Ch. 1121 (S.B. 1148), Sec. 1, eff. January 1, 2018.

CHAPTER 1467. OUT-OF-NETWORK CLAIM DISPUTE RESOLUTION
SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1467.001. DEFINITIONS. In this chapter:

- (1) "Administrator" means:
 - (A) an administering firm for a health benefit plan providing coverage under Chapter 1551, 1575, or 1579; and
 - (B) if applicable, the claims administrator for the health benefit plan.

(1-a) "Arbitration" means a process in which an impartial

arbiter issues a binding determination in a dispute between a health benefit plan issuer or administrator and an out-of-network provider or the provider's representative to settle a health benefit claim.

(2) Repealed by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 3.03(2), eff. September 1, 2019.

(2-a) "Diagnostic imaging provider" means a health care provider who performs a diagnostic imaging service on a patient for a fee or interprets imaging produced by a diagnostic imaging service.

(2-b) "Diagnostic imaging service" means magnetic resonance imaging, computed tomography, positron emission tomography, or any hybrid technology that combines any of those imaging modalities.

(2-c) "Emergency care" has the meaning assigned by Section 1301.155.

(2-d) "Emergency care provider" means a physician, health care practitioner, facility, or other health care provider who provides and bills an enrollee, administrator, or health benefit plan for emergency care.

(3) "Enrollee" means an individual who is eligible to receive benefits through a health benefit plan subject to this chapter.

(3-a) "Facility" has the meaning assigned by Section 324.001, Health and Safety Code.

(4) "Facility-based provider" means a physician, health care practitioner, or other health care provider who provides health care or medical services to patients of a facility.

(4-a) "Health care practitioner" means an individual who is licensed to provide health care services.

(4-b) "Laboratory service provider" means an accredited facility in which a specimen taken from a human body is interpreted and pathological diagnoses are made or a physician who makes an interpretation of or diagnosis based on a specimen or information provided by a laboratory based on a specimen.

(5) "Mediation" means a process in which an impartial mediator facilitates and promotes agreement between the health benefit plan issuer or the administrator and an out-of-network provider or the provider's representative to settle a health benefit claim of an enrollee.

(6) "Mediator" means an impartial person who is appointed to conduct a mediation under this chapter.

(6-a) "Out-of-network provider" means a diagnostic imaging

provider, emergency care provider, facility-based provider, or laboratory service provider that is not a participating provider for a health benefit plan.

(7) "Party" means a health benefit plan issuer offering a health benefit plan, an administrator, or an out-of-network provider or the provider's representative who participates in a mediation or arbitration conducted under this chapter.

Added by Acts 2009, 81st Leg., R.S., Ch. 1290 (H.B. 2256), Sec. 1, eff. June 19, 2009.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 467 (S.B. 481), Sec. 4, eff. September 1, 2015.

Acts 2017, 85th Leg., R.S., Ch. 100 (S.B. 507), Sec. 1, eff. September 1, 2017.

Acts 2017, 85th Leg., R.S., Ch. 139 (H.B. 1428), Sec. 1, eff. September 1, 2017.

Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 2.01, eff. September 1, 2019.

Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 3.03(2), eff. September 1, 2019.

Sec. 1467.002. APPLICABILITY OF CHAPTER. This chapter applies to:

(1) a health benefit plan offered by a health maintenance organization operating under Chapter 843;

(2) a preferred provider benefit plan, including an exclusive provider benefit plan, offered by an insurer under Chapter 1301; and

(3) an administrator of a health benefit plan, other than a health maintenance organization plan, under Chapter 1551, 1575, or 1579.

Added by Acts 2009, 81st Leg., R.S., Ch. 1290 (H.B. 2256), Sec. 1, eff. June 19, 2009.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 100 (S.B. 507), Sec. 2, eff. September 1, 2017.

Acts 2017, 85th Leg., R.S., Ch. 139 (H.B. 1428), Sec. 2, eff. September 1, 2017.

Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 2.02, eff. September 1, 2019.

Sec. 1467.003. RULES. (a) The commissioner, the Texas Medical Board, and any other appropriate regulatory agency shall adopt rules as necessary to implement their respective powers and duties under this chapter.

(b) Section 2001.0045, Government Code, does not apply to a rule adopted under this chapter.

Added by Acts 2009, 81st Leg., R.S., Ch. 1290 (H.B. 2256), Sec. 1, eff. June 19, 2009.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 100 (S.B. 507), Sec. 3, eff. September 1, 2017.

Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 2.02, eff. September 1, 2019.

Sec. 1467.004. REMEDIES NOT EXCLUSIVE. The remedies provided by this chapter are in addition to any other defense, remedy, or procedure provided by law, including the common law.

Added by Acts 2009, 81st Leg., R.S., Ch. 1290 (H.B. 2256), Sec. 1, eff. June 19, 2009.

Sec. 1467.005. REFORM. This chapter may not be construed to prohibit:

- (1) a health benefit plan issuer or administrator from, at any time, offering a reformed claim settlement; or
- (2) an out-of-network provider from, at any time, offering a reformed charge for health care or medical services or supplies.

Added by Acts 2009, 81st Leg., R.S., Ch. 1290 (H.B. 2256), Sec. 1, eff. June 19, 2009.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 100 (S.B. 507), Sec. 4, eff. September 1, 2017.

Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 2.02, eff.

September 1, 2019.

Sec. 1467.006. BENCHMARKING DATABASE. (a) In this section, "geozip area" means an area that includes all zip codes with identical first three digits. For purposes of this section, a health care or medical service or supply provided at a location that does not have a zip code is considered to be provided in the geozip area closest to the location at which the service or supply is provided.

(b) The commissioner shall select an organization to maintain a benchmarking database in accordance with this section. The organization may not:

(1) be affiliated with a health benefit plan issuer or administrator or a physician, health care practitioner, or other health care provider; or

(2) have any other conflict of interest.

(c) The benchmarking database must contain information necessary to calculate, with respect to a health care or medical service or supply, for each geozip area in this state:

(1) the 80th percentile of billed charges of all physicians or health care providers who are not facilities; and

(2) the 50th percentile of rates paid to participating providers who are not facilities.

(d) The commissioner may adopt rules governing the submission of information for the benchmarking database described by Subsection (c).

Added by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. [1264](#)), Sec. 2.03, eff. September 1, 2019.

SUBCHAPTER B. MANDATORY MEDIATION FOR OUT-OF-NETWORK FACILITIES

Sec. 1467.050. APPLICABILITY OF SUBCHAPTER. (a) This subchapter applies only with respect to a health benefit claim submitted by an out-of-network provider that is a facility.

(b) This subchapter does not apply to a health benefit claim for the professional or technical component of a physician service.

Added by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. [1264](#)), Sec. 2.05, eff. September 1, 2019.

Sec. 1467.0505. ESTABLISHMENT AND ADMINISTRATION OF MEDIATION PROGRAM. (a) The commissioner shall establish and administer a mediation program to resolve disputes over out-of-network provider charges in accordance with this subchapter.

(b) The commissioner:

(1) shall adopt rules, forms, and procedures necessary for the implementation and administration of the mediation program, including the establishment of a portal on the department's Internet website through which a request for mediation under Section 1467.051 may be submitted; and

(2) shall maintain a list of qualified mediators for the program.

Added by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. [1264](#)), Sec. 2.05, eff. September 1, 2019.

Sec. 1467.051. AVAILABILITY OF MANDATORY MEDIATION. (a) An out-of-network provider or a health benefit plan issuer or administrator may request mediation of a settlement of an out-of-network health benefit claim through a portal on the department's Internet website if:

(1) there is an amount billed by the provider and unpaid by the issuer or administrator after copayments, deductibles, and coinsurance for which an enrollee may not be billed; and

(2) the health benefit claim is for:

(A) emergency care;

(B) an out-of-network laboratory service; or

(C) an out-of-network diagnostic imaging service.

(b) If a person requests mediation under this subchapter, the out-of-network provider or the provider's representative, and the health benefit plan issuer or the administrator, as appropriate, shall participate in the mediation.

(c) Repealed by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. [1264](#)), Sec. 3.03(3), eff. September 1, 2019.

(d) Repealed by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. [1264](#)), Sec. 3.03(3), eff. September 1, 2019.

Added by Acts 2009, 81st Leg., R.S., Ch. 1290 (H.B. [2256](#)), Sec. 1, eff. June 19, 2009.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 467 (S.B. 481), Sec. 5, eff. September 1, 2015.

Acts 2017, 85th Leg., R.S., Ch. 100 (S.B. 507), Sec. 5, eff. September 1, 2017.

Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 2.06, eff. September 1, 2019.

Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 2.07, eff. September 1, 2019.

Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 3.03(3), eff. September 1, 2019.

Sec. 1467.052. MEDIATOR QUALIFICATIONS. (a) Except as provided by Subsection (b), to qualify for an appointment as a mediator under this subchapter a person must have completed at least 40 classroom hours of training in dispute resolution techniques in a course conducted by an alternative dispute resolution organization or other dispute resolution organization approved by the commissioner.

(b) A person not qualified under Subsection (a) may be appointed as a mediator on agreement of the parties.

(c) A person may not act as mediator for a claim settlement dispute if the person has been employed by, consulted for, or otherwise had a business relationship with a health benefit plan issuer or administrator or a physician, health care practitioner, or other health care provider during the three years immediately preceding the request for mediation.

(d) The commissioner shall immediately terminate the approval of a mediator who no longer meets the requirements under this subchapter and rules adopted under this subchapter to serve as a mediator.

Added by Acts 2009, 81st Leg., R.S., Ch. 1290 (H.B. 2256), Sec. 1, eff. June 19, 2009.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 100 (S.B. 507), Sec. 7, eff. September 1, 2017.

Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 2.08, eff. September 1, 2019.

Sec. 1467.053. APPOINTMENT OF MEDIATOR; FEES. (a) A mediation shall be conducted by one mediator.

(b) Repealed by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 3.03(5), eff. September 1, 2019.

(b-1) If the parties do not select a mediator by mutual agreement on or before the 30th day after the date the mediation is requested, the party requesting the mediation shall notify the commissioner, and the commissioner shall select a mediator from the commissioner's list of approved mediators.

(c) Repealed by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 3.03(5), eff. September 1, 2019.

(d) The mediator's fees shall be split evenly and paid by the health benefit plan issuer or administrator and the out-of-network provider.

Added by Acts 2009, 81st Leg., R.S., Ch. 1290 (H.B. 2256), Sec. 1, eff. June 19, 2009.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 100 (S.B. 507), Sec. 8, eff. September 1, 2017.

Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 2.09, eff. September 1, 2019.

Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 3.03(5), eff. September 1, 2019.

Sec. 1467.054. REQUEST AND PRELIMINARY PROCEDURES FOR MANDATORY MEDIATION. (a) An out-of-network provider or a health benefit plan issuer or administrator may request mandatory mediation under this subchapter.

(b) Repealed by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 3.03(6), eff. September 1, 2019.

(b-1) The person who requests the mediation shall provide written notice on the date the mediation is requested in the form and manner provided by commissioner rule to:

- (1) the department; and
- (2) each other party.

(c) Repealed by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 3.03(6), eff. September 1, 2019.

(d) In an effort to settle the claim before mediation, all

parties must participate in an informal settlement teleconference not later than the 30th day after the date on which a person submits a request for mediation under this subchapter.

(e) A dispute to be mediated under this chapter that does not settle as a result of a teleconference conducted under Subsection (d) must be conducted in the county in which the health care or medical services were rendered.

(f) Repealed by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. [1264](#)), Sec. 3.03(6), eff. September 1, 2019.

(g) Repealed by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. [1264](#)), Sec. 3.03(6), eff. September 1, 2019.

Added by Acts 2009, 81st Leg., R.S., Ch. 1290 (H.B. [2256](#)), Sec. 1, eff. June 19, 2009.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 100 (S.B. [507](#)), Sec. 9, eff. September 1, 2017.

Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. [1264](#)), Sec. 2.10, eff. September 1, 2019.

Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. [1264](#)), Sec. 3.03(6), eff. September 1, 2019.

Sec. 1467.055. CONDUCT OF MEDIATION; CONFIDENTIALITY. (a) A mediator may not impose the mediator's judgment on a party about an issue that is a subject of the mediation.

(b) A mediation session is under the control of the mediator.

(c) Except as provided by this chapter, the mediator must hold in strict confidence all information provided to the mediator by a party and all communications of the mediator with a party.

(c-1) Information submitted by the parties to the mediator is confidential and not subject to disclosure under Chapter 552, Government Code.

(d) Repealed by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. [1264](#)), Sec. 3.03(7), eff. September 1, 2019.

(e) A party must have an opportunity during the mediation to speak and state the party's position.

(f) Except on the agreement of the participating parties, a mediation may not last more than four hours.

(g) A mediation shall be held not later than the 180th day

after the date of the request for mediation.

(h) Repealed by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 3.03(7), eff. September 1, 2019.

(i) A health care or medical service or supply provided by an out-of-network provider may not be summarily disallowed. This subsection does not require a health benefit plan issuer or administrator to pay for an uncovered service or supply.

(j) A mediator may not testify in a proceeding, other than a proceeding to enforce this chapter, related to the mediation agreement.

(k) On agreement of all parties, any deadline under this subchapter may be extended.

Added by Acts 2009, 81st Leg., R.S., Ch. 1290 (H.B. 2256), Sec. 1, eff. June 19, 2009.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 100 (S.B. 507), Sec. 10, eff. September 1, 2017.

Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 2.11, eff. September 1, 2019.

Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 3.03(7), eff. September 1, 2019.

Sec. 1467.056. MATTERS CONSIDERED IN MEDIATION; AGREED RESOLUTION. (a) In a mediation under this subchapter, the parties shall evaluate whether:

(1) the amount charged by the out-of-network provider for the health care or medical service or supply is excessive; and

(2) the amount paid by the health benefit plan issuer or administrator represents the usual and customary rate for the health care or medical service or supply or is unreasonably low.

(b) The out-of-network provider may present information regarding the amount charged for the health care or medical service or supply. The health benefit plan issuer or administrator may present information regarding the amount paid by the issuer or administrator.

(c) Nothing in this chapter prohibits mediation of more than one claim between the parties during a mediation.

(d) The goal of the mediation is to reach an agreement between

the out-of-network provider and the health benefit plan issuer or administrator, as applicable, as to the amount paid by the issuer or administrator to the out-of-network provider and the amount charged by the out-of-network provider.

Added by Acts 2009, 81st Leg., R.S., Ch. 1290 (H.B. 2256), Sec. 1, eff. June 19, 2009.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 100 (S.B. 507), Sec. 11, eff. September 1, 2017.

Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 2.12, eff. September 1, 2019.

Sec. 1467.0575. RIGHT TO FILE ACTION. Not later than the 45th day after the date that the mediator's report is provided to the department under Section 1467.060, either party to a mediation for which there was no agreement may file a civil action to determine the amount due to an out-of-network provider. A party may not bring a civil action before the conclusion of the mediation process under this subchapter.

Added by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 2.13, eff. September 1, 2019.

Sec. 1467.060. REPORT OF MEDIATOR. Not later than the 45th day after the date the mediation concludes, the mediator shall report to the commissioner and the Texas Medical Board or other appropriate regulatory agency:

- (1) the names of the parties to the mediation; and
- (2) whether the parties reached an agreement.

Added by Acts 2009, 81st Leg., R.S., Ch. 1290 (H.B. 2256), Sec. 1, eff. June 19, 2009.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 100 (S.B. 507), Sec. 15, eff. September 1, 2017.

Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 2.14, eff. September 1, 2019.

SUBCHAPTER B-1. MANDATORY BINDING ARBITRATION FOR OTHER PROVIDERS

Sec. 1467.081. APPLICABILITY OF SUBCHAPTER. This subchapter applies only with respect to a health benefit claim submitted by an out-of-network provider who is not a facility.

Added by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. [1264](#)), Sec. 2.15, eff. September 1, 2019.

Sec. 1467.082. ESTABLISHMENT AND ADMINISTRATION OF ARBITRATION PROGRAM. (a) The commissioner shall establish and administer an arbitration program to resolve disputes over out-of-network provider charges in accordance with this subchapter.

(b) The commissioner:

(1) shall adopt rules, forms, and procedures necessary for the implementation and administration of the arbitration program, including the establishment of a portal on the department's Internet website through which a request for arbitration under Section 1467.084 may be submitted; and

(2) shall maintain a list of qualified arbitrators for the program.

Added by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. [1264](#)), Sec. 2.15, eff. September 1, 2019.

Sec. 1467.083. ISSUE TO BE ADDRESSED; BASIS FOR DETERMINATION.

(a) The only issue that an arbitrator may determine under this subchapter is the reasonable amount for the health care or medical services or supplies provided to the enrollee by an out-of-network provider.

(b) The determination must take into account:

(1) whether there is a gross disparity between the fee billed by the out-of-network provider and:

(A) fees paid to the out-of-network provider for the same services or supplies rendered by the provider to other enrollees for which the provider is an out-of-network provider; and

(B) fees paid by the health benefit plan issuer to reimburse similarly qualified out-of-network providers for the same services or supplies in the same region;

(2) the level of training, education, and experience of the

out-of-network provider;

(3) the out-of-network provider's usual billed charge for comparable services or supplies with regard to other enrollees for which the provider is an out-of-network provider;

(4) the circumstances and complexity of the enrollee's particular case, including the time and place of the provision of the service or supply;

(5) individual enrollee characteristics;

(6) the 80th percentile of all billed charges for the service or supply performed by a health care provider in the same or similar specialty and provided in the same geozip area as reported in a benchmarking database described by Section 1467.006;

(7) the 50th percentile of rates for the service or supply paid to participating providers in the same or similar specialty and provided in the same geozip area as reported in a benchmarking database described by Section 1467.006;

(8) the history of network contracting between the parties;

(9) historical data for the percentiles described by Subdivisions (6) and (7); and

(10) an offer made during the informal settlement teleconference required under Section 1467.084(d).

Added by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. [1264](#)), Sec. 2.15, eff. September 1, 2019.

Sec. 1467.084. AVAILABILITY OF MANDATORY ARBITRATION. (a) Not later than the 90th day after the date an out-of-network provider receives the initial payment for a health care or medical service or supply, the out-of-network provider or the health benefit plan issuer or administrator may request arbitration of a settlement of an out-of-network health benefit claim through a portal on the department's Internet website if:

(1) there is a charge billed by the provider and unpaid by the issuer or administrator after copayments, coinsurance, and deductibles for which an enrollee may not be billed; and

(2) the health benefit claim is for:

(A) emergency care;

(B) a health care or medical service or supply provided by a facility-based provider in a facility that is a participating

provider;

- (C) an out-of-network laboratory service; or
- (D) an out-of-network diagnostic imaging service.

(b) If a person requests arbitration under this subchapter, the out-of-network provider or the provider's representative, and the health benefit plan issuer or the administrator, as appropriate, shall participate in the arbitration.

(c) The person who requests the arbitration shall provide written notice on the date the arbitration is requested in the form and manner prescribed by commissioner rule to:

- (1) the department; and
- (2) each other party.

(d) In an effort to settle the claim before arbitration, all parties must participate in an informal settlement teleconference not later than the 30th day after the date on which the arbitration is requested. A health benefit plan issuer or administrator, as applicable, shall make a reasonable effort to arrange the teleconference.

(e) The commissioner shall adopt rules providing requirements for submitting multiple claims to arbitration in one proceeding. The rules must provide that:

- (1) the total amount in controversy for multiple claims in one proceeding may not exceed \$5,000; and
- (2) the multiple claims in one proceeding must be limited to the same out-of-network provider.

Added by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. [1264](#)), Sec. 2.15, eff. September 1, 2019.

Sec. 1467.085. EFFECT OF ARBITRATION AND APPLICABILITY OF OTHER LAW. (a) Notwithstanding Section 1467.004, an out-of-network provider or health benefit plan issuer or administrator may not file suit for an out-of-network claim subject to this chapter until the conclusion of the arbitration on the issue of the amount to be paid in the out-of-network claim dispute.

(b) An arbitration conducted under this subchapter is not subject to Title 7, Civil Practice and Remedies Code.

Added by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. [1264](#)), Sec. 2.15, eff. September 1, 2019.

Sec. 1467.086. SELECTION AND APPROVAL OF ARBITRATOR. (a) If the parties do not select an arbitrator by mutual agreement on or before the 30th day after the date the arbitration is requested, the party requesting the arbitration shall notify the commissioner, and the commissioner shall select an arbitrator from the commissioner's list of approved arbitrators.

(b) In selecting an arbitrator under this section, the commissioner shall give preference to an arbitrator who is knowledgeable and experienced in applicable principles of contract and insurance law and the health care industry generally.

(c) In approving an individual as an arbitrator, the commissioner shall ensure that the individual does not have a conflict of interest that would adversely impact the individual's independence and impartiality in rendering a decision in an arbitration. A conflict of interest includes current or recent ownership or employment of the individual or a close family member in any health benefit plan issuer or administrator or physician, health care practitioner, or other health care provider.

(d) The commissioner shall immediately terminate the approval of an arbitrator who no longer meets the requirements under this subchapter and rules adopted under this subchapter to serve as an arbitrator.

Added by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. [1264](#)), Sec. 2.15, eff. September 1, 2019.

Sec. 1467.087. PROCEDURES. (a) The arbitrator shall set a date for submission of all information to be considered by the arbitrator.

(b) A party may not engage in discovery in connection with the arbitration.

(c) On agreement of all parties, any deadline under this subchapter may be extended.

(d) Unless otherwise agreed to by the parties, an arbitrator may not determine whether a health benefit plan covers a particular health care or medical service or supply.

(e) The parties shall evenly split and pay the arbitrator's

fees and expenses.

(f) Information submitted by the parties to the arbitrator is confidential and not subject to disclosure under Chapter 552, Government Code.

Added by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 2.15, eff. September 1, 2019.

Sec. 1467.088. DECISION. (a) Not later than the 51st day after the date the arbitration is requested, an arbitrator shall provide the parties with a written decision in which the arbitrator:

(1) determines whether the billed charge or the payment made by the health benefit plan issuer or administrator, as those amounts were last modified during the issuer's or administrator's internal appeal process, if the provider elects to participate, or the informal settlement teleconference required by Section 1467.084(d), as applicable, is the closest to the reasonable amount for the services or supplies determined in accordance with Section 1467.083(b); and

(2) selects the amount determined to be closest under Subdivision (1) as the binding award amount.

(b) An arbitrator may not modify the binding award amount selected under Subsection (a).

(c) An arbitrator shall provide written notice in the form and manner prescribed by commissioner rule of the reasonable amount for the services or supplies and the binding award amount. If the parties settle before a decision, the parties shall provide written notice in the form and manner prescribed by commissioner rule of the amount of the settlement. The department shall maintain a record of notices provided under this subsection.

Added by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 2.15, eff. September 1, 2019.

Sec. 1467.089. EFFECT OF DECISION. (a) An arbitrator's decision under Section 1467.088 is binding.

(b) Not later than the 45th day after the date of an arbitrator's decision under Section 1467.088, a party not satisfied with the decision may file an action to determine the payment due to

an out-of-network provider.

(c) In an action filed under Subsection (b), the court shall determine whether the arbitrator's decision is proper based on a substantial evidence standard of review.

(d) Not later than the 30th day after the date of an arbitrator's decision under Section 1467.088, a health benefit plan issuer or administrator shall pay to an out-of-network provider any additional amount necessary to satisfy the binding award.

Added by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. [1264](#)), Sec. 2.15, eff. September 1, 2019.

SUBCHAPTER C. BAD FAITH PARTICIPATION

Sec. 1467.101. BAD FAITH. (a) The following conduct constitutes bad faith participation for purposes of this chapter:

(1) failing to participate in the informal settlement teleconference under Section 1467.084(d) or an arbitration or mediation under this chapter;

(2) failing to provide information the arbitrator or mediator believes is necessary to facilitate a decision or agreement; or

(3) failing to designate a representative participating in the arbitration or mediation with full authority to enter into any agreement.

(b) Failure to reach an agreement under Subchapter B is not conclusive proof of bad faith participation.

Added by Acts 2009, 81st Leg., R.S., Ch. 1290 (H.B. [2256](#)), Sec. 1, eff. June 19, 2009.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 100 (S.B. [507](#)), Sec. 17, eff. September 1, 2017.

Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. [1264](#)), Sec. 2.16, eff. September 1, 2019.

Sec. 1467.102. PENALTIES. (a) Bad faith participation or otherwise failing to comply with Subchapter B-1 is grounds for imposition of an administrative penalty by the regulatory agency that issued a license or certificate of authority to the party who

committed the violation.

(b) Except for good cause shown, on a report of a mediator and appropriate proof of bad faith participation under Subchapter B, the regulatory agency that issued the license or certificate of authority shall impose an administrative penalty.

Added by Acts 2009, 81st Leg., R.S., Ch. 1290 (H.B. 2256), Sec. 1, eff. June 19, 2009.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 2.16, eff. September 1, 2019.

SUBCHAPTER D. COMPLAINTS; CONSUMER PROTECTION

Sec. 1467.151. CONSUMER PROTECTION; RULES. (a) The commissioner and the Texas Medical Board or other regulatory agency, as appropriate, shall adopt rules regulating the investigation and review of a complaint filed that relates to the settlement of an out-of-network health benefit claim that is subject to this chapter. The rules adopted under this section must:

- (1) distinguish among complaints for out-of-network coverage or payment and give priority to investigating allegations of delayed health care or medical care;
- (2) develop a form for filing a complaint; and
- (3) ensure that a complaint is not dismissed without appropriate consideration.

(b) The department and the Texas Medical Board or other appropriate regulatory agency shall maintain information on each complaint filed that concerns a claim, arbitration, or mediation subject to this chapter, including:

- (1) the type of services or supplies that gave rise to the dispute;
- (2) the type and specialty, if any, of the out-of-network provider who provided the out-of-network service or supply;
- (3) the county and metropolitan area in which the health care or medical service or supply was provided;
- (4) whether the health care or medical service or supply was for emergency care; and
- (5) any other information about:
 - (A) the health benefit plan issuer or administrator

that the commissioner by rule requires; or

(B) the out-of-network provider that the Texas Medical Board or other appropriate regulatory agency by rule requires.

(c) The information collected and maintained under Subsection (b) is public information as defined by Section 552.002, Government Code, and may not include personally identifiable information or health care or medical information.

(d) Repealed by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 3.03(11), eff. September 1, 2019.

Added by Acts 2009, 81st Leg., R.S., Ch. 1290 (H.B. 2256), Sec. 1, eff. June 19, 2009.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 100 (S.B. 507), Sec. 16, eff. September 1, 2017.

Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 2.17, eff. September 1, 2019.

Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 3.03(11), eff. September 1, 2019.

SUBTITLE G. HEALTH COVERAGE AVAILABILITY

CHAPTER 1501. HEALTH INSURANCE PORTABILITY AND AVAILABILITY ACT

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1501.001. SHORT TITLE. This chapter may be cited as the Health Insurance Portability and Availability Act.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.002. DEFINITIONS. In this chapter:

(1) "Agent" means a person who may act as an agent for the sale of a health benefit plan under a license issued under Title 13.

(2) "Dependent" means:

(A) a spouse;

(B) a child younger than 25 years of age, including a newborn child;

(C) a child of any age who is:

(i) medically certified as disabled; and

(ii) dependent on the parent;

(D) an individual who must be covered under:

- (i) Section 1251.154; or
- (ii) Section 1201.062; and

(E) any other child eligible under an employer's health benefit plan, including a child described by Section 1503.003.

(3) "Eligible employee" means an employee who works on a full-time basis and who usually works at least 30 hours a week. The term includes a sole proprietor, a partner, and an independent contractor, if the individual is included as an employee under a health benefit plan of a small or large employer. The term does not include an employee who:

(A) works on a part-time, temporary, seasonal, or substitute basis;

(B) is covered under:

(i) another health benefit plan; or

(ii) a self-funded or self-insured employee welfare benefit plan that provides health benefits and is established in accordance with the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.); or

(C) elects not to be covered under the employer's health benefit plan and is covered under:

(i) the Medicaid program;

(ii) another federal program, including the CHAMPUS program or Medicare program; or

(iii) a benefit plan established in another country.

(4) "Employee" means an individual employed by an employer.

(5) "Health benefit plan" means a group, blanket, or franchise insurance policy, a certificate issued under a group policy, a group hospital service contract, or a group subscriber contract or evidence of coverage issued by a health maintenance organization that provides benefits for health care services. The term does not include:

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

(B) credit-only insurance coverage;

(C) disability insurance coverage;

(D) coverage for a specified disease or illness;

(E) Medicare services under a federal contract;

(F) Medicare supplement and Medicare Select benefit

plans regulated in accordance with federal law;

(G) long-term care coverage or benefits, nursing home care coverage or benefits, home health care coverage or benefits, community-based care coverage or benefits, or any combination of those coverages or benefits;

(H) coverage that provides limited-scope dental or vision benefits;

(I) coverage provided by a single service health maintenance organization;

(J) workers' compensation insurance coverage or similar insurance coverage;

(K) coverage provided through a jointly managed trust authorized under 29 U.S.C. Section 141 et seq. that contains a plan of benefits for employees that is negotiated in a collective bargaining agreement governing wages, hours, and working conditions of the employees that is authorized under 29 U.S.C. Section 157;

(L) hospital indemnity or other fixed indemnity insurance coverage;

(M) reinsurance contracts issued on a stop-loss, quota-share, or similar basis;

(N) short-term major medical contracts;

(O) liability insurance coverage, including general liability insurance coverage and automobile liability insurance coverage, and coverage issued as a supplement to liability insurance coverage, including automobile medical payment insurance coverage;

(P) coverage for on-site medical clinics;

(Q) coverage that provides other limited benefits specified by federal regulations; or

(R) other coverage that:

(i) is similar to the coverage described by this subdivision under which benefits for medical care are secondary or incidental to other coverage benefits; and

(ii) is specified by federal regulations.

(6) "Health benefit plan issuer" means an entity authorized under this code or another insurance law of this state that provides health insurance or health benefits in this state, including:

(A) an insurance company;

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

(C) a health maintenance organization operating under

Chapter 843; and

(D) a stipulated premium company operating under

Chapter 884.

(7) "Health status related factor" means:

(A) health status;

(B) medical condition, including both physical and mental illness;

(C) claims experience;

(D) receipt of health care;

(E) medical history;

(F) genetic information;

(G) evidence of insurability, including conditions arising out of acts of family violence; and

(H) disability.

(8) "Large employer" means a person who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year. The term includes a governmental entity subject to Article 3.51-1, 3.51-4, or 3.51-5, to Subchapter C, Chapter 1364, to Chapter 1578, or to Chapter 177, Local Government Code, that otherwise meets the requirements of this subdivision. For purposes of this definition, a partnership is the employer of a partner.

(9) "Large employer health benefit plan" means a health benefit plan offered to a large employer.

(10) "Large employer health benefit plan issuer" means a health benefit plan issuer, to the extent that the issuer is offering, delivering, issuing for delivery, or renewing health benefit plans subject to Subchapters C and M.

(11) "Person" means an individual, corporation, partnership, or other legal entity.

(12) "Preexisting condition provision" means a provision that excludes or limits coverage as to a disease or condition for a specified period after the effective date of coverage.

(13) "Premium" means all amounts paid by a small or large employer and employees as a condition of receiving coverage from a small or large employer health benefit plan issuer, including any fees or other contributions associated with a health benefit plan.

(14) "Small employer" means a person who employed an average of at least two employees but not more than 50 employees on business days during the preceding calendar year and who employs at

least two employees on the first day of the plan year. The term includes a governmental entity subject to Article 3.51-1, 3.51-4, or 3.51-5, to Subchapter C, Chapter 1364, to Chapter 1578, or to Chapter 177, Local Government Code, that otherwise meets the requirements of this subdivision. For purposes of this definition, a partnership is the employer of a partner.

(15) "Small employer health benefit plan" means a health benefit plan developed by the commissioner under Subchapter F or any other health benefit plan offered to a small employer in accordance with Section 1501.252(c) or 1501.255.

(16) "Small employer health benefit plan issuer" means a health benefit plan issuer, to the extent that the issuer is offering, delivering, issuing for delivery, or renewing health benefit plans subject to Subchapters C-H.

(16-a) "Small employer health coalition" means a private purchasing cooperative composed solely of small employers that is formed under Subchapter B.

(17) "Waiting period" means a period established by an employer that must elapse before an individual who is a potential enrollee in a health benefit plan is eligible to be covered for benefits.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.046(a), eff. September 1, 2005.

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2G.013, eff. April 1, 2009.

Acts 2013, 83rd Leg., R.S., Ch. 199 (S.B. 1332), Sec. 1, eff. September 1, 2013.

Sec. 1501.003. APPLICABILITY: SMALL EMPLOYER HEALTH BENEFIT PLANS. An individual or group health benefit plan is a small employer health benefit plan subject to Subchapters C-H if it provides health care benefits covering two or more employees of a small employer and:

- (1) the employer pays a portion of the premium or benefits;
- (2) the employer or a covered individual treats the health benefit plan as part of a plan or program for purposes of Section 106

or 162, Internal Revenue Code of 1986 (26 U.S.C. Section 106 or 162);
or

(3) the health benefit plan is an employee welfare benefit plan under 29 C.F.R. Section 2510.3-1(j).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 199 (S.B. 1332), Sec. 2, eff. September 1, 2013.

Sec. 1501.004. APPLICABILITY: LARGE EMPLOYER HEALTH BENEFIT PLANS. An individual or group health benefit plan is a large employer health benefit plan subject to Subchapters C and M if the plan provides health care benefits to employees of a large employer and:

(1) the employer pays a portion of the premium or benefits;
(2) the employer or a covered individual treats the health benefit plan as part of a plan or program for purposes of Section 106 or 162, Internal Revenue Code of 1986 (26 U.S.C. Section 106 or 162);
or

(3) the health benefit plan is an employee welfare benefit plan under 29 C.F.R. Section 2510.3-1(j).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 199 (S.B. 1332), Sec. 3, eff. September 1, 2013.

Sec. 1501.005. EXCEPTION: CERTAIN INDIVIDUALLY UNDERWRITTEN POLICIES. Except as provided by Section 1501.003 or 1501.004, this chapter does not apply to an individual health insurance policy that is subject to individual underwriting, even if the premium is paid through a payroll deduction method.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.006. CERTIFICATION. (a) In accordance with rules adopted by the commissioner, each health benefit plan issuer shall

certify that the issuer is offering, delivering, issuing for delivery, or renewing, or that the issuer intends to offer, deliver, issue for delivery, or renew:

(1) a health benefit plan to or through a small employer in this state that is subject to this chapter; or

(2) a health benefit plan to or through a large employer in this state that is subject to this chapter.

(b) A health benefit plan issuer must submit a revised certification to the commissioner only if the issuer changes its status as a small or large employer health benefit plan issuer or changes its intent to become a small or large employer health benefit plan issuer to the extent that its previous certification ceases to be accurate.

(c) The certification must include a statement that the health benefit plan issuer is complying with this chapter to the extent it applies to the issuer.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.007. AFFILIATES. (a) In this section, "affiliate" has the meaning described by Section 823.003.

(b) For purposes of this chapter, health benefit plan issuers that are affiliates or that are eligible to file a consolidated tax return are considered to be one issuer, and a restriction imposed by this chapter applies as if the health benefit plans delivered or issued for delivery to small employers in this state by the affiliates were issued by one issuer.

(c) Notwithstanding Subsection (b), a health maintenance organization that is an affiliate is considered to be a separate health benefit plan issuer for purposes of this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.008. LATE ENROLLEES. (a) For purposes of this chapter, an employee or dependent eligible for enrollment in a small or large employer's health benefit plan is a late enrollee if the individual requests enrollment after the expiration of:

(1) the initial enrollment period established under the terms of the first plan for which the individual was eligible through

the small or large employer; or

(2) an open enrollment period under Section 1501.156(a) or 1501.606(a).

(b) An employee or dependent eligible for enrollment is not a late enrollee if the individual:

(1) was covered under another health benefit plan or self-funded employer health benefit plan at the time the individual was eligible to enroll;

(2) declined enrollment in writing, at the time of the initial eligibility for enrollment, stating that coverage under another health benefit plan or self-funded employer health benefit plan was the reason for declining enrollment;

(3) has lost coverage under the other health benefit plan or self-funded employer health benefit plan as a result of:

(A) the termination of employment;

(B) a reduction in the number of hours of employment;

(C) the termination of the other plan's coverage;

(D) the termination of contributions toward the premium made by the employer; or

(E) the death of a spouse or divorce; and

(4) requests enrollment not later than the 31st day after the date coverage under the other health benefit plan or self-funded employer health benefit plan terminates.

(c) An employee or dependent eligible for enrollment is also not a late enrollee if the individual is:

(1) employed by an employer that offers multiple health benefit plans and the individual elects a different health benefit plan during an open enrollment period;

(2) a spouse for whom a court has ordered coverage under a covered employee's plan and the request for enrollment of the spouse is made not later than the 31st day after the date the court order is issued;

(3) a child for whom a court has ordered coverage under a covered employee's plan and the request for enrollment is made not later than the 31st day after the date the employer receives the court order; or

(4) a child of a covered employee who has lost coverage under Title XIX of the Social Security Act (42 U.S.C. Section 1396 et seq.), other than coverage consisting solely of benefits under Section 1928 of that Act (42 U.S.C. Section 1396s), or under Chapter

62, Health and Safety Code, and the request for enrollment is made not later than the 31st day after the date on which the child loses coverage.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.009. SCHOOL DISTRICT ELECTION. (a) An independent school district may elect to participate as a small employer without regard to the number of employees in the district. An independent school district that makes the election is treated as a small employer under this chapter for all purposes.

(b) An independent school district that is participating in the uniform group coverage program established under Chapter 1579 may not participate in the small employer market under this section for health insurance coverage and may not renew a health insurance contract obtained in accordance with this section after the date on which the program of coverages provided under Chapter 1579 is implemented. This subsection does not affect a contract for the provision of optional coverages not included in a health benefit plan under this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2G.014, eff. April 1, 2009.

Acts 2013, 83rd Leg., R.S., Ch. 199 (S.B. 1332), Sec. 4, eff. September 1, 2013.

Sec. 1501.0095. SCHOOL DISTRICT EMPLOYEE ELECTION. (a) Notwithstanding any other provision of this chapter, a school district employee who is eligible for coverage under a large or small employer health benefit plan providing coverage to the school district's employees and who is the spouse of another school district employee covered under the plan may elect whether to be treated under the plan as:

- (1) an employee; or
- (2) the dependent of the other employee.

(b) The commissioner shall adopt rules under Section 1501.010 governing the manner in which an election under this section must be

made.

Added by Acts 2005, 79th Leg., Ch. 998 (H.B. 407), Sec. 1, eff. June 18, 2005.

Sec. 1501.010. GENERAL RULES. The commissioner shall adopt rules necessary to:

- (1) implement this chapter; and
- (2) meet the minimum requirements of federal law, including regulations.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.011. DETERMINATION OF EMPLOYER STATUS FOR CERTAIN EMPLOYERS. (a) For an employer that did not exist throughout the calendar year preceding the year in which the determination of whether the employer is a small employer is made, the determination is based on the average number of employees the employer reasonably expects to employ on business days in the calendar year in which the determination is made.

(b) For an employer that did not exist throughout the calendar year preceding the year in which the determination of whether the employer is a large employer is made, the determination is based on the average number of employees the employer reasonably expects to employ on business days in the calendar year in which the determination is made.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 199 (S.B. 1332), Sec. 5, eff. September 1, 2013.

SUBCHAPTER B. COALITIONS AND COOPERATIVES

Sec. 1501.051. DEFINITIONS. In this subchapter:

- (1) "Board of directors" means the board of directors elected by a private purchasing cooperative or a health group cooperative.
- (2) "Board of trustees" means the board of trustees of the

Texas cooperative.

(3) "Cooperative" means a private purchasing cooperative or a health group cooperative established under this subchapter.

(3-a) "Eligible single-employee business" means a business entity that:

(A) is owned and operated by a sole proprietor;

(B) employed an average of fewer than two employees on business days during the preceding calendar year; and

(C) is eligible to participate in a cooperative under this subchapter in accordance with Section 1501.066.

(3-b) "Expanded service area" means any area larger than one county in which a health group cooperative offers coverage.

(4) "Texas cooperative" means the Texas Health Benefits Purchasing Cooperative established under Section 1501.052.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.048(a), eff. September 1, 2005.

Acts 2011, 82nd Leg., R.S., Ch. 1067 (S.B. 859), Sec. 1, eff. June 17, 2011.

Sec. 1501.052. TEXAS HEALTH BENEFITS PURCHASING COOPERATIVE; BOARD OF TRUSTEES. (a) The Texas Health Benefits Purchasing Cooperative is a nonprofit corporation established to make health care coverage available to small and large employers and their eligible employees and the eligible employees' dependents.

(b) The Texas cooperative is administered by a board of trustees of five members appointed by the governor with the advice and consent of the senate. Two members must represent employers, two members must represent employees, and one member must represent the public.

(c) Members of the board of trustees serve staggered six-year terms, with the terms of one or two members expiring February 1 of each odd-numbered year.

(d) A member of the board of trustees may not be compensated for serving on the board but is entitled to reimbursement for actual expenses incurred in performing functions as a member of the board as provided by the General Appropriations Act.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.049(a), eff. September 1, 2005.

Sec. 1501.053. TEXAS HEALTH BENEFITS PURCHASING COOPERATIVE: EXECUTIVE DIRECTOR AND OTHER EMPLOYEES. (a) The board of trustees shall employ an executive director. The executive director may hire other employees of the Texas cooperative as necessary.

(b) Salaries for employees of the Texas cooperative and related costs may be paid from administrative fees collected from employers and participating health benefit plan issuers or other sources of funding arranged by the Texas cooperative.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.054. REGIONAL SUBDIVISIONS OF TEXAS HEALTH BENEFITS PURCHASING COOPERATIVE. The board of trustees may:

- (1) develop regional subdivisions of the Texas cooperative;
- and
- (2) authorize each subdivision to separately exercise the powers and duties of a cooperative.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.055. APPLICABILITY OF PUBLIC INFORMATION LAW TO TEXAS HEALTH BENEFITS PURCHASING COOPERATIVE. The Texas cooperative is subject to the public information law, Chapter 552, Government Code.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.056. PRIVATE PURCHASING COOPERATIVES AND HEALTH GROUP COOPERATIVES. (a) Two or more small or large employers may form a private purchasing cooperative to purchase small or large employer health benefit plans. Subject to Subsection (d), a person may form a health group cooperative to purchase employer health benefit plans. A cooperative must be organized as a nonprofit corporation and has

the rights and duties provided by the Texas Non-Profit Corporation Act (Article 1396-1.01 et seq., Vernon's Texas Civil Statutes).

(b) On receipt of a certificate of incorporation or certificate of authority from the secretary of state, the cooperative shall file written notice of the receipt of the certificate and a copy of the cooperative's organizational documents with the commissioner.

(c) Repealed by Acts 2015, 84th Leg., R.S., Ch. 42 , Sec. 3.01(5), eff. September 1, 2015.

(d) A health benefit plan issuer may not form, or be a member of, a health group cooperative. A health benefit plan issuer may associate with a sponsoring entity, such as a business association, chamber of commerce, or other organization representing employers or serving an analogous function, to assist the sponsoring entity in forming a health group cooperative.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.050(a), eff. September 1, 2005.

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.050(b), eff. September 1, 2005.

Acts 2015, 84th Leg., R.S., Ch. 42 (S.B. 784), Sec. 3.01(5), eff. September 1, 2015.

Sec. 1501.057. IMMUNITY. (a) The Texas cooperative or a member of the board of trustees, the executive director, or an employee or agent of the Texas cooperative is not liable for:

(1) an act performed in good faith in the execution of duties in connection with the cooperative; or

(2) an independent action of a small employer health benefit plan issuer or a person who provides health care services under a health benefit plan.

(b) A private purchasing cooperative, a health group cooperative, or a member of the board of directors, the executive director, or an employee or agent of the private purchasing or health group cooperative is not liable for:

(1) an act performed in good faith in the execution of duties in connection with the private purchasing or health group cooperative; or

(2) an independent action of a small or large employer health benefit plan issuer or a person who provides health care services under a health benefit plan.

(c) A health group cooperative or a member of the board of directors, the executive director, or an employee or agent of the health group cooperative is not liable for failure to arrange for coverage of any particular illness, disease, or health condition.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.050(c), eff. September 1, 2005.

Sec. 1501.0575. VOLUNTARY PARTICIPATION BY ISSUER IN COOPERATIVE. A health benefit plan issuer may elect not to participate in a health group cooperative. The health benefit plan issuer may elect to participate in one or more health group cooperatives and may select the cooperatives in which the issuer will participate.

Added by Acts 2005, 79th Leg., Ch. 823 (S.B. 805), Sec. 1, eff. September 1, 2005.

Sec. 1501.058. POWERS AND DUTIES OF COOPERATIVES. (a) A cooperative shall:

(1) arrange for small or large employer health benefit plan coverage for small employer groups, large employer groups, and, subject to Section 1501.0581, eligible single-employee businesses that participate in the cooperative by contracting with small or large employer health benefit plan issuers that meet the requirements established by Section 1501.061;

(2) collect premiums to cover the cost of:

(A) small or large employer health benefit plan coverage purchased through the cooperative; and

(B) the cooperative's administrative expenses;

(3) establish administrative and accounting procedures for the operation of the cooperative;

(4) establish procedures under which an applicant for or participant in coverage issued through the cooperative may have a

grievance reviewed by an impartial person;

(5) contract with small or large employer health benefit plan issuers to provide services to small or large employers covered through the cooperative; and

(6) develop and implement a plan to maintain public awareness of the cooperative and publicize the eligibility requirements for, and the procedures for enrollment in, coverage through the cooperative.

(b) A cooperative may:

(1) contract with agents to market coverage issued through the cooperative;

(2) contract with a small or large employer health benefit plan issuer or third-party administrator to provide administrative services to the cooperative;

(3) negotiate the premiums paid by its members; and

(4) offer other ancillary products and services to its members that are customarily offered in conjunction with health benefit plans.

(c) A cooperative shall comply with:

(1) federal laws applicable to cooperatives and health benefit plans issued through cooperatives, to the extent required by state law or rules adopted by the commissioner; and

(2) state laws applicable to cooperatives and health benefit plans issued through cooperatives.

(d) To be eligible to exercise the authority granted under Subsection (a)(1), a health group cooperative must have at least 10 participating employers.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.053(a), eff. September 1, 2005.

Acts 2011, 82nd Leg., R.S., Ch. 1067 (S.B. 859), Sec. 2, eff. June 17, 2011.

Sec. 1501.0581. SPECIAL PROVISIONS RELATING TO HEALTH GROUP COOPERATIVES. (a) The membership of a health group cooperative may consist of only small employers; only large employers; both small and large employers; small employers and eligible single-employee

businesses; large employers and eligible single-employee businesses; or small employers, large employers, and eligible single-employee businesses. To participate as a member of a health group cooperative, an employer must be a small or large employer as described by this chapter or an eligible single-employee business.

(a-1) Notwithstanding Subsections (b) and (c), membership in a health group cooperative may be restricted to small and large employers within a single industry grouping as defined by the most recent edition of the United States Census Bureau's North American Industry Classification System.

(b) Subject to the requirements imposed on small employer health benefit plan issuers under Section 1501.101 and subject to Subsections (a-1) and (o), a health group cooperative:

(1) shall allow a small employer to join a health group cooperative, other than a health group cooperative consisting of only large employers, and enroll in health benefit plan coverage;

(2) subject to Subsection (t), may allow eligible single-employee businesses to join a health group cooperative and enroll in health benefit plan coverage; and

(3) may allow a large employer to join the health group cooperative and enroll in health benefit plan coverage.

(c) Subject to Subsections (a-1) and (o), a health group cooperative consisting of only small employers or both small and large employers shall allow any small employer to join the health group cooperative and enroll in the cooperative's health benefit plan coverage during the initial enrollment and annual open enrollment periods.

(d) A sponsoring entity of a health group cooperative may inform the members of the entity about the cooperative and the health benefit plans offered by the cooperative. Coverage issued through the cooperative must be issued through a licensed agent marketing the coverage in accordance with Section 1501.058(b)(1).

(e) The commissioner shall adopt rules that govern the manner in which an employer may terminate, because of a financial hardship affecting the employer, participation in a health group cooperative.

(f) An employer's participation in a health group cooperative is voluntary, but an employer electing to participate in a health group cooperative must commit to purchasing coverage through the health group cooperative for two years, except as provided by Subsection (e).

(g) A health benefit plan issuer issuing coverage to a health group cooperative:

(1) shall use a standard presentation form, prescribed by the commissioner by rule, to market health benefit plan coverage through the health group cooperative;

(2) may contract to provide health benefit plan coverage with only one health group cooperative in any county, except that a health benefit plan issuer may contract with additional health group cooperatives if it is providing health benefit plan coverage in an expanded service area in accordance with Subsection (1);

(3) shall allow enrollment in health benefit plan coverage in compliance with Subsection (c) and with the health benefit plan issuer's agreement with the health group cooperative;

(4) is exempt from the premium tax or tax on revenues imposed by Chapter 222, and the retaliatory tax under Chapter 281 for two years, with respect to the premiums or revenues received for coverage provided to each uninsured employee or dependent as defined by the commissioner in accordance with Subsection (h); and

(5) shall maintain documentation to be provided by health group cooperatives to ensure compliance with the rules adopted by the commissioner under Subsection (h) with respect to uninsured employees or dependents.

(h) The commissioner by rule shall determine who constitutes an uninsured employee or dependent for purposes of Subsection (g)(4).

(i) Notwithstanding any other law, and except as provided by Subsection (n), a health benefit plan issued by a health benefit plan issuer to provide coverage with a health group cooperative is not subject to a state law, including a rule, that:

(1) relates to a particular illness, disease, or treatment;
or

(2) regulates the differences in rates applicable to services provided within a health benefit plan network or outside the network.

(j) The commissioner by rule shall implement the exemption authorized by Subsection (i).

(k) A health group cooperative may offer more than one health benefit plan, but each plan offered must be made available to all employers participating in the cooperative.

(l) A health benefit plan issuer may, with notice to the commissioner, provide health benefit plan coverage to an expanded

service area that includes the entire state. A health benefit plan issuer may apply for approval of an expanded service area that comprises less than the entire state by filing with the commissioner an application, in a form and manner prescribed by the commissioner, at least 60 days before the date the health benefit plan issuer issues coverage to the health group cooperative in the expanded service area. At the expiration of 60 days after the date of receipt by the department of a filed application, the application is considered approved by the department unless, before that date, the application was either affirmatively approved or disapproved by written order of the commissioner. The commissioner, after notice and opportunity for hearing, may rescind an approval granted to a health benefit plan issuer under this subsection if the commissioner finds that the health benefit plan issuer has failed to market fairly to all eligible employers in the state or the expanded service area.

(m) The provisions of this section do not limit or restrict a small or large employer's access to health benefit plans under this chapter.

(n) A health benefit plan provided through a health group cooperative must provide coverage for diabetes equipment, supplies, and services as required by Subchapter B, Chapter 1358.

(o) A health group cooperative consisting only of small employers is not required to allow a small employer to join the health group cooperative under Subsection (c) if:

(1) the cooperative has elected to restrict membership in the cooperative in accordance with this subsection and Subsection (p); and

(2) after the small employer has joined the cooperative, the total number of eligible employees employed on business days during the preceding calendar year by all small employers participating in the cooperative would exceed 50.

(p) A health group cooperative must make the election described by Subsection (o) at the time the cooperative is initially formed. A health group cooperative making this election may not include an eligible single-employee business. Evidence of the election must be filed in writing with the commissioner in the form and at the time prescribed by the commissioner by rule.

(q) Except as provided by Subsection (r), a health group cooperative may file an election with the commissioner, on a form and in the manner prescribed by the commissioner, to permit eligible

single-employee businesses to join the cooperative and to enroll in health benefit plan coverage. The election must be filed not later than the 90th day before the date coverage for eligible single-employee businesses is to become effective.

(r) A health group cooperative may file an election under Subsection (q) only if a small or large employer health benefit plan issuer has agreed in writing to offer to issue coverage to the cooperative based on its membership after the election to permit eligible single-employee businesses to participate in the cooperative has become effective.

(s) On the date an election under Subsection (q) becomes effective and until the election is rescinded, the provisions of this subchapter relating to guaranteed issuance of plans, to rating requirements, and to mandated benefits that are applicable to small employers apply to eligible single-employee businesses that are members of the health group cooperative.

(t) A health group cooperative that files an election with the commissioner to permit an eligible single-employee business to join the health group cooperative and enroll in health benefit plan coverage must permit participation and enrollment in the cooperative's health benefit plan coverage during the initial enrollment and annual open enrollment periods by each eligible single-employee business that elects to participate and agrees to satisfy requirements associated with participation in and coverage through the cooperative. For purposes of this subsection, the provisions of Subsection (a-1) applicable to small employers apply to eligible single-employee businesses.

(u) A health group cooperative may rescind its election to permit eligible single-employee businesses to join the cooperative and enroll in health benefit plan coverage only if:

(1) the election has been effective for at least two years, except as provided by Subsection (v);

(2) the health group cooperative files notice of the rescission with the commissioner not later than the 180th day before the effective date of the rescission; and

(3) the health group cooperative provides written notice of termination of coverage to all eligible single-employee business members of the cooperative not later than the 180th day before the effective date of the termination.

(v) The commissioner shall adopt rules under which a health

group cooperative may for good cause rescind an election described by Subsection (u) before the second anniversary of the effective date of the election.

(w) Notwithstanding Subsection (u), a health group cooperative that files notice of rescission may choose to permit existing eligible single-employee businesses to remain active, covered members of the cooperative, but only if all such members of the cooperative are provided the same opportunity.

(x) A health group cooperative that has rescinded an election under Subsection (u) may not file a subsequent election to permit eligible single-employee businesses to join the cooperative and enroll in health benefit plan coverage before the fifth anniversary of the effective date of the rescission.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.051(a), eff. September 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 823 (S.B. 805), Sec. 2, eff. September 1, 2005.

Acts 2007, 80th Leg., R.S., Ch. 547 (S.B. 1255), Sec. 1, eff. September 1, 2007.

Acts 2011, 82nd Leg., R.S., Ch. 1067 (S.B. 859), Sec. 3, eff. June 17, 2011.

Sec. 1501.0582. HEALTH GROUP COOPERATIVE: EXPEDITED APPROVAL PROCESS. The department shall develop an expedited approval process for health benefit plan coverage arranged by a health group cooperative.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.052(a), eff. September 1, 2005.

Sec. 1501.059. SELF-INSURED OR SELF-FUNDED PLAN PROHIBITED. A cooperative may not self-insure or self-fund any health benefit plan or portion of a plan.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.060. SCOPE OF GROUP COVERAGE. Subchapter B, Chapter 1251, does not limit the type of group that may be covered by a group health benefit plan issued through a cooperative.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.061. REQUIREMENTS APPLICABLE TO HEALTH BENEFIT PLAN ISSUERS WITH WHICH COOPERATIVE MAY CONTRACT. A cooperative may contract only with a small or large employer health benefit plan issuer that demonstrates that the issuer:

- (1) is in good standing with the department;
- (2) has the capacity to administer health benefit plans;
- (3) is able to monitor and evaluate the quality and cost-effectiveness of care and applicable procedures;
- (4) is able to conduct utilization management and establish applicable procedures and policies;
- (5) is able to ensure that enrollees have adequate access to health care providers, including adequate numbers and types of providers;
- (6) has a satisfactory grievance procedure and is able to respond to enrollees' calls, questions, and complaints; and
- (7) has financial capacity, either through satisfying financial solvency standards, as applied by the commissioner, or through appropriate reinsurance or other risk-sharing mechanisms.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.053(b), eff. September 1, 2005.

Sec. 1501.062. COOPERATIVE NOT INSURER; AGENTS AND ADMINISTRATORS. (a) A cooperative is not an insurer and the employees of the cooperative are not required to be licensed under Title 13. This exemption from licensure includes a health group cooperative that acts to provide information about and to solicit membership in the cooperative, subject to Section 1501.0581(d).

(b) An agent or third-party administrator used and compensated by a cooperative must be licensed as required by Title 13.

(c) An agent used and compensated by a cooperative may market

the products and services sponsored by the cooperative without being appointed by each small or large employer health benefit plan issuer participating in the cooperative. The agent may not market any other product or service of a participating small or large employer health benefit plan issuer that is not sponsored by the cooperative unless the agent has been appointed by that issuer.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.052(b), eff. September 1, 2005.

Sec. 1501.063. STATUS AS EMPLOYER. (a) A small employer health coalition that otherwise meets the description of a small employer is considered a single small employer for all purposes under this chapter.

(b) A health group cooperative that is composed of only small employers, only large employers, or both small and large employers is considered a single employer under this code.

(b-1) A health group cooperative that is composed only of small employers and that has made the election described by Section 1501.0581(o)(1) in accordance with Subsection (p) of that section shall be treated in the same manner as a small employer for the purposes of this chapter, including for the purposes of any provision relating to premium rates and issuance and renewal of coverage.

(b-2) A health group cooperative that is composed only of small employers and that has not made the election described by Section 1501.0581(o)(1) in accordance with Subsection (p) of that section, or a health group cooperative that is composed of both small and large employers, may be treated in the same manner as a large employer for the purposes of this chapter, including for the purposes of any provision relating to premium rates and issuance and renewal of coverage.

(b-3) Except as provided by Section 1501.0581(k), a health group cooperative shall have sole authority to make benefit elections and perform other administrative functions under this code for the cooperative's participating employers.

(c) Any other cooperative formed under this subchapter is considered an employer solely for the purposes of benefit elections

under this code.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.052(c), eff. September 1, 2005.

Acts 2005, 79th Leg., Ch. 823 (S.B. 805), Sec. 3, eff. September 1, 2005.

Acts 2007, 80th Leg., R.S., Ch. 547 (S.B. 1255), Sec. 2, eff. September 1, 2007.

Acts 2011, 82nd Leg., R.S., Ch. 1067 (S.B. 859), Sec. 4, eff. June 17, 2011.

Sec. 1501.064. CERTAIN USE OF APPROPRIATED MONEY PROHIBITED. The Texas cooperative may not use money appropriated by the state to pay or otherwise subsidize any portion of the premium for a small employer covered through the cooperative.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.065. CERTAIN ACTIONS BASED ON RISK CHARACTERISTICS OR HEALTH STATUS PROHIBITED. A cooperative may not limit, restrict, or condition an employer's or employee's membership in a cooperative or an employee's choice among benefit plans based on:

(1) risk characteristics of a group or of any member of a group; or

(2) health status related factors, duration of coverage, or any similar characteristic related to the health status or experience of a group or of any member of a group.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.053(c), eff. September 1, 2005.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 1067 (S.B. 859), Sec. 5, eff. June 17, 2011.

Sec. 1501.066. ELECTION TO TREAT PARTICIPATING EMPLOYERS SEPARATELY FOR RATING PURPOSES. (a) Notwithstanding Section

1501.063, a health group cooperative may file with the commissioner, on a form and in the manner prescribed by the commissioner, an election to treat each participating employer within the cooperative as a separate employer for purposes of rating small and large employer health benefit plans, subject to the rating requirements of this code applicable to such plans. An existing health group cooperative must file the election with the department not later than the 90th day before the date on which the election is to become effective.

(b) A health group cooperative must provide to all participating and prospective employers, in a manner prescribed by the commissioner, a written notice of the cooperative's election to treat participating employers within the cooperative as separate employers for purposes of rating small and large employer health benefit plans. Employers participating in the cooperative when such an election is made must be provided notice of the election not later than the 90th day before the date the election is to become effective. For a participating employer, the notice must contain the quote for the premium rate applicable to the employer as of the date the plan is renewed. Prospective employers must be provided notice of the election when the prospective employer applies to become a participating employer in the health group cooperative.

(c) An election under this section is effective on the earliest date after the election is made on which the plan to which the election applies is initially issued or renewed. The election remains in effect for not less than 12 months after the effective date.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1067 (S.B. 859), Sec. 6, eff. June 17, 2011.

Sec. 1501.067. ELIGIBLE SINGLE-EMPLOYEE BUSINESS. The commissioner shall adopt rules governing the eligibility of a single-employee business to participate in a health group cooperative under this subchapter. The rules must include provisions to ensure that each eligible single-employee business has a business purpose and was not formed solely to obtain health benefit plan coverage under this subchapter.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1067 (S.B. 859), Sec. 6,

eff. June 17, 2011.

SUBCHAPTER C. PROVISION OF COVERAGE

Sec. 1501.101. GEOGRAPHIC SERVICE AREAS. (a) Repealed by Acts 2015, 84th Leg., R.S., Ch. 42 , Sec. 3.01(6), eff. September 1, 2015.

(b) A small employer health benefit plan issuer that refuses to issue a small employer health benefit plan in a geographic service area may not offer a health benefit plan to a small employer in the applicable service area before the fifth anniversary of the date of the refusal.

(c) A small or large employer health benefit plan issuer is not required to offer or issue a small or large employer health benefit plan to:

(1) a small or large employer that is not located within a geographic service area of the issuer;

(2) an employee of a small or large employer who neither resides nor works in the geographic service area of the issuer; or

(3) a small or large employer located within a geographic service area of the issuer with respect to which area the issuer demonstrates to the commissioner's satisfaction that the issuer:

(A) reasonably anticipates that it will not have the capacity to deliver services adequately because of obligations to existing covered individuals; and

(B) is acting uniformly without regard to the claims experience of the employer or any health status related factor of employees, employees' dependents, or new employees or dependents who may become eligible for the coverage.

(d) A small or large employer health benefit plan issuer that is unable to offer coverage in a geographic service area in accordance with a determination made by the commissioner under Subsection (c)(3) may not offer a small or large employer benefit plan, as applicable, in that service area before the 180th day after the later of:

(1) the date the issuer refuses to offer coverage; or

(2) the date the issuer demonstrates to the satisfaction of the commissioner that it has regained the capacity to deliver services to small or large employers in the geographic service area.

(e) If the commissioner determines that requiring the acceptance of small or large employers under this chapter would place

a small or large employer health benefit plan issuer in a financially impaired condition and that the issuer is acting uniformly without regard to the claims experience of the small or large employer or any health status related factors of eligible employees, eligible employees' dependents, or new employees or dependents who may become eligible for the coverage, the issuer may not offer coverage to small or large employers until the later of:

(1) the 180th day after the date the commissioner makes the determination; or

(2) the date the commissioner determines that accepting small or large employers would not place the issuer in a financially impaired condition.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 42 (S.B. 784), Sec. 3.01(6), eff. September 1, 2015.

Sec. 1501.102. PREEXISTING CONDITION PROVISION. (a) In this section, "creditable coverage" has the meaning assigned by Section 1205.004 and includes coverage provided under:

(1) a political subdivision health benefits risk pool; and

(2) a short-term limited duration coverage plan.

(b) A preexisting condition provision in a small or large employer health benefit plan may apply only to coverage for a disease or condition for which medical advice, diagnosis, care, or treatment was recommended or received during the six months before the earlier of:

(1) the effective date of coverage; or

(2) the first day of the waiting period.

(c) A preexisting condition provision in a small or large employer health benefit plan may not apply to expenses incurred on or after the first anniversary of the initial effective date of coverage of the enrollee, including a late enrollee.

(d) A preexisting condition provision in a small or large employer health benefit plan may not apply to an individual who was continuously covered for an aggregate period of 12 months under creditable coverage that was in effect until a date not more than 63 days before the effective date of coverage under the plan, excluding

any waiting period.

(e) In determining whether a preexisting condition provision applies to an individual covered by a small or large employer health benefit plan, the plan issuer shall credit the time the individual was covered under previous creditable coverage if the previous coverage was in effect at any time during the 12 months preceding the effective date of coverage under the plan. If the previous coverage was issued under a health benefit plan, any waiting period that applied before that coverage became effective must also be credited against the preexisting condition provision period.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.103. TREATMENT OF CERTAIN CONDITIONS AS PREEXISTING PROHIBITED. (a) A small or large employer health benefit plan issuer may not treat genetic information as a preexisting condition described by Section 1501.102(b) in the absence of a diagnosis of the condition related to the information.

(b) A small or large employer health benefit plan issuer may not treat pregnancy as a preexisting condition described by Section 1501.102(b).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.104. AFFILIATION PERIOD. (a) In this section, "affiliation period" means a period that, under a small or large employer health benefit plan offered by a health maintenance organization, must expire before the coverage becomes effective.

(b) A health maintenance organization may impose an affiliation period if the period is applied uniformly without regard to any health status related factor. The affiliation period may not exceed:

(1) two months for an enrollee, other than a late enrollee;
or

(2) 90 days for a late enrollee.

(c) An affiliation period under a small or large employer health benefit plan must run concurrently with any applicable waiting period under the plan. A health maintenance organization must credit an affiliation period against any preexisting condition provision period.

(d) During an affiliation period, a health maintenance organization:

(1) is not required to provide health care services or benefits to the participant or beneficiary; and

(2) may not charge a premium to the participant or beneficiary.

(e) A health maintenance organization may use an alternative method approved by the commissioner to address adverse selection.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.105. WAITING PERIOD PERMITTED. Sections 1501.102-1501.104 do not preclude application of a waiting period that applies to all new enrollees under a small or large employer health benefit plan.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.106. CERTAIN LIMITATIONS OR EXCLUSIONS OF COVERAGE PROHIBITED. (a) A small or large employer health benefit plan may not limit or exclude, by use of a rider or amendment applicable to a specific individual, coverage by type of illness, treatment, medical condition, or accident.

(b) This section does not preclude a small or large employer health benefit plan from limiting or excluding coverage for a preexisting condition in accordance with Section 1501.102.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.107. DISCOUNTS, REBATES, AND REDUCTIONS. (a) A small or large employer health benefit plan issuer may establish premium discounts, rebates, or a reduction in otherwise applicable copayments, coinsurance, or deductibles, or any combination of these incentives, in return for participation in programs promoting disease prevention, wellness, and health.

(b) A discount, rebate, or reduction established under this section does not violate Section 541.056(a).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 112 (H.B. 2252), Sec. 3, eff. May 17, 2007.

Sec. 1501.108. RENEWABILITY OF COVERAGE; CANCELLATION. (a) Except as provided by this section and Section 1501.109, a small or large employer health benefit plan issuer shall renew the small or large employer health benefit plan for any covered small or large employer, as applicable, at the employer's option, unless:

(1) a premium has not been paid as required by the terms of the plan;

(2) the employer has committed fraud or has intentionally misrepresented a material fact;

(3) the employer has not complied with the terms of the plan;

(4) no enrollee in the plan resides or works in the geographic service area of the small or large employer health benefit plan issuer or in the area for which the issuer is authorized to do business; or

(5) membership of the employer in an association terminates, but only if coverage is terminated uniformly without regard to a health status related factor of a covered individual.

(b) A small or large employer health benefit plan issuer may refuse to renew the coverage of a covered employee or dependent for fraud or intentional misrepresentation of a material fact by that individual.

(c) A small or large employer health benefit plan issuer may not cancel a small or large employer health benefit plan except for a reason specified for refusal to renew under Subsection (a). A small or large employer health benefit plan issuer may not cancel the coverage of a covered employee or dependent except for a reason specified for refusal to renew under Subsection (b).

(d) Notwithstanding Subsection (a), a small or large employer health benefit plan issuer may modify a small or large employer health benefit plan in accordance with Section 1369.0541 or if:

(1) the modification occurs at the time of coverage renewal;

(2) the modification is effective uniformly among all small

or large employers covered by that health benefit plan; and

(3) the issuer notifies the commissioner and each affected covered small or large employer of the modification not later than the 60th day before the date the modification is effective.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 891 (H.B. 2467), Sec. 1, eff. September 1, 2007.

Acts 2011, 82nd Leg., R.S., Ch. 501 (H.B. 1405), Sec. 8, eff. September 1, 2011.

Sec. 1501.109. REFUSAL TO RENEW; DISCONTINUATION OF COVERAGE.

(a) A small or large employer health benefit plan issuer may elect to refuse to renew all small or large employer health benefit plans delivered or issued for delivery by the issuer in this state or in a geographic service area. The issuer shall notify:

(1) the commissioner of the election not later than the 180th day before the date coverage under the first plan terminates under this subsection; and

(2) each affected covered small or large employer not later than the 180th day before the date coverage terminates for that employer.

(b) A small employer health benefit plan issuer that elects under this section to refuse to renew all small employer health benefit plans in this state or in a geographic service area may not write a new small employer health benefit plan in this state or in the geographic service area, as applicable, before the fifth anniversary of the date notice is provided to the commissioner under Subsection (a).

(c) A large employer health benefit plan issuer that elects under this section to refuse to renew all large employer health benefit plans in this state or in a geographic service area may not write a new large employer health benefit plan in this state or in the geographic service area, as applicable, before the fifth anniversary of the date notice is provided to the commissioner under Subsection (a).

(d) A small or large employer health benefit plan issuer may elect to discontinue a particular type of small or large employer

coverage only if the issuer:

(1) before the 90th day preceding the date of the discontinuation of the coverage:

(A) provides notice of the discontinuation to the employer and the commissioner; and

(B) offers to each employer the option to purchase other small or large employer coverage offered by the issuer at the time of the discontinuation; and

(2) acts uniformly without regard to the claims experience of the employer or any health status related factors of eligible employees, eligible employees' dependents, or new employees or dependents who may become eligible for the coverage.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2015, 84th Leg., R.S., Ch. 42 (S.B. 784), Sec. 2.01, eff. September 1, 2015.

Sec. 1501.110. NOTICE TO COVERED PERSONS. (a) A small or large employer health benefit plan issuer that cancels or refuses to renew coverage under a small or large employer health benefit plan under Section 1501.108 or 1501.109 shall, not later than the 30th day before the date termination of coverage is effective, notify the small or large employer of the cancellation of or refusal to renew coverage. The employer is responsible for notifying enrollees in the plan of the cancellation of or refusal to renew coverage.

(b) The notice provided to a small or large employer by a small or large employer health benefit plan issuer under this section is in addition to any other notice required by Section 1501.109.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.111. WRITTEN STATEMENT OF DENIAL, CANCELLATION, OR REFUSAL TO RENEW REQUIRED. Denial by a small or large employer health benefit plan issuer of an application from a small or large employer for coverage from the issuer or cancellation of or refusal to renew coverage by a small or large employer health benefit plan issuer must:

(1) be in writing; and

(2) state the reason or reasons for the denial, cancellation, or refusal to renew.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

SUBCHAPTER D. GUARANTEED ISSUE OF SMALL EMPLOYER HEALTH BENEFIT PLANS; CONTINUATION OF COVERAGE

Sec. 1501.151. GUARANTEED ISSUE. (a) A small employer health benefit plan issuer shall issue the small employer health benefit plan chosen by the small employer to each small employer that elects to be covered under the plan and agrees to satisfy the other requirements of the plan.

(b) A small employer health benefit plan issuer shall provide small employer health benefit plans without regard to health status related factors.

(c) This chapter does not require a small employer to purchase health coverage for the employer's employees.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.152. EXCLUSION OF ELIGIBLE EMPLOYEE OR DEPENDENT PROHIBITED. A small employer health benefit plan issuer may not exclude an eligible employee or dependent, including a late enrollee, who would otherwise be covered under a small employer group.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.153. EMPLOYER CONTRIBUTION. (a) This chapter does not require a small employer to make an employer contribution to the premium paid to a small employer health benefit plan issuer, but the issuer may require an employer contribution in accordance with the issuer's usual and customary practices applicable to the issuer's employer group health benefit plans in this state. The issuer shall apply the employer contribution level uniformly to each small employer offered or issued coverage by the issuer in this state.

(a-1) Notwithstanding Subsection (a), a small employer health benefit plan issuer may offer a small employer the option of a small employer health benefit plan for which the employer is required to

contribute 100 percent of the premium paid. A plan offered under this subsection may be offered in addition to a plan offered by the issuer in accordance with Subsection (a) that requires a lower percentage of the premium paid to be contributed by the employer. A plan issued under this subsection must require the employer to contribute 100 percent of the premium paid for each eligible participating employee.

(b) If two or more small employer health benefit plan issuers participate in a purchasing cooperative established under Section 1501.056, each participating issuer may use the employer contribution requirement established by the cooperative for policies marketed by the cooperative.

(c) A small employer that elects to make an employer contribution to the premium paid to a small employer health benefit plan issuer is not required to pay any amount with respect to an employee who elects not to be covered.

(d) A small employer may elect to pay the premium for additional coverage.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2009, 81st Leg., R.S., Ch. 462 (S.B. 80), Sec. 1, eff. September 1, 2009.

Sec. 1501.154. MINIMUM PARTICIPATION REQUIREMENT. (a) Except as provided by Section 1501.155, coverage is available under a small employer health benefit plan if at least 75 percent of a small employer's eligible employees elect to participate in the plan.

(b) If a small employer offers multiple health benefit plans, the collective participation in those plans must be at least:

- (1) 75 percent of the employer's eligible employees; or
- (2) if applicable, the lower participation level offered by the small employer health benefit plan issuer under Section 1501.155.

(c) A small employer health benefit plan issuer may elect not to offer a health benefit plan to a small employer that offers multiple health benefit plans if:

- (1) the plans are provided by more than one issuer; and
- (2) the issuer would have less than 75 percent of the employer's eligible employees enrolled in the issuer's plan.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.054(a), eff. September 1, 2005.

Sec. 1501.155. EXCEPTION TO MINIMUM PARTICIPATION REQUIREMENT.

(a) A small employer health benefit plan issuer may offer a small employer health benefit plan to a small employer with a participation level of less than 75 percent of the employer's eligible employees if the issuer permits the same qualifying participation level for each small employer health benefit plan offered by the issuer in this state.

(b) A small employer health benefit plan issuer may offer a small employer health benefit plan to a small employer even if the employer's participation level is less than the issuer's qualifying participation level established in accordance with Subsection (a) if:

(1) the employer obtains a written waiver from each eligible employee who declines coverage under a health benefit plan offered to the employer stating that the employee was not induced or pressured to decline coverage because of the employee's risk characteristics; and

(2) the issuer accepts or rejects the entire group of eligible employees who choose to participate and excludes only those employees who have declined coverage.

(c) A small employer health benefit plan issuer may underwrite the group of eligible employees who do not decline coverage under Subsection (b).

(d) A small employer health benefit plan issuer may not provide coverage to a small employer or the employer's employees under Subsection (b) if the issuer or an agent for the issuer knows that the employer has induced or pressured an eligible employee or a dependent of the employee to decline coverage because of the individual's risk characteristics.

(e) A small employer health benefit plan issuer, a small employer, or an agent may not use the exception provided by Subsection (b) to circumvent the requirements of this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.156. EMPLOYEE ENROLLMENT; WAITING PERIOD. (a) The initial enrollment period under a small employer health benefit plan for employees and dependents must be at least 31 days, with a 31-day open enrollment period provided annually.

(b) A small employer may establish a waiting period not to exceed 90 days from the first day of employment.

(c) A small employer health benefit plan issuer may not deny coverage to a new employee of a covered small employer or the employee's dependents if the issuer receives an application for coverage not later than the 31st day after the date employment begins or on completion of a waiting period established under Subsection (b).

(d) A small employer health benefit plan issuer may deny coverage to a late enrollee until the next annual open enrollment period and may subject the enrollee to a one-year preexisting condition provision as described by Section 1501.102. The period during which the preexisting condition provision applies may not exceed 18 months from the date of the initial application.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.157. COVERAGE FOR NEWBORN CHILDREN. (a) A small employer health benefit plan may not limit or exclude initial coverage of a newborn child of a covered employee.

(b) Coverage of a newborn child of a covered employee under this section ends on the 32nd day after the date of the child's birth unless, not later than the 31st day after the date of birth, the small employer health benefit plan issuer receives:

- (1) notice of the birth; and
- (2) any required additional premium.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.158. COVERAGE FOR ADOPTED CHILDREN. (a) A small employer health benefit plan may not limit or exclude initial coverage of an adopted child of an insured. A child is considered to be the child of an insured if the insured is a party to a suit in which the insured seeks to adopt the child.

(b) An adopted child of an insured may be enrolled, at the

insured's option, not later than the 31st day after:

(1) the date the insured becomes a party to a suit in which the insured seeks to adopt the child; or

(2) the date the adoption becomes final.

(c) Coverage of an adopted child of an insured under this section ends unless the small employer health benefit plan issuer receives notice of the adoption and any required additional premium not later than the 31st day after:

(1) the date the insured becomes a party to a suit in which the insured seeks to adopt the child; or

(2) the date the adoption becomes final.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.159. CONTINUATION OF COVERAGE FOR CERTAIN DEPENDENTS. An employee's dependent may choose to continue coverage under a small employer health benefit plan if:

(1) the dependent:

(A) is under one year of age; or

(B) has been covered by the small employer under a plan for at least one year;

(2) the dependent loses eligibility for coverage because of the death, divorce, or retirement of the employee, as provided by Subchapter G, Chapter 1251; and

(3) the Consolidated Omnibus Budget Reconciliation Act of 1985 (Pub. L. No. 99-272) does not require continuation or conversion coverage for dependents of an employee.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

SUBCHAPTER E. UNDERWRITING AND RATING OF SMALL EMPLOYER HEALTH BENEFIT PLANS

Sec. 1501.201. DEFINITIONS. In this subchapter:

(1) "Base premium rate" means, for each class of business and for a specific rating period, the lowest premium rate that is charged or that could be charged under a rating system for that class of business by a small employer health benefit plan issuer to small employers with similar case characteristics for small employer health benefit plans that provide the same or similar coverage.

(2) "Case characteristics" means, with respect to a small employer, the geographic area in which the employer's employees reside, the age and gender of the individual employees and their dependents, the number of employees and dependents, the appropriate industry classification as determined by the small employer health benefit plan issuer, and other objective criteria established by the issuer that are considered by the issuer in setting premium rates for the employer. The term does not include:

- (A) health status related factors;
- (B) duration of coverage since the date of issuance of a health benefit plan; or
- (C) whether a covered individual is or may become pregnant.

(3) "Class of business" means all small employers or a separate grouping of small employers established under this subchapter.

(4) "Index rate" means, for each class of business and for a specific rating period for small employers with similar case characteristics, the arithmetic average of the applicable base premium rate and corresponding highest premium rate.

(5) "New business premium rate" means, for each class of business and for a specific rating period, the lowest premium rate that is charged or offered or that could be charged or offered by a small employer health benefit plan issuer to small employers with similar case characteristics for newly issued small employer health benefit plans that provide the same or similar coverage.

(6) "Rating period" means a calendar period during which premium rates established by a small employer health benefit plan issuer are assumed to be in effect.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.202. ESTABLISHMENT OF CLASSES OF BUSINESS. (a) Except as otherwise provided by this subchapter, a small employer health benefit plan issuer may not establish a separate class or classes of business for small employers.

(b) A small employer health benefit plan issuer may establish a separate class of business only to reflect substantial differences in expected claims experience or administrative costs related to the

following reasons:

(1) the issuer uses more than one type of system to market and sell small employer health benefit plans to small employers;

(2) the issuer has acquired a class of business from another small employer health benefit plan issuer; or

(3) the issuer provides coverage to one or more employer-based association groups.

(c) Except as provided by Subsection (e), a small employer health benefit plan issuer may not establish more than nine separate classes of business under this section.

(d) The commissioner may adopt rules to provide for a transition period to permit a small employer health benefit plan issuer to comply with Subsection (c) after acquiring an additional class of business from another small employer health benefit plan issuer.

(e) On application to the commissioner, the commissioner may approve the establishment of additional classes of business if the commissioner finds that the establishment of additional classes would enhance the efficiency and fairness of the health coverage market for small employers.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.203. ESTABLISHMENT OF CLASSES OF BUSINESS ON CERTAIN BASES PROHIBITED. (a) A small employer health benefit plan issuer may not establish a separate class of business based on:

(1) participation requirements; or

(2) whether the coverage provided to a small employer group is provided on a guaranteed issue basis or is subject to underwriting or proof of insurability.

(b) A small employer health benefit plan issuer may not directly or indirectly use as a criterion for establishing a separate class of business:

(1) the number of employees and dependents of a small employer; or

(2) except as provided by Section 1501.202(b)(3), the trade or occupation of the employees of a small employer or the industry or type of business of the small employer.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.204. INDEX RATES. Under a small employer health benefit plan:

(1) the index rate for a class of business may not exceed the index rate for any other class of business by more than 20 percent; and

(2) premium rates charged during a rating period to small employers in a class of business with similar case characteristics for the same or similar coverage, or premium rates that could be charged to those employers under the rating system for that class of business, may not vary from the index rate by more than 25 percent.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.205. PREMIUM RATES: ESTABLISHMENT. (a) In this section:

(1) "Risk characteristic" means:

(A) a health status related factor;

(B) the duration of coverage; or

(C) any characteristic similar to a characteristic described by Paragraph (A) or (B) that is related to the health status or experience of a small employer group or of any member of a small employer group.

(2) "Risk load" means the percentage above the applicable base premium rate a small employer health benefit plan issuer charges to a small employer to reflect the risk characteristics associated with that particular small employer group.

(b) Small employer health benefit plan issuers shall develop premium rates for each small employer group in a two-step process. In the first step, the small employer health benefit plan issuer shall develop a base premium rate for each small employer group without regard to any risk characteristic of the group. In the second step, the small employer health benefit plan issuer may adjust the resulting base premium rate by the risk load of the group, subject to this subchapter, to reflect the risk characteristics of the group.

(c) The risk load assessed to a particular group shall reflect the risk characteristics of the particular group.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.206. PREMIUM RATES: ADJUSTMENTS. (a) The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of:

(1) the percentage change in the new business premium rate, measured from the first day of the preceding rating period to the first day of the new rating period;

(2) any adjustment, not to exceed 15 percent annually and adjusted pro rata for a rating period of less than one year, due to the claims experience, health status, or duration of coverage of the employees or dependents of employees of the small employer, as determined under the small employer health benefit plan issuer's rate manual for the class of business; and

(3) any adjustment due to change in coverage or change in the case characteristics of the small employer, as determined under the issuer's rate manual for the class of business.

(b) An adjustment in the premium rate for claims experience, health status, or duration of coverage:

(1) may not be charged to individual employees or dependents; and

(2) must be applied uniformly to the rates charged for all employees and dependents of employees of the small employer.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.207. PREMIUM RATE ADJUSTMENT IN CLOSED PLAN. For a closed health benefit plan under which a small employer health benefit plan issuer is no longer enrolling new small employers, the issuer shall use the percentage change in the base premium rate to adjust premium rates under Section 1501.206(a)(1). The portion of change in premium rates computed under that subdivision may not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan under which the issuer is enrolling new small employers.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.208. PREMIUM RATES: INDUSTRY CLASSIFICATION. A small employer health benefit plan issuer may use the industry classification to which a small employer belongs as a case characteristic in establishing the premium rate, but the highest rate factor associated with any industry classification may not exceed by more than 15 percent the lowest rate factor associated with any industry classification.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.209. PREMIUM RATES: NUMBER OF EMPLOYEES. A small employer health benefit plan issuer may use the number of employees and dependents of a small employer as a case characteristic in establishing premium rates for the group. The highest rate factor associated with a classification based on the number of employees and dependents of a small employer may not exceed by more than 20 percent the lowest rate factor associated with a classification based on the number of employees and dependents of a small employer.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.210. PREMIUM RATES: NONDISCRIMINATION. (a) A small employer health benefit plan issuer shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business. Rating factors must produce premium rates for identical groups that:

- (1) differ only by the amounts attributable to health benefit plan design; and
- (2) do not reflect differences because of the nature of the groups assumed to select particular health benefit plans.

(b) A small employer health benefit plan issuer shall treat each health benefit plan issued or renewed in the same calendar month as having the same rating period.

(c) Without the prior approval of the commissioner, a small employer health benefit plan issuer may not use case characteristics other than:

- (1) the geographic area in which the small employer's employees reside;
- (2) the age and gender of the individual employees and

their dependents;

(3) the number of employees and dependents; and

(4) the appropriate industry classification.

(d) Premium rates for a small employer health benefit plan must comply with the requirements of this chapter, notwithstanding any assessment paid or payable by a small employer health benefit plan issuer.

(e) A small employer health benefit plan issuer may not transfer a small employer involuntarily into or out of a class of business. The issuer may not offer to transfer a small employer into or out of a class of business unless the offer is made to transfer all other small employers in the employer's class of business without regard to case characteristics, claims experience, health status, or duration of coverage since the issuance of the health benefit plan.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.211. RULES CONCERNING PREMIUM RATES. Rules adopted under Section 1501.010 may ensure that:

(1) rating practices used by small employer health benefit plan issuers are consistent with the purposes of this chapter; and

(2) differences in premium rates charged for each small employer health benefit plan are reasonable and reflect objective differences in plan design.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.212. RESTRICTED PROVIDER NETWORK. (a) A small employer health benefit plan may use a restricted provider network to provide benefits under the plan.

(b) A small employer health benefit plan that uses a restricted provider network does not provide similar coverage to a plan that does not use a restricted provider network if the use of the network results in reduced premium rates charged to the small employer or substantial differences in claim costs.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.213. PREMIUM RATES: HEALTH MAINTENANCE ORGANIZATION HEALTH BENEFIT PLAN. (a) The premium rates for a state-approved health benefit plan offered by a health maintenance organization under Section 1501.255 must be established in accordance with formulas or schedules of charges filed with the department.

(b) A health maintenance organization that participates in a purchasing cooperative that provides employees of small employers a choice of health benefit plans may use rating methods in accordance with this subchapter that are used by other small employer health benefit plan issuers participating in the same cooperative, including rating by age and gender, if the health maintenance organization has established:

(1) a separate class of business, as provided by Section 1501.202; and

(2) a separate line of business, as provided under Section 1501.255(b).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.055(a), eff. September 1, 2005.

Sec. 1501.214. ENFORCEMENT. If the commissioner determines that a small employer health benefit plan issuer subject to this chapter exceeds the applicable premium rate established under this subchapter, the commissioner may order restitution and assess penalties as provided by Chapter 82.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.215. REPORTING REQUIREMENTS. (a) Annually, each small employer health benefit plan issuer that offers a small employer health benefit plan shall file with the commissioner an actuarial certification stating that the issuer's underwriting and rating methods:

(1) comply with accepted actuarial practices;

(2) are uniformly applied to each small employer health benefit plan covering a small employer; and

(3) comply with this subchapter.

(b) Each small employer health benefit plan issuer shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based on commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

(c) A small employer health benefit plan issuer shall make the information and documentation described in Subsection (b) available to the commissioner on request. Unless the information or documentation relates to a violation of this chapter, the information or documentation is considered proprietary and trade secret information and is not subject to disclosure by the commissioner to a person outside the department except as agreed to by the issuer or as ordered by a court.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

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

- (1) give written notice to the small employer of the effective date of the increase; and
- (2) provide the small employer a table that clearly lists:
 - (A) the actual dollar amount of the premium on the date of the notice;
 - (B) the actual dollar amount of the premium after the premium rate increase; and
 - (C) the percentage change between the amounts described by Paragraphs (A) and (B).

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

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

(d) An insurer may not require a small employer entitled to notice under this section to respond to the insurer to renew the

policy or take other action relating to the renewal or extension of the policy before the 45th day after the date the notice described by Subsection (a) is given.

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

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

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

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

Added by Acts 2011, 82nd Leg., R.S., Ch. 1147 (H.B. 1951), Sec. 3.003, eff. September 1, 2011.

SUBCHAPTER F. COVERAGE UNDER SMALL EMPLOYER HEALTH BENEFIT PLANS

Sec. 1501.251. EXCEPTION FROM CERTAIN MANDATED BENEFIT REQUIREMENTS. Except as expressly provided by this chapter, a small employer health benefit plan is not subject to a law that requires coverage or the offer of coverage of a health care service or benefit.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.252. HEALTH BENEFIT PLANS. (a) A small employer health benefit plan issuer shall offer a standard health benefit plan as authorized by Chapter 1507.

(b) A small employer health benefit plan issuer may offer to a small employer additional benefit riders to the standard health benefit plan or may design and offer standard health benefit plans with additional mandatory benefits.

(c) Subject to this chapter, a small employer health benefit plan issuer shall also offer to a small employer at least one other health benefit plan authorized under this code that provides state-mandated health benefits. Section 1501.251 does not apply to a health benefit plan offered to a small employer under this

subsection.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.056(a), eff. September 1, 2005.

Sec. 1501.254. ALCOHOL AND SUBSTANCE ABUSE BENEFITS. (a) This section applies only if the basic coverage health benefit plan developed by the commissioner under Section 1501.253 includes coverage for alcohol and substance abuse benefits.

(b) A small employer health benefit plan issuer may offer and the employees of a small employer group may accept a basic coverage health benefit plan without coverage for alcohol and substance abuse benefits if:

(1) at least 50 percent of the employees in writing:

(A) waive the benefits; and

(B) indicate that they have undergone alcoholism or substance abuse treatment or counseling within the preceding three years; and

(2) the exclusion of those benefits applies only to those employees.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.255. HEALTH MAINTENANCE ORGANIZATION PLANS. (a) In this section, "point-of-service contract" means a health benefit plan offered through a health maintenance organization that:

(1) includes corresponding indemnity benefits in addition to benefits relating to out-of-area or emergency services provided through insurers or group hospital service corporations; and

(2) permits the covered individual to obtain coverage under either the health maintenance organization conventional plan or the indemnity plan as determined in accordance with the terms of the contract.

(b) A health maintenance organization:

(1) shall offer at least one state-approved basic health care plan that complies with this chapter, Chapters 843, 1271, 1272, and 1367, Subchapter A, Chapter 1452, Subchapter B, Chapter 1507,

Title XIII, Public Health Service Act (42 U.S.C. Section 300e et seq.), and its subsequent amendments, and rules adopted under those laws and may offer additional such plans;

(2) shall offer a standard health benefit plan under Subchapter B, Chapter 1507, and may offer additional benefit riders to the standard health benefit plan or offer standard health benefit plans with additional mandatory benefits; and

(3) may offer a point-of-service contract in connection with an insurer that includes optional coverage for out-of-area services, emergency care, or out-of-network care.

(c) A point-of-service contract offered under Subsection (b)(3) is subject to this chapter unless specifically exempted. The insurer with which the health maintenance organization offers a point-of-service contract is not required to otherwise make available the health benefit plans adopted under this subchapter if the insurer's small employer products are limited to the point-of-service contract.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.057(a), eff. September 1, 2005.

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.074(i), eff. September 1, 2005.

Sec. 1501.256. COORDINATION WITH FEDERAL LAW. (a) To the extent required to comply with federal law applicable to a small employer health benefit plan described by this subchapter, the commissioner by rule may:

- (1) modify the plan; or
- (2) adopt a substitute for the plan.

(b) The commissioner shall use the Texas Health Benefits Purchasing Cooperative in implementing this section.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.2561. WAIVER OF CERTAIN FEDERAL REQUIREMENTS. The commissioner may apply to and negotiate with the United States secretary of health and human services to obtain a waiver under 42 U.S.C. Section 18052 for small employer health benefit plans of the

actuarial value requirements and related levels of health plan coverage requirements imposed under 42 U.S.C. Section 18022(d)(3).

Added by Acts 2017, 85th Leg., R.S., Ch. 106 (S.B. 1406), Sec. 1, eff. May 23, 2017.

Sec. 1501.257. COST CONTAINMENT. (a) A small employer health benefit plan issuer may use cost containment and managed care features in a small employer health benefit plan, including:

- (1) utilization review of health care services, including review of the medical necessity of hospital and physician services;
- (2) case management, including discharge planning and review of stays in hospitals or other health care facilities;
- (3) selective contracting with hospitals, physicians, and other health care providers;
- (4) reasonable benefit differentials applicable to health care providers that participate or do not participate in restricted network arrangements;
- (5) precertification or preauthorization for certain covered services; and
- (6) coordination of benefits.

(b) A provision of a small employer health benefit plan that provides for coordination of benefits must comply with this chapter and guidelines established by the commissioner.

(c) Utilization review performed for any cost containment, case management, or managed care arrangement must comply with Chapter 4201.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2G.015, eff. April 1, 2009.

Sec. 1501.258. FORMS. (a) A small employer health benefit plan issuer shall comply with:

- (1) Chapter 1701 as it relates to policy form approval; and
- (2) Chapter 1271 as it relates to evidence of coverage approval.

(b) A small employer health benefit plan issuer may not offer

benefit plans through a policy form or evidence of coverage that does not comply with this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.058(b), eff. September 1, 2005.

Sec. 1501.259. RIDERS; FILING WITH COMMISSIONER. (a) A small employer health benefit plan issuer shall file with the commissioner, in a form and manner prescribed by the commissioner, each rider to a small employer health benefit plan to be used by the issuer, as authorized by Section 1501.252.

(b) A small employer health benefit plan issuer may use a rider filed under this section after the 30th day after the date the rider is filed unless the commissioner disapproves its use.

(c) The commissioner, after notice and an opportunity for a hearing, may disapprove the continued use of a rider by a small employer health benefit plan issuer if the rider does not meet the requirements of this chapter and other applicable statutes.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.260. PLAIN LANGUAGE REQUIRED. (a) A health benefit plan issuer may not issue and the commissioner may not approve a health benefit plan certificate or policy or a rider to a health benefit plan certificate or policy unless it is written in plain language.

(b) Each provision of a health benefit plan certificate or policy or a rider to a health benefit plan certificate or policy relating to renewal of coverage, conditions of coverage, or per occurrence or aggregate dollar limitations on coverage must be clearly explained in plain language.

(c) A health benefit plan issuer may not use and the commissioner may not approve a health benefit plan application form unless it is written in plain language.

(d) Subsections (a)-(c) do not apply if the specific language to be used is required by federal law or state statute or by rules implementing federal law.

(e) For purposes of Subsections (a)-(d), a health benefit plan certificate or policy, a rider to or a provision of a health benefit plan certificate or policy, or a health benefit plan application form is written in plain language if it achieves the minimum score established by the commissioner on the Flesch reading ease test or an equivalent test selected by the commissioner.

(f) This section does not apply to:

- (1) a health benefit plan group master policy; or
- (2) a policy application or enrollment form for a health benefit plan group master policy.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

SUBCHAPTER G. REINSURANCE FOR SMALL EMPLOYER HEALTH BENEFIT PLANS

Sec. 1501.301. DEFINITIONS. In this subchapter:

(1) "Board" means the board of directors of the Texas Health Reinsurance System.

(2) "Plan of operation" means the plan of operation of the system established under Section 1501.306.

(3) "Reinsured health benefit plan issuer" means a small employer health benefit plan issuer that participates in the system.

(4) "Risk-assuming health benefit plan issuer" means a small employer health benefit plan issuer that does not participate in the system.

(5) "System" means the Texas Health Reinsurance System established under this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.302. TEXAS HEALTH REINSURANCE SYSTEM. (a) The Texas Health Reinsurance System is a nonprofit entity administered by a board of directors and subject to the supervision and control of the commissioner.

(b) The system may operate only during the period an order authorizing operation of the system under Section 1501.3021 is in effect. The system may not operate after the effective date of an order of suspension of operation of the system under Section 1501.3022 until a subsequent order authorizing the operation of the system under Section 1501.3021, if any, is effective.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2017, 85th Leg., R.S., Ch. 105 (S.B. 1171), Sec. 1, eff. May 23, 2017.

Sec. 1501.3021. AUTHORIZATION OF OPERATION. (a) The commissioner shall hold a hearing if:

(1) the commissioner believes small employer health benefit plan issuers in this state are threatened with the inability to secure reinsurance coverage in the open market; or

(2) the commissioner receives a petition requesting the hearing from an association of health benefit plan issuers in this state or a group of at least 15 small employer health benefit plan issuers operating in this state.

(b) If, after a hearing under Subsection (a), the commissioner finds that the operation of the system is in the public interest, the commissioner by order shall:

(1) authorize the operation of the system;

(2) appoint a board of directors under Section 1501.303;

and

(3) direct the board to develop a plan of operation under Section 1501.306 to ensure the system is fully implemented on a date specified in the order that is not later than the 60th day after the effective date of the order.

(c) Sections 1501.307-1501.326 apply to the operation of the system after the date the system is implemented as described by Subsection (b)(3).

Added by Acts 2017, 85th Leg., R.S., Ch. 105 (S.B. 1171), Sec. 2, eff. May 23, 2017.

Sec. 1501.3022. SUSPENSION OF OPERATION. (a) The commissioner shall hold a hearing if the system is operating or is authorized to operate and:

(1) the commissioner believes small employer health benefit plan issuers in this state are not threatened with the inability to secure reinsurance coverage in the open market; or

(2) the commissioner receives a petition requesting the

hearing from an association of health benefit plan issuers in this state or a group of at least 15 small employer health benefit plan issuers operating in this state.

(b) If, after a hearing under Subsection (a), the commissioner finds that suspension of the operation of the system is in the public interest, the commissioner by order shall direct the board to submit to the commissioner for approval, not later than the 60th day after the date of the order, a plan of suspension of operation of the system.

(c) A plan of suspension under Subsection (b) must:

(1) specify the date after which a health benefit plan issuer that is a risk-assuming health benefit plan issuer on the effective date of the plan of suspension may not:

(A) become a reinsured health benefit plan issuer under Sections 1501.310, 1501.311, and 1501.312; and

(B) reinsure with the system a small employer group, or any risk, covered under any small employer health benefit plan;

(2) specify the date after which a health benefit plan issuer that is a reinsured health benefit plan issuer on the effective date of the plan of suspension may not:

(A) reinsure with the system additional small employer groups in accordance with Section 1501.314; or

(B) cede additional eligible lives to the system in accordance with Section 1501.314;

(3) provide for:

(A) the filing, receipt, processing, and payment of all claims against and debts of the system, and extinguishment of all liabilities of the system, including balances on any lines of credit that may have been established by or on behalf of the system;

(B) the collection and receipt of all assessments made with respect to reinsured health benefit plan issuers, including any deferred assessments and any final assessment made under Subsection (f); and

(C) a final audit of the system by the state auditor as provided by Subsection (g);

(4) specify that the transactions required by the plan of suspension and addressed in Subdivisions (1)-(3) must be closed not later than the effective date of the suspension of the operation of the system as specified under Subdivision (5);

(5) state the effective date of the suspension of the

operation of the system; and

(6) provide for the proportionate distribution of any surplus assets of the system that remain after the date specified under Subdivision (5).

(d) The effective date of the suspension of the operation of the system as specified under Subsection (c)(5) may not be later than the 270th day after the date the commissioner by order approves the plan of suspension.

(e) If the board fails to submit a suitable plan of suspension, the commissioner, after notice and hearing, shall adopt a plan in accordance with Subsection (c).

(f) The board may make a final assessment of the small employer health benefit plan issuers that, for any portion of the last year in which the system operated, were reinsured health benefit plan issuers. An assessment under this subsection may be made only if the board determines the assessment is necessary to recover net losses of the system, as provided in Sections 1501.319-1501.326, including administrative expenses for transactions essential to complete execution of the plan of suspension, and the cost of the final audit by the state auditor.

(g) The transactions necessary to complete execution of the plan of suspension are subject to audit by the state auditor under Chapter 321, Government Code. The state auditor shall report the cost of the final audit conducted under this section to the board and the comptroller, and the board shall remit that amount to the comptroller for deposit to the general revenue fund.

(h) The board serving immediately before the effective date of the suspension of the operation of the system is discharged on the effective date of the suspension of the operation of the system as specified under Subsection (c)(5).

(i) After the effective date of the suspension of the operation of the system as specified under Subsection (c)(5), the commissioner shall take any action necessary under Subsection (c)(6) to distribute the surplus assets of the system until all remaining assets are distributed.

(j) During a period in which the operation of the system is suspended, Sections 1501.307-1501.326 have no effect.

Added by Acts 2017, 85th Leg., R.S., Ch. 105 (S.B. [1171](#)), Sec. 2, eff. May 23, 2017.

Sec. 1501.303. SYSTEM BOARD OF DIRECTORS. (a) The board of directors of the system is composed of:

- (1) nine members appointed by the commissioner; and
- (2) the commissioner or the commissioner's representative, who serves as an ex officio member.

(b) Five of the appointed members must be representatives of reinsured health benefit plan issuers selected from individuals nominated by small employer health benefit plan issuers in this state according to procedures developed by the commissioner.

(c) Four of the appointed members must represent the public. A member representing the public may not:

(1) be an officer, director, or employee of an insurance company, agency, agent, broker, solicitor, or adjuster or any other business entity regulated by the department;

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

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

(d) Appointed members serve two-year terms expiring December 31 of each odd-numbered year. A member's term continues until a successor is appointed.

(e) A member of the board may not be compensated for serving on the board but is entitled to reimbursement for actual expenses incurred in performing functions as a member of the board as provided by the General Appropriations Act.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.304. OPEN MEETINGS; PUBLIC INFORMATION. The board is subject to:

(1) the open meetings law, Chapter 551, Government Code; and

(2) the public information law, Chapter 552, Government Code.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.305. BOARD MEMBER IMMUNITY. (a) A member of the board is not liable for an act performed, or omission made, in good faith in the performance of powers and duties under this subchapter.

(b) A cause of action does not arise against a member of the board for an act or omission described by Subsection (a).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.306. SYSTEM PLAN OF OPERATION. (a) The board shall submit to the commissioner a plan of operation and any amendments to that plan necessary or suitable to ensure the fair, reasonable, and equitable administration of the system.

(b) The commissioner, after notice and hearing, may approve the plan of operation if the commissioner determines the plan:

(1) is suitable to ensure the fair, reasonable, and equitable administration of the system; and

(2) provides for the sharing of system gains or losses on an equitable and proportionate basis in accordance with this subchapter.

(c) The plan of operation is effective on the written approval of the commissioner.

(d) The plan of operation must:

(1) establish procedures for:

(A) handling and accounting for system assets and money;

(B) making an annual fiscal report to the commissioner;

(C) selecting an administering health benefit plan issuer or third-party administrator and establishing the powers and duties of the administering issuer or third-party administrator;

(D) reinsuring risks in accordance with this subchapter; and

(E) collecting assessments from reinsured health benefit plan issuers to fund claims and administrative expenses incurred or estimated to be incurred by the system, including the imposition of penalties for late payment of an assessment; and

(2) provide for any additional matter necessary to implement and administer the system.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.307. SYSTEM POWERS. (a) The system has the general powers and authority granted under state law to an insurer or a health maintenance organization authorized to engage in business, except that the system may not directly issue a health benefit plan.

(b) The system may:

(1) enter into contracts necessary or proper to implement this subchapter, including, with the commissioner's approval, contracts with similar programs of other states for the joint performance of common functions or with persons or other organizations for the performance of administrative functions;

(2) sue or be sued, including taking legal action necessary or proper to recover assessments and penalties for, on behalf of, or against the system or a reinsured health benefit plan issuer;

(3) take legal action necessary to avoid the payment of improper claims against the system;

(4) issue reinsurance contracts in accordance with this subchapter;

(5) establish guidelines, conditions, and procedures for reinsuring risks under the plan of operation;

(6) establish actuarial functions as appropriate for the operation of the system;

(7) assess reinsured health benefit plan issuers in accordance with Sections 1501.319-1501.323;

(8) appoint appropriate legal, actuarial, and other committees necessary to provide technical assistance in:

(A) the operation of the system;

(B) policy and other contract design; and

(C) any other function within the authority of the system; and

(9) borrow money for a period not to exceed one year to accomplish the purposes of the system.

(c) The system is exempt from all taxes.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.308. SYSTEM NOTES AS LEGAL INVESTMENT FOR SMALL EMPLOYER HEALTH BENEFIT PLAN ISSUER. A note or other evidence of indebtedness of the system that is not in default is a legal investment for a small employer health benefit plan issuer and may be

carried as an admitted asset.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.309. SYSTEM AUDIT. (a) The transactions of the system are subject to audit by the state auditor in accordance with Chapter 321, Government Code.

(b) The state auditor shall report the cost of each audit conducted under this section to the board and the comptroller, and the board shall remit that amount to the comptroller.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.310. ELECTION OF STATUS. (a) Each small employer health benefit plan issuer shall notify the commissioner of the issuer's election to operate as a risk-assuming health benefit plan issuer or as a reinsured health benefit plan issuer. An issuer that elects to operate as a risk-assuming health benefit plan issuer shall file an application in accordance with Section 1501.312.

(b) A small employer health benefit plan issuer's election under this section is effective until the fifth anniversary of the date of the election.

(c) The commissioner may permit a small employer health benefit plan issuer to modify its election at any time for good cause shown.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.311. CHANGE IN STATUS. (a) The commissioner shall establish an application process for a small employer health benefit plan issuer that elects to change its status under this subchapter.

(b) A reinsured health benefit plan issuer that elects to change its status to operate as a risk-assuming health benefit plan issuer may not continue to reinsure a small employer health benefit plan with the system. The issuer shall pay a prorated assessment based on business issued as a reinsured health benefit plan issuer for the portion of the year the business was reinsured.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.312. APPLICATION TO OPERATE AS RISK-ASSUMING HEALTH BENEFIT PLAN ISSUER. (a) A small employer health benefit plan issuer may apply to operate as a risk-assuming health benefit plan issuer by filing an application with the commissioner in a form and manner prescribed by the commissioner.

(b) In evaluating an application, the commissioner shall consider the small employer health benefit plan issuer's:

- (1) financial condition;
- (2) history of rating and underwriting small employer groups;
- (3) commitment to market fairly to all small employers in the state or in the issuer's established geographic service area; and
- (4) experience managing the risk of small employer groups.

(c) The commissioner shall provide public notice of an application and shall provide at least a 60-day period for public comment before making a decision on the application. If the commissioner does not act on the application before the 90th day after the date the commissioner receives the application, the issuer may request and the commissioner shall grant a hearing.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.313. RESCISSION OF APPROVAL TO OPERATE AS RISK-ASSUMING HEALTH BENEFIT PLAN ISSUER. The commissioner, after notice and hearing, may rescind approval to operate as a risk-assuming health benefit plan issuer if the commissioner finds that the issuer:

- (1) is not financially able to support the assumption of risk from issuing coverage to small employers without the protection provided by the system;
- (2) has failed to market fairly to all small employers in the state or in the issuer's established geographic service area; or
- (3) has failed to provide coverage to eligible small employers.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.314. REINSURANCE. (a) A small employer health benefit plan issuer may reinsure risks covered under a small employer health benefit plan with the system as provided by this subchapter.

(b) The system shall reinsure the level of coverage provided under the small employer health benefit plan.

(c) A small employer health benefit plan issuer may reinsure:

(1) an entire small employer group not later than the 60th day after the date the group's coverage under the small employer health benefit plan takes effect;

(2) an eligible employee of a small employer or the employee's dependent not later than the 60th day after the date the person's coverage takes effect; or

(3) a newly eligible employee of a reinsured small employer group, the employee's dependent, or an individual covered under the small employer health benefit plan not later than the 60th day after the date the individual's coverage takes effect.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.315. LIMITS ON REINSURANCE. (a) The system may not reimburse a reinsured health benefit plan issuer for the claims of a reinsured individual until the issuer has incurred an initial level of claims of \$5,000 in a calendar year for that individual for benefits covered by the system. In addition, the reinsured health benefit plan issuer is responsible for 10 percent of the next \$50,000 of benefit payments during a calendar year, and the system shall reinsure the remainder. A reinsured health benefit plan issuer's liability to a reinsured individual may not exceed a maximum of \$10,000 in a calendar year.

(b) The board annually shall adjust the initial level of claims and the maximum liability to be retained by a reinsured health benefit plan issuer under Subsection (a) to reflect increases in:

(1) costs; and

(2) the use of small employer health benefit plans in this state.

(c) An adjustment under Subsection (b) may not be less than the annual change in the medical component of the Consumer Price Index for All Urban Consumers published by the Bureau of Labor Statistics of the United States Department of Labor unless the board proposes

and the commissioner approves a lower adjustment factor.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.316. TERMINATION OF REINSURANCE. A small employer health benefit plan issuer may terminate reinsurance with the system for one or more reinsured employees or dependents of employees of a small employer on a contract anniversary of the small employer health benefit plan.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.317. APPLICATION OF MANAGED CARE PROCEDURES. Except as provided by the plan of operation, a reinsured health benefit plan issuer shall apply consistently with respect to reinsured and nonreinsured business all managed care procedures, including utilization review, individual case management, preferred provider provisions, and other managed care provisions or methods of operation.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.318. PREMIUM RATES FOR REINSURANCE. (a) As part of the plan of operation, the board shall adopt a method to determine premium rates to be charged by the system for reinsuring small employer groups and individuals under this subchapter.

(b) The method adopted must:

(1) include a classification system for small employer groups that reflects the variations in premium rates allowed by this chapter; and

(2) provide for the development of base reinsurance premium rates that reflect the allowable variations.

(c) Subject to approval by the commissioner, the board shall establish the base reinsurance premium rates at levels that reasonably approximate the gross premiums charged to small employers by small employer health benefit plan issuers for small employer health benefit plans, adjusted to reflect retention levels required under this subchapter.

(d) The board shall periodically review the method adopted under this section, including the classification system and any rating factors, to ensure that the method reasonably reflects the claims experience of the system. The board may propose changes to the method. Any changes are subject to approval by the commissioner.

(e) An entire small employer group may be reinsured at a rate that is 1-1/2 times the base reinsurance premium rate for that group. An eligible employee of a small employer or the employee's dependent covered under a small employer health benefit plan may be reinsured at a rate that is five times the base reinsurance premium rate for that individual.

(f) The board may consider adjustments to the premium rates charged by the system to reflect the use of effective cost containment and managed care arrangements.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.319. DETERMINATION OF NET LOSS. (a) Not later than March 1 of each year, the board shall determine the system's net loss for the preceding calendar year, including administrative expenses and incurred losses for the year, and report the net loss to the commissioner.

(b) In determining the net loss, the board shall take into account investment income and other appropriate gains and losses.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.320. ASSESSMENTS TO RECOVER NET LOSSES. (a) The board shall recover any net loss of the system by assessing each reinsured health benefit plan issuer an amount determined annually by the board based on information in annual statements and other reports required by and filed with the board.

(b) The board shall establish, as part of the plan of operation, a formula by which to make assessments against reinsured health benefit plan issuers. With the approval of the commissioner, the board may periodically change the assessment formula as appropriate. The board shall base the assessment formula on each reinsured issuer's share of:

(1) the total premiums earned in the preceding calendar

year from small employer health benefit plans delivered or issued for delivery by reinsured health benefit plan issuers to small employer groups in this state; and

(2) the premiums earned in the preceding calendar year from newly issued small employer health benefit plans delivered or issued for delivery during the calendar year by reinsured health benefit plan issuers to small employer groups in this state.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.321. LIMITS ON ASSESSMENTS. (a) The formula established under Section 1501.320(b) may not result in an assessment for a reinsured health benefit plan issuer that is less than 50 percent or more than 150 percent of an amount based on the proportion of the total premiums earned in the preceding calendar year from small employer health benefit plans delivered or issued for delivery to small employer groups in this state by that issuer to the total premiums earned in the preceding calendar year from small employer health benefit plans delivered or issued for delivery to small employer groups in this state by all reinsured health benefit plan issuers.

(b) In determining assessments, the board may not consider premiums earned by a reinsured health benefit plan issuer that are less than an amount determined by the board to justify the cost of collecting an assessment based on those premiums.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.322. ADJUSTMENT TO ASSESSMENTS ON FEDERALLY QUALIFIED HEALTH MAINTENANCE ORGANIZATIONS. With the commissioner's approval, the board may adjust the formula established under Section 1501.320(b) for a reinsured health benefit plan issuer that is an approved health maintenance organization that is federally qualified under Title XIII, Public Health Service Act (42 U.S.C. Section 300e et seq.), to the extent that any restriction is imposed on that issuer that is not imposed on other issuers.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.323. ADVANCE INTERIM ASSESSMENTS. (a) The system may make advance interim assessments as reasonable and necessary for organizational and interim operating expenses.

(b) After the end of the fiscal year, the system shall credit an interim assessment made under this section as an offset against regular assessments due.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.324. LIMIT ON TOTAL ASSESSMENTS. The maximum assessment amount payable for a calendar year may not exceed five percent of the total premiums earned in the preceding calendar year from small employer health benefit plans delivered or issued for delivery by reinsured health benefit plan issuers in this state.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.325. ESTIMATE OF ASSESSMENTS; EVALUATION AND PROTECTION OF SYSTEM. (a) Not later than March 1 of each year, the board shall file with the commissioner an estimate of the assessments necessary to fund the losses for small employer groups incurred by the system during the preceding calendar year.

(b) If the board determines that the necessary assessments exceed five percent of the total premiums earned in the preceding calendar year from small employer health benefit plans delivered or issued for delivery by reinsured health benefit plan issuers to small employer groups in this state, the board shall evaluate the operation of the system and shall report its findings, including any recommendations for changes to the plan of operation, to the commissioner not later than April 1 of the year following the calendar year in which the losses were incurred. The evaluation must:

- (1) include an estimate of future assessments; and
- (2) consider:
 - (A) the administrative costs of the system;
 - (B) the appropriateness of the premiums charged;
 - (C) the level of health benefit plan issuer retention under the system; and
 - (D) the costs of coverage for small employer groups.

(c) If the board fails to timely file a report required by Subsection (b), the commissioner may:

- (1) evaluate the operations of the system; and
- (2) implement amendments to the plan of operation that the commissioner considers necessary to reduce future losses and assessments.

(d) A reinsured health benefit plan issuer may not cede additional eligible lives to the system during a calendar year if the assessment amount payable for the preceding calendar year is at least five percent of the total premiums earned in that calendar year from small employer health benefit plans delivered or issued for delivery by reinsured health benefit plan issuers in this state.

(e) A reinsured health benefit plan issuer may not cede additional eligible lives to the system after the board determines that the expected loss from the reinsurance system for a year will exceed the total amount of assessments payable at a rate of five percent of the total premiums earned for the preceding calendar year. A reinsured health benefit plan issuer may not resume ceding additional eligible lives to the system until the board determines that the expected loss will be less than the maximum established by this subsection.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2005, 79th Leg., Ch. 823 (S.B. 805), Sec. 5, eff. September 1, 2005.

Sec. 1501.326. DEFERMENT OF ASSESSMENT. (a) A reinsured health benefit plan issuer may petition the commissioner for a deferment in whole or in part of an assessment imposed by the board.

(b) The commissioner may defer all or part of the assessment if the commissioner determines that payment of the assessment would endanger the ability of the reinsured health benefit plan issuer to fulfill its contractual obligations.

(c) The board shall assess the amount of a deferred assessment against other reinsured health benefit plan issuers in a manner consistent with the basis for assessment established by this subchapter.

(d) A reinsured health benefit plan issuer that receives a

deferment:

- (1) is liable to the system for the amount deferred; and
- (2) until the issuer pays the outstanding assessment, may

not:

- (A) market, deliver, or issue for delivery a small employer health benefit plan; or
- (B) reinsure any individual or group with the system.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

SUBCHAPTER H. MARKETING OF SMALL EMPLOYER HEALTH BENEFIT PLANS

Sec. 1501.351. **MARKETING REQUIREMENTS.** (a) Each small employer health benefit plan issuer shall market a small employer health benefit plan to eligible small employers in this state through properly licensed agents.

(b) Each small employer purchasing a small employer health benefit plan must be given a summary, in a format prescribed by the commissioner, of the health benefit plans established by the commissioner under Subchapter F.

(c) An agent shall offer and explain to a small employer on inquiry and request by the employer each health benefit plan established by the commissioner under Subchapter F.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.352. **HEALTH STATUS AND CLAIMS EXPERIENCE; PROHIBITED ACTS.** (a) A small employer health benefit plan issuer or agent may not, because of the health status or claims experience of the eligible employees of a small employer and those employees' dependents, directly or indirectly encourage or direct the employer to:

- (1) refrain from applying for coverage with the issuer;
- (2) seek coverage from another issuer;
- (3) apply for a particular small employer health benefit plan; or
- (4) become or not become a member of a particular small employer health coalition.

(b) A small employer health benefit plan issuer may not directly or indirectly enter into an agreement or arrangement with an

agent that provides for or results in compensation paid to the agent for the sale of small employer health benefit plans that varies because of health status or claims experience.

(c) Subsection (b) does not apply to an arrangement that provides compensation to an agent based on a percentage of premium, provided that:

(1) the percentage may not vary because of health status or claims experience; and

(2) the small employer health benefit plan issuer does not:

(A) exclude any additional premium charged to the small employer because of health status or claims experience from the premium amount to which the percentage is applied; or

(B) apply a smaller percentage to any additional premium charged to the small employer because of health status or claims experience than is applied to other premiums charged to the small employer.

(d) A small employer health benefit plan issuer or agent may not encourage a small employer to exclude an eligible employee from health coverage provided in connection with the employee's employment.

(e) A small employer health benefit plan issuer may not terminate, fail to renew, or limit its contract or agreement of representation with an agent for a reason related to the health status or claims experience of a small employer group placed by the agent with the issuer.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.059(a), eff. September 1, 2005.

Sec. 1501.353. AGENT COMPENSATION. (a) A small employer health benefit plan issuer shall pay the same commission, percentage of premium, or other amount to an agent for renewal of a small employer health benefit plan as the issuer paid for original placement of the plan, except that the issuer may increase compensation for renewal of a plan to reflect an increase in the cost of living or similar factors.

(b) A small employer health benefit plan issuer may not

implement, directly or indirectly, agent commission schedules that vary the level of agent commissions based on the size of the group or otherwise reduce access to small employer health benefit plans.

(c) Notwithstanding Subsection (b), a small employer health benefit plan issuer may:

(1) vary agent commission amounts or percentages based on group size if the variation in the commission amounts or percentages are inversely related to the size of the group;

(2) vary agent commission amounts or percentages based on the cumulative premium paid by a single small employer over a specific period if the variation in the commission amounts or percentages are inversely related to the cumulative premium paid during the period; or

(3) pay agent commissions as a percentage of premiums charged to a small employer if the commission percentage is based on all premiums paid by the small employer.

(d) A small employer health benefit plan issuer may not use an agent compensation schedule that provides compensation in a specific dollar amount for each individual covered during a specified period or for each group of individuals covered during a specified period.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.059(b), eff. September 1, 2005.

Sec. 1501.354. REQUIRED DISCLOSURES. (a) In connection with offering a small employer health benefit plan for sale, each small employer health benefit plan issuer and agent shall make a reasonable disclosure, as part of its solicitation and sales materials, of:

(1) the extent to which premium rates for a specific small employer are established or adjusted based on the actual or expected variation in:

(A) claim costs; or

(B) health status of the employer's employees and their dependents;

(2) provisions concerning the issuer's right to change premium rates and factors other than claims experience that affect changes in premium rates;

(3) provisions relating to renewability of policies and contracts; and

(4) any preexisting condition provisions.

(b) On request by a small employer, each small employer health benefit plan issuer shall disclose the benefits and premiums available under all small employer coverage for which the employer is qualified.

(c) A small employer health benefit plan issuer is not required to disclose information to a small employer that is proprietary or trade secret information under applicable law.

(d) Information provided under this section to a small employer must be provided in a manner that is:

(1) understandable by the average small employer; and

(2) sufficient to reasonably inform a small employer of its rights and obligations under a small employer health benefit plan.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.355. RULES CONCERNING MARKETING AND AVAILABILITY.

Rules adopted under Section 1501.010 may establish additional standards to provide for the fair marketing and broad availability of small employer health benefit plans to small employers in this state.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.356. REPORTING REQUIREMENTS. (a) In this section,

"case characteristics" has the meaning assigned by Section 1501.201.

(b) The department may require periodic reports by small employer health benefit plan issuers and agents regarding small employer health benefit plans issued by those issuers and agents. The reporting requirements must include information regarding:

(1) case characteristics; and

(2) the number of small employer health benefit plans in various categories that are marketed or issued to small employers.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.357. VIOLATIONS. A violation of Section 1501.352 by

a small employer health benefit plan issuer or agent is an unfair method of competition and an unfair or deceptive act or practice under Chapter 541.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.358. APPLICABILITY TO THIRD-PARTY ADMINISTRATOR. If a small employer health benefit plan issuer enters into an agreement with a third-party administrator to provide administrative, marketing, or other services related to offering small employer health benefit plans to small employers in this state, the third-party administrator is subject to Sections 1501.111, 1501.351-1501.353, and 1501.355-1501.357.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

SUBCHAPTER M. LARGE EMPLOYER HEALTH BENEFIT PLANS

Sec. 1501.601. PARTICIPATION CRITERIA. (a) In this subchapter, "participation criteria" means any criteria or rules established by a large employer to determine the employees who are eligible for enrollment or continued enrollment under the terms of a health benefit plan.

(b) The participation criteria may not be based on health status related factors.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.602. COVERAGE REQUIREMENTS. (a) A large employer health benefit plan issuer:

(1) may refuse to provide coverage to a large employer in accordance with the issuer's underwriting standards and criteria;

(2) shall accept or reject the entire group of individuals who meet the participation criteria and choose coverage; and

(3) may exclude only those employees or dependents who decline coverage.

(b) On issuance of a health benefit plan to a large employer, a large employer health benefit plan issuer shall provide coverage to the employees who meet the participation criteria without regard to

an individual's health status related factors.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.603. EXCLUSION OF ELIGIBLE EMPLOYEE OR DEPENDENT PROHIBITED. A large employer health benefit plan issuer may not exclude an employee who meets the participation criteria or an eligible dependent, including a late enrollee, who would otherwise be covered under a large employer group.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.604. DECLINING COVERAGE. (a) A large employer health benefit plan issuer shall obtain a written waiver from each employee who meets the participation criteria and declines coverage under a health benefit plan offered to a large employer. The waiver must ensure that the employee was not induced or pressured to decline coverage because of the employee's health status related factors.

(b) A large employer health benefit plan issuer may not provide coverage to a large employer or the employer's employees if the issuer or an agent for the issuer knows that the employer has induced or pressured an employee who meets the participation criteria or a dependent of the employee to decline coverage because of the individual's health status related factors.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.605. MINIMUM CONTRIBUTION OR PARTICIPATION REQUIREMENTS. (a) A large employer health benefit plan issuer may require a large employer to meet a minimum contribution or participation requirement as a condition of issuance or renewal in accordance with the issuer's usual and customary practices for all the issuer's employer health benefit plans in this state.

(b) A participation requirement may determine the percentage of eligible employees who meet the participation criteria and who must be enrolled in the health benefit plan.

(c) A large employer health benefit plan issuer may apply a participation requirement to a large employer's eligible employees,

but may not apply the requirement to eligible dependents of those employees.

(d) A participation requirement must be stated in the health benefit plan contract and must be applied uniformly to each large employer offered or issued coverage by a large employer health benefit plan issuer in this state.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.606. EMPLOYEE ENROLLMENT; WAITING PERIOD. (a) The initial enrollment period for employees meeting the participation criteria under a large employer health benefit plan must be at least 31 days, with a 31-day annual open enrollment period.

(b) A large employer may establish a waiting period. The employer shall determine the duration of the waiting period.

(c) A new employee who meets the participation criteria may not be denied coverage if the application for coverage is received by the large employer not later than the 31st day after the later of:

- (1) the date employment begins; or
- (2) the date the waiting period established under

Subsection (b) expires.

(d) If dependent coverage is offered to the enrollees under a large employer health benefit plan:

(1) the initial enrollment period for the dependents must be at least 31 days, with a 31-day annual open enrollment period; and

(2) a dependent of a new employee who meets the participation criteria may not be denied coverage if the application for coverage is received by the large employer not later than the 31st day after the latest of:

- (A) the date on which the employment begins;
- (B) the date the waiting period established under

Subsection (b) expires; or

(C) the date the dependent becomes eligible for enrollment.

(e) A late enrollee may be excluded from coverage until the next annual open enrollment period and may be subject to a one-year preexisting condition provision as described by Section 1501.102. The period during which a preexisting condition provision applies may

not exceed 18 months from the date of the initial application.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.607. COVERAGE FOR NEWBORN CHILDREN. (a) A large employer health benefit plan may not limit or exclude initial coverage of a newborn child of a covered employee.

(b) Coverage of a newborn child of a covered employee under this section ends on the 32nd day after the date of the child's birth unless:

(1) children are eligible for coverage under the large employer health benefit plan; and

(2) not later than the 31st day after the date of birth, the large employer health benefit plan issuer receives:

(A) notice of the birth; and

(B) any required additional premium.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.608. COVERAGE FOR ADOPTED CHILDREN. (a) This section applies only if children are eligible for coverage under a large employer health benefit plan.

(b) A large employer health benefit plan may not limit or exclude initial coverage of an adopted child of an insured. A child is considered to be the adopted child of an insured if the insured is a party to a suit in which the insured seeks to adopt the child.

(c) An adopted child of an insured may be enrolled, at the insured's option, not later than the 31st day after:

(1) the date the insured becomes a party to a suit in which the insured seeks to adopt the child; or

(2) the date the adoption becomes final.

(d) Coverage of an adopted child of an insured under this section ends unless the large employer health benefit plan issuer receives notice of the adoption and any required additional premium not later than the 31st day after:

(1) the date the insured becomes a party to a suit in which the insured seeks to adopt the child; or

(2) the date the adoption becomes final.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.609. COVERAGE FOR UNMARRIED CHILDREN. (a) This section applies only if children are eligible for coverage under a large employer health benefit plan.

(b) Any limiting age applicable under a large employer health benefit plan to an unmarried child of an enrollee is 25 years of age.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.610. PREMIUM RATES; ADJUSTMENTS. (a) A large employer health benefit plan issuer may charge premiums in accordance with this section to the group of employees or dependents who meet the participation criteria and do not decline coverage.

(b) A large employer health benefit plan issuer may not charge an adjustment to premium rates for individual employees or dependents for health status related factors or duration of coverage. Any adjustment must be applied uniformly to the rates charged for all employees and dependents of employees of a large employer.

(c) Subsection (b) does not restrict the amount that a large employer may be charged for coverage.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.611. MARKETING REQUIREMENTS. On request, each large employer purchasing a health benefit plan shall be given a summary of all plans for which the employer is eligible.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.612. ENCOURAGING EXCLUSION OF EMPLOYEE PROHIBITED. A large employer health benefit plan issuer or agent may not encourage a large employer to exclude an employee who meets the participation criteria from health coverage provided in connection with the employee's employment.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.613. AGENTS. A large employer health benefit plan issuer may not terminate, fail to renew, or limit its contract or agreement of representation with an agent because of health status related factors of a large employer group placed by the agent with the issuer.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.615. ADDITIONAL REPORTING REQUIREMENTS. The department may require periodic reports by large employer health benefit plan issuers and agents regarding the large employer health benefit plans issued by those issuers. The reporting requirements must:

- (1) require information regarding the number of plans in various categories that are marketed or issued to large employers; and
- (2) comply with federal law, including regulations.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.616. APPLICABILITY TO THIRD-PARTY ADMINISTRATOR. If a large employer health benefit plan issuer enters into an agreement with a third-party administrator to provide administrative, marketing, or other services related to offering large employer health benefit plans to large employers in this state, the third-party administrator is subject to this subchapter and Subchapter C.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

CHAPTER 1502. HEALTH BENEFIT PLANS FOR CHILDREN

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1502.001. APPLICABILITY OF CHAPTER. This chapter applies only to the issuer of a health benefit plan that:

- (1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

- (i) an insurance company;
- (ii) a group hospital service corporation operating under Chapter 842;
- (iii) a fraternal benefit society operating under Chapter 885;
- (iv) a stipulated premium company operating under Chapter 884; or
- (v) a health maintenance organization operating under Chapter 843; and

(B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:

- (i) a multiple employer welfare arrangement as defined by Section 3 of that Act or another analogous benefit arrangement; or
- (ii) an entity not authorized under this code or another insurance law of this state that contracts directly for health care services on a risk-sharing basis, including a capitation basis; or

(2) is offered by an approved nonprofit health corporation that holds a certificate of authority under Chapter 844.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1502.0011. EXCEPTION. This chapter does not apply to a health benefit plan provided under the state Medicaid program or the state child health plan.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.061(a), eff. September 1, 2005.

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

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

(2) establish an open enrollment period; and

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

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

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

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 1147 (H.B. 1951), Sec. 9.001, eff. September 1, 2011.

SUBCHAPTER B. CHILDREN'S HEALTH BENEFIT PLAN

Sec. 1502.051. CHILDREN'S HEALTH BENEFIT PLAN. A health benefit plan issuer may offer a children's health benefit plan that provides coverage only to children younger than 18 years of age. The issuer may offer the plan only if the commissioner approves the plan's structure and the benefits offered under the plan.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1502.052. MANDATED BENEFIT PROVISIONS INAPPLICABLE. A children's health benefit plan is not subject to any law that requires coverage or the offer of coverage of a health care service or benefit.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1502.053. EXEMPTION FROM CERTAIN TAXES. (a) The issuer of a children's health benefit plan approved under Section 1502.051 is not subject to the premium tax or the tax on revenues imposed under Chapter 222 with respect to money received for coverage provided under that plan.

(b) The issuer of a children's health benefit plan approved

under Section 1502.051 is not subject to the retaliatory tax imposed under Chapter 281 with respect to money received for coverage provided under that plan.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.062(a), eff. September 1, 2005.

Acts 2007, 80th Leg., R.S., Ch. 932 (H.B. 3315), Sec. 19, eff. June 15, 2007.

CHAPTER 1503. COVERAGE OF CERTAIN STUDENTS

Sec. 1503.001. APPLICABILITY OF CHAPTER. This chapter applies only to a health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(i) an insurance company;

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

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

(iv) a stipulated premium company operating under Chapter 884; or

(v) a health maintenance organization operating under Chapter 843; and

(B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:

(i) a multiple employer welfare arrangement as defined by Section 3 of that Act; or

(ii) an analogous benefit arrangement; or

(2) is offered by:

(A) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844; or

(B) another entity that:

(i) is not authorized under this code or another insurance law of this state; and

(ii) contracts directly for health care services on a risk-sharing basis, including a capitation basis.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1503.002. EXCEPTION. This chapter does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease;

(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; or

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

(2) a small employer health benefit plan written under Chapter 1501;

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

(4) a workers' compensation insurance policy;

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

(6) 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 as described by Section 1503.001.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1503.003. COVERAGE OF CERTAIN STUDENTS. (a) A health benefit plan may not condition coverage for a child younger than 25 years of age on the child's being enrolled at an educational institution.

(b) A health benefit plan that requires as a condition of coverage for a child 25 years of age or older that the child be a full-time student at an educational institution must provide the coverage:

(1) for the entire academic term during which the child begins as a full-time student and remains enrolled, regardless of whether the number of hours of instruction for which the child is enrolled is reduced to a level that changes the child's academic status to less than that of a full-time student; and

(2) continuously until the 10th day of instruction of the subsequent academic term, on which date the health benefit plan may terminate coverage for the child if the child does not return to full-time student status before that date.

(c) For purposes of this section, determination of the full-time student status of a child is made in the manner provided by the educational institution at which the child is enrolled.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.063(a), eff. September 1, 2005.

CHAPTER 1504. MEDICAL AND DENTAL CHILD SUPPORT

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1504.001. DEFINITIONS. In this chapter:

(1) "Child" has the meaning assigned by Section 101.003, Family Code.

(2) "Child support agency" has the meaning assigned by Section 101.004, Family Code.

(3) "Custodial parent" means an individual who:

(A) is a managing conservator of a child or a possessory conservator of a child who is a parent of the child; or

(B) is a guardian of the person or other custodian of a child and is designated as guardian or custodian by a court or administrative agency of this or another state.

(4) "Benefit plan issuer" means:

(A) an insurance company, group hospital service corporation, or health maintenance organization that delivers or issues for delivery an individual, group, blanket, or franchise insurance policy or agreement, a group hospital service contract, or an evidence of coverage that provides benefits for medical or surgical expenses incurred as a result of an accident or sickness, or dental expenses;

(B) a governmental entity subject to Subchapter D, Chapter 1355, Subchapter C, Chapter 1364, Chapter 1578, Article 3.51-1, 3.51-4, or 3.51-5, or Chapter 177, Local Government Code;

(C) the issuer of a multiple employer welfare arrangement as defined by Section 846.001; or

(D) the issuer of a group health plan as defined by Section 607, Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1167).

(5) "Medical assistance" means medical assistance under the state Medicaid program.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2G.016, eff. April 1, 2009.

Acts 2015, 84th Leg., R.S., Ch. 1150 (S.B. 550), Sec. 60, eff. September 1, 2018.

Sec. 1504.002. RULES. (a) The commissioner shall adopt reasonable rules as necessary to implement this chapter and 42 U.S.C. Section 1396a(a)(60), including rules that define acts that constitute unfair or deceptive practices under Subchapter I, Chapter 541.

(b) The commissioner shall adopt rules that define "comparable health or dental coverage" in a manner that:

(1) is consistent with federal law; and

(2) complies with the requirements necessary to maintain federal Medicaid funding.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1150 (S.B. 550), Sec. 61, eff. September 1, 2018.

Sec. 1504.003. VIOLATION OF CHAPTER: RELIEF AVAILABLE TO INJURED PERSON. A benefit plan issuer that violates this chapter is subject to the same penalties, and an injured person has the same rights and remedies, as those provided by Subchapter D, Chapter 541.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1150 (S.B. 550), Sec. 62, eff.
September 1, 2018.

SUBCHAPTER B. DUTIES OF BENEFIT PLAN ISSUER

Sec. 1504.051. ENROLLMENT OF CERTAIN CHILDREN REQUIRED. (a) A benefit plan issuer shall permit a parent to enroll a child in dependent health or dental coverage offered through the issuer regardless of any enrollment period restriction if the parent is:

- (1) eligible for dependent health or dental coverage; and
- (2) required by a court order or administrative order to provide health or dental insurance coverage for the child.

(b) A benefit plan issuer shall enroll a child of a parent described by Subsection (a) in dependent health or dental coverage offered through the issuer if:

- (1) the parent does not apply to obtain health or dental coverage for the child through the issuer; and
- (2) the child, a custodial parent of the child, or a child support agency having a duty to collect or enforce support for the child applies for the coverage.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1150 (S.B. 550), Sec. 64, eff.
September 1, 2018.

Sec. 1504.052. CHILD RESIDING OUTSIDE SERVICE AREA; COMPARABLE HEALTH OR DENTAL COVERAGE REQUIRED. (a) A benefit plan issuer may not deny enrollment of a child under the health or dental coverage of the child's parent on the ground that the child does not reside in the issuer's service area.

(b) A benefit plan issuer may not enforce an otherwise applicable provision of the health or dental coverage that would deny, limit, or reduce payment of a claim for a covered child who resides outside the issuer's service area but inside the United States.

(c) For a covered child who resides outside the benefit plan

issuer's service area and whose coverage under a policy or plan is required by a medical support order or dental support order, the issuer shall provide coverage that is comparable health or dental coverage to that provided to other dependents under the policy or plan.

(d) Comparable health or dental coverage may include coverage in which a benefit plan issuer uses different procedures for service delivery and health care provider reimbursement. Comparable health or dental coverage may not include coverage:

- (1) that is limited to emergency services only; or
- (2) for which the issuer charges a higher premium.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1150 (S.B. 550), Sec. 65, eff. September 1, 2018.

Sec. 1504.053. CANCELLATION OR NONRENEWAL OF COVERAGE FOR CERTAIN CHILDREN. (a) A benefit plan issuer may not cancel or refuse to renew health or dental coverage provided to a child who is enrolled or entitled to enrollment under this chapter unless satisfactory written evidence is filed with the issuer showing that:

(1) the court or administrative order that required the coverage is not in effect; or

(2) the child:

(A) is enrolled in comparable health or dental coverage; or

(B) will be enrolled in comparable health or dental coverage that takes effect not later than the effective date of the cancellation or nonrenewal.

(b) For purposes of this section, a child is not enrolled or entitled to enrollment under this chapter if the child's eligibility for health or dental coverage ends because the parent ceases to be eligible for dependent health or dental coverage.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1150 (S.B. 550), Sec. 66, eff. September 1, 2018.

Sec. 1504.054. CONTINUATION OR CONVERSION OF COVERAGE. (a) If a child's eligibility for dependent health or dental coverage ends because the parent ceases to be eligible for the coverage and the coverage provides for the continuation or conversion of the coverage for the child, the benefit plan issuer shall notify the custodial parent and the child support agency of the costs and other requirements for continuing or converting the coverage.

(b) The benefit plan issuer shall, on application of a parent of the child, a child support agency, or the child, enroll or continue enrollment of a child whose eligibility for coverage ended under Subsection (a).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1150 (S.B. 550), Sec. 67, eff. September 1, 2018.

Sec. 1504.055. PROCEDURE FOR CLAIMS. (a) A benefit plan issuer that provides health or dental coverage to a child through a covered parent of the child shall:

(1) provide to each custodial parent of the child or to an adult child documents and other information necessary for the child to obtain benefits under the coverage, including:

(A) the name of the issuer;
(B) the number of the policy or evidence of coverage;
(C) a copy of the policy or evidence of coverage and schedule of benefits;
(D) a health or dental coverage membership card;
(E) claim forms; and
(F) any other document or information necessary to submit a claim in accordance with the issuer's policies and procedures;

(2) permit a custodial parent, health care provider, state agency that has been assigned medical or dental support rights, or adult child to submit claims for covered services without the approval of the covered parent; and

(3) make payments on covered claims submitted in accordance with this subsection directly to a custodial parent, health care or dental care provider, adult child, or state agency making a claim.

(b) A benefit plan issuer shall provide to a state agency that provides medical assistance, including medical assistance for dental services, to the child or shall provide to a child support agency that enforces medical or dental support on behalf of a child the information necessary to obtain reimbursement of medical or dental services provided to or paid on behalf of the child.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1150 (S.B. 550), Sec. 68, eff. September 1, 2018.

SUBCHAPTER C. PROHIBITED CONDUCT

Sec. 1504.101. DENIAL OF ENROLLMENT ON CERTAIN GROUNDS PROHIBITED. A benefit plan issuer may not deny enrollment of a child under the health or dental coverage of the child's parent on the ground that the child:

- (1) has a preexisting condition;
- (2) was born out of wedlock;
- (3) is not claimed as a dependent on the parent's federal income tax return;
- (4) does not reside with the parent; or
- (5) receives or has applied for medical assistance.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1150 (S.B. 550), Sec. 69, eff. September 1, 2018.

Sec. 1504.102. ASSIGNMENT OF MEDICAL OR DENTAL SUPPORT RIGHTS: DIFFERENT REQUIREMENTS PROHIBITED. A benefit plan issuer may not require a state agency that has been assigned the rights of an individual who is eligible for medical assistance and is covered for health or dental benefits from the issuer to comply with a requirement that is different from a requirement imposed on an agent or assignee of any other covered individual.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1150 (S.B. 550), Sec. 70, eff. September 1, 2018.

CHAPTER 1505. GROUP HEALTH INSURANCE PLANS FOR PERSONS 65 YEARS OF AGE OR OLDER

Sec. 1505.001. DEFINITION. In this chapter, "health insurer" means an insurance company authorized to provide a hospital, surgical, and medical expense insurance plan in this state, including:

- (1) a stock insurance company;
- (2) a reciprocal or interinsurance exchange;
- (3) a Lloyd's plan;
- (4) a fraternal benefit society;
- (5) a stipulated premium company; and
- (6) a mutual insurance company, including a statewide mutual assessment company or a local mutual aid association.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1505.002. PLANS FOR CERTAIN PERSONS 65 YEARS OF AGE OR OLDER. (a) Two or more health insurers may provide a hospital, surgical, and medical expense insurance plan under a group insurance policy that covers residents of this state who are at least 65 years of age and the spouses of those residents.

(b) The participating health insurers may enter into agreements regarding matters within the scope of this chapter, including:

- (1) premium rates;
- (2) policy provisions; and
- (3) sales, administrative, technical, and accounting procedures.

(c) Each participating health insurer is subject to regulation under the laws of this state and is severally liable on a group insurance policy issued under this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1505.003. APPLICATION AND OTHER EVIDENCE OF INSURANCE FORMS. An application, policy, certificate, or other evidence of

insurance form for an insurance plan under this chapter is subject to Chapter 1701.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1505.004. EXECUTION OF POLICY. An authorized person may execute an insurance policy subject to this chapter on behalf of the participating health insurers.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1505.005. USE OF UNINCORPORATED ENTITY. (a) The participating health insurers may issue the group insurance policy in their own names or in the name of an unincorporated association, trust, or other organization formed for the sole purposes of this chapter and evidenced by a written contract executed by the insurers. An unincorporated association, trust, or other organization formed under this subsection may sue and be sued in the name of the association, trust, or organization.

(b) A person licensed as a general life, accident, and health agent under Chapter 4054, as a general property and casualty agent under Chapter 4051 authorized to write health and accident insurance under Section 4051.053, or as a personal lines property and casualty agent authorized to write health and accident insurance under Section 4051.402, may act in the licensed capacity in connection with an insurance policy or a certificate of insurance issued by an unincorporated association, trust, or other organization formed under Subsection (a). The agent is not required to notify the department that the person has been appointed to act for that purpose.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 548 (S.B. [1263](#)), Sec. 2.12, eff. September 1, 2007.

Sec. 1505.006. REQUIRED FILINGS; DEPARTMENT APPROVAL. (a) The participating health insurers shall provide for the filing with the department on behalf of the insurers of:

- (1) a copy of any contract of association or organization or trust agreement entered into by the insurers under this chapter;
- (2) the schedule of premium rates to be charged for the insurance coverage; and
- (3) the plan for operating and marketing the insurance.

(b) Except as provided by Subsection (c), a contract, schedule, or plan described by Subsection (a) may not be effective until approved by the commissioner.

(c) A contract, schedule, or plan described by Subsection (a) that is not approved or disapproved in a written order of the commissioner on or before the 30th day after the date on which the document is filed with the department is considered approved on the 31st day after the date of filing.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1505.007. EFFECT OF COMMISSIONER DISAPPROVAL. If, after notice and public hearing, the commissioner determines under reasonable assumptions that a premium rate charged for the insurance coverage offered under this chapter or the plan for operating and marketing that insurance is excessive, inadequate, or contrary to the public interest or that any activity or practice performed in connection with the insurance is unfair, unreasonable, or contrary to the public interest, the commissioner shall:

(1) enter an order containing the commissioner's determination and disapproving the premium rate or plan or the activity or practice; and

(2) require the discontinuance of the premium rate, plan, activity, or practice within a period that is not less than 30 days after the date of the commissioner's order containing the determination.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1505.008. EXEMPTION FROM PREMIUM TAXES. Each premium received for group insurance coverage authorized by this chapter is exempt from any premium tax imposed by any other law of this state.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1505.009. EXEMPTION FROM CERTAIN ANTITRUST REQUIREMENTS. An association, trust, or other organization formed and operated in accordance with this chapter or an insurance business conducted in accordance with this chapter is not considered a combination in restraint of trade, an illegal monopoly, or an attempt to lessen competition or fix prices arbitrarily and does not otherwise violate the antitrust laws of this state.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

CHAPTER 1507. CONSUMER CHOICE OF BENEFITS PLANS

SUBCHAPTER A. CONSUMER CHOICE OF BENEFITS HEALTH INSURANCE PLANS

Sec. 1507.001. PURPOSE. The legislature recognizes the need for individuals, employers, and other purchasers of coverage in this state to have the opportunity to choose health insurance plans that are more affordable and flexible than existing market policies offering accident and sickness insurance coverage. The legislature, therefore, seeks to increase the availability of health insurance coverage by allowing insurers authorized to engage in the business of insurance in this state to issue accident and sickness policies that, in whole or in part, do not offer or provide state-mandated health benefits.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.074(a), eff. September 1, 2005.

Sec. 1507.002. DEFINITIONS. In this subchapter:

(1) "Health carrier" means any entity authorized under this code or another insurance law of this state that provides health insurance or health benefits in this state. The term includes an insurance company, a group hospital service corporation under Chapter 842, and a stipulated premium company under Chapter 884.

(2) "Standard health benefit plan" means an accident or sickness insurance policy that, in whole or in part, does not offer or provide state-mandated health benefits, but that provides creditable coverage as defined by Section 1205.004(a) or 1501.102(a).

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.074(a), eff. September 1, 2005.

Sec. 1507.003. STATE-MANDATED HEALTH BENEFITS. (a) For purposes of this subchapter, "state-mandated health benefits" means coverage required under this code or other laws of this state to be provided in an individual, blanket, or group policy for accident and health insurance or a contract for a health-related condition that:

(1) includes coverage for specific health care services or benefits;

(2) places limitations or restrictions on deductibles, coinsurance, copayments, or any annual or lifetime maximum benefit amounts; or

(3) includes a specific category of licensed health care practitioner from whom an insured is entitled to receive care.

(b) For purposes of this subchapter, "state-mandated health benefits" does not include benefits that are mandated by federal law or standard provisions or rights required under this code or other laws of this state to be provided in an individual, blanket, or group policy for accident and health insurance that are unrelated to a specific health illness, injury, or condition of an insured, including provisions related to:

(1) continuation of coverage under:

(A) Subchapters F and G, Chapter 1251;

(B) Section 1201.059; and

(C) Subchapter B, Chapter 1253;

(2) termination of coverage under Sections 1202.051 and 1501.108;

(3) preexisting conditions under Subchapter D, Chapter 1201, and Sections 1501.102-1501.105;

(4) coverage of children, including newborn or adopted children, under:

(A) Subchapter D, Chapter 1251;

(B) Sections 1201.053, 1201.061, 1201.063-1201.065, and Subchapter A, Chapter 1367;

(C) Chapter 1504;

(D) Chapter 1503;

(E) Section 1501.157;

(F) Section 1501.158; and

- (G) Sections 1501.607-1501.609;
- (5) services of practitioners under:
 - (A) Subchapters A, B, and C, Chapter 1451; or
 - (B) Section 1301.052;
- (6) supplies and services associated with the treatment of diabetes under Subchapter B, Chapter 1358;
- (7) coverage for serious mental illness under Subchapter A, Chapter 1355;
- (8) coverage for childhood immunizations and hearing screening as required by Subchapters B and C, Chapter 1367, other than Section 1367.053(c) and Chapter 1353;
- (9) coverage for reconstructive surgery for certain craniofacial abnormalities of children as required by Subchapter D, Chapter 1367;
- (10) coverage for the dietary treatment of phenylketonuria as required by Chapter 1359;
- (11) coverage for referral to a non-network physician or provider when medically necessary covered services are not available through network physicians or providers, as required by Section 1271.055; and
- (12) coverage for cancer screenings under:
 - (A) Chapter 1356;
 - (B) Chapter 1362;
 - (C) Chapter 1363; and
 - (D) Chapter 1370.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. [2018](#)), Sec. 11.074(a), eff. September 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 3B.029(a), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. [3167](#)), Sec. 9.029(a), eff. September 1, 2007.

Sec. 1507.004. STANDARD HEALTH BENEFIT PLANS AUTHORIZED; MINIMUM REQUIREMENT. (a) A health carrier may offer one or more standard health benefit plans.

(b) Any standard health benefit plan must include coverage for direct services to an obstetrical or gynecological care provider as

required by Subchapter F, Chapter 1451.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.074(a), eff. September 1, 2005.

Sec. 1507.005. NOTICE TO POLICYHOLDER. (a) Each written application for participation in a standard health benefit plan must contain the following language at the beginning of the document in bold type:

"You have the option to choose this Consumer Choice of Benefits Health Insurance Plan that, either in whole or in part, does not provide state-mandated health benefits normally required in accident and sickness insurance policies in Texas. This standard health benefit plan may provide a more affordable health insurance policy for you, although, at the same time, it may provide you with fewer health benefits than those normally included as state-mandated health benefits in policies in Texas. If you choose this standard health benefit plan, please consult with your insurance agent to discover which state-mandated health benefits are excluded in this policy."

(b) Each standard health benefit plan must contain the following language at the beginning of the document in bold type:

"This Consumer Choice of Benefits Health Insurance Plan, either in whole or in part, does not provide state-mandated health benefits normally required in accident and sickness insurance policies in Texas. This standard health benefit plan may provide a more affordable health insurance policy for you, although, at the same time, it may provide you with fewer health benefits than those normally included as state-mandated health benefits in policies in Texas. Please consult with your insurance agent to discover which state-mandated health benefits are excluded in this policy."

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.074(a), eff. September 1, 2005.

Sec. 1507.006. DISCLOSURE STATEMENT. (a) A health carrier providing a standard health benefit plan must provide a proposed policyholder or policyholder with a written disclosure statement

that:

(1) acknowledges that the standard health benefit plan being purchased does not provide some or all state-mandated health benefits;

(2) lists those state-mandated health benefits not included in the standard health benefit plan; and

(3) if the standard health benefit plan is issued to an individual policyholder, provides a notice that purchase of the plan may limit the policyholder's future coverage options in the event the policyholder's health changes and needed benefits are not available under the standard health benefit plan.

(b) Each applicant for initial coverage must sign the disclosure statement provided by the health carrier under Subsection (a) and return the statement to the health carrier. Under a group policy or contract, the term "applicant" means the employer.

(c) A health carrier must:

(1) retain the signed disclosure statement in the health carrier's records; and

(2) on request from the commissioner, provide the signed disclosure statement to the department.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. [2018](#)), Sec. 11.074(a), eff. September 1, 2005.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 657 (S.B. [1852](#)), Sec. 1, eff. September 1, 2019.

Sec. 1507.007. ADDITIONAL POLICIES. A health carrier that offers one or more standard health benefit plans under this subchapter must also offer at least one accident or sickness insurance policy that provides state-mandated health benefits and is otherwise authorized by this code.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. [2018](#)), Sec. 11.074(a), eff. September 1, 2005.

Sec. 1507.008. RATES. A health carrier shall file for informational purposes the rates to be used with a standard health benefit plan. Nothing in this section shall be construed as granting

the commissioner any power or authority to determine, fix, prescribe, or promulgate the rates to be charged for any individual accident and sickness insurance policy or policies.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.074(a), eff. September 1, 2005.

Sec. 1507.009. RULES. The commissioner shall adopt rules necessary to implement this subchapter.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.074(a), eff. September 1, 2005.

SUBCHAPTER B. CONSUMER CHOICE OF BENEFITS HEALTH MAINTENANCE ORGANIZATION PLANS

Sec. 1507.051. PURPOSE. The legislature recognizes the need for individuals and employers in this state to have the opportunity to choose health maintenance organization plans that are more affordable and flexible than existing market health care plans offered by health maintenance organizations. The legislature, therefore, seeks to increase the availability of health care plans by allowing health maintenance organizations authorized to operate health maintenance organizations in this state to issue group or individual evidences of coverage that, in whole or in part, do not offer or provide state-mandated health benefits.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.074(a), eff. September 1, 2005.

Sec. 1507.052. DEFINITIONS. (a) In this subchapter, "standard health benefit plan" means a group or individual evidence of coverage that, in whole or in part, does not offer or provide state-mandated health benefits but that provides creditable coverage as defined by Section 1205.004(a) or 1501.102(a).

(b) In this subchapter, terms defined by Section 843.002 have the meanings assigned by that section.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.074(a),

eff. September 1, 2005.

Sec. 1507.053. STATE-MANDATED HEALTH BENEFITS. (a) For purposes of this subchapter, "state-mandated health benefits" means coverage required under this code or other laws of this state to be provided in an evidence of coverage that:

(1) includes coverage for specific health care services or benefits;

(2) places limitations or restrictions on deductibles, coinsurance, copayments, or any annual or lifetime maximum benefit amounts, including limitations provided in Section 1271.151; or

(3) includes a specific category of licensed health care practitioner from whom an enrollee is entitled to receive care.

(b) For purposes of this subchapter, "state-mandated health benefits" does not include coverage that is mandated by federal law or standard provisions or rights required under this code or other laws of this state to be provided in an evidence of coverage that are unrelated to a specific health illness, injury, or condition of an enrollee, including provisions related to:

(1) continuation of coverage under Subchapter G, Chapter 1251;

(2) termination of coverage under Sections 1202.051 and 1501.108;

(3) preexisting conditions under Subchapter D, Chapter 1201, and Sections 1501.102-1501.105;

(4) coverage of children, including newborn or adopted children, under:

(A) Chapter 1504;

(B) Chapter 1503;

(C) Section 1501.157;

(D) Section 1501.158; and

(E) Sections 1501.607-1501.609;

(5) services of providers under Section 843.304;

(6) coverage for serious mental health illness under Subchapter A, Chapter 1355; and

(7) coverage for cancer screenings under:

(A) Chapter 1356;

(B) Chapter 1362;

(C) Chapter 1363; and

(D) Chapter 1370.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.074(a), eff. September 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.030(a), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.030(a), eff. September 1, 2007.

Sec. 1507.054. STANDARD HEALTH BENEFIT PLANS AUTHORIZED. A health maintenance organization authorized to issue an evidence of coverage in this state may offer one or more standard health benefit plans.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.074(a), eff. September 1, 2005.

Sec. 1507.055. NOTICE TO ENROLLEES. (a) Each written application for enrollment in a standard health benefit plan must contain the following language at the beginning of the document in bold type:

"You have the option to choose this Consumer Choice of Benefits Health Maintenance Organization health care plan that, either in whole or in part, does not provide state-mandated health benefits normally required in evidences of coverage in Texas. This standard health benefit plan may provide a more affordable health plan for you, although, at the same time, it may provide you with fewer health plan benefits than those normally included as state-mandated health benefits in Texas. If you choose this standard health benefit plan, please consult with your insurance agent to discover which state-mandated health benefits are excluded in this evidence of coverage."

(b) Each standard health benefit plan must contain the following language at the beginning of the document in bold type:

"This Consumer Choice of Benefits Health Maintenance Organization health care plan, either in whole or in part, does not provide state-mandated health benefits normally required in evidences of coverage in Texas. This standard health benefit

plan may provide a more affordable health plan for you, although, at the same time, it may provide you with fewer health plan benefits than those normally included as state-mandated health benefits in Texas. Please consult with your insurance agent to discover which state-mandated health benefits are excluded in this evidence of coverage."

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.074(a), eff. September 1, 2005.

Sec. 1507.056. DISCLOSURE STATEMENT. (a) A health maintenance organization providing a standard health benefit plan must provide a proposed contract holder or a contract holder with a written disclosure statement that:

(1) acknowledges that the standard health benefit plan being purchased does not provide some or all state-mandated health benefits;

(2) lists those state-mandated health benefits not included in the standard health benefit plan; and

(3) if the standard health benefit plan is issued to an individual certificate holder, provides a notice that purchase of the plan may limit the certificate holder's future coverage options in the event the certificate holder's health changes and needed benefits are not available under the standard health benefit plan.

(b) Each applicant for initial enrollment must sign the disclosure statement provided by the health maintenance organization under Subsection (a) and return the statement to the health maintenance organization. Under a group evidence of coverage, the term "applicant" means the employer.

(c) A health maintenance organization must:

(1) retain the signed disclosure statement in the organization's records; and

(2) on request from the commissioner, provide the signed disclosure statement to the department.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.074(a), eff. September 1, 2005.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 657 (S.B. 1852), Sec. 2, eff. September 1, 2019.

Sec. 1507.057. ADDITIONAL EVIDENCES OF COVERAGE. A health maintenance organization that offers one or more standard health benefit plans under this subchapter must also offer at least one evidence of coverage that provides state-mandated health benefits and is otherwise authorized by this code.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.074(a), eff. September 1, 2005.

Sec. 1507.058. RATES. A health maintenance organization shall file for informational purposes the rates to be used with a standard health benefit plan. Nothing in this section shall be construed as granting the commissioner any power or authority to determine, fix, prescribe, or promulgate the rates to be charged for any evidence of coverage.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.074(a), eff. September 1, 2005.

Sec. 1507.059. RULES. The commissioner shall adopt rules necessary to implement this subchapter.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.074(a), eff. September 1, 2005.

Text of chapter effective on September 1, 2009, but only if a specific appropriation is provided as described by Acts 2009, 81st Leg., R.S., Ch. 721, Sec. 2.04, which states: This Act does not make an appropriation. This Act takes effect only if a specific appropriation for the implementation of the Act is provided in a general appropriations act of the 81st Legislature.

CHAPTER 1508. HEALTHY TEXAS PROGRAM

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1508.001. PURPOSE. (a) The purposes of the Healthy Texas Program are to:

- (1) provide access to quality small employer health benefit

plans at an affordable price;

(2) encourage small employers to offer health benefit plan coverage to employees and the dependents of employees; and

(3) maximize reliance on proven managed care strategies and procedures.

(b) The Healthy Texas Program is not intended to diminish the availability of traditional small employer health benefit plan coverage under Chapter 1501.

Added by Acts 2009, 81st Leg., R.S., Ch. 721 (S.B. 78), Sec. 2.01, eff. September 1, 2009.

Sec. 1508.002. DEFINITIONS. In this chapter:

(1) "Dependent" has the meaning assigned by Section 1501.002(2).

(2) "Eligible employee" has the meaning assigned by Section 1501.002(3).

(3) "Fund" means the healthy Texas small employer premium stabilization fund established under Subchapter F.

(4) "Health benefit plan" and "health benefit plan issuer" have the meanings assigned by Sections 1501.002(5) and 1501.002(6), respectively.

(5) "Program" means the Healthy Texas Program established under this chapter.

(6) "Qualifying health benefit plan" means a health benefit plan that provides benefits for health care services in the manner described by this chapter.

(7) "Small employer" has the meaning assigned by Section 1501.002(14).

Added by Acts 2009, 81st Leg., R.S., Ch. 721 (S.B. 78), Sec. 2.01, eff. September 1, 2009.

Sec. 1508.003. RULES. The commissioner may adopt rules as necessary to implement this chapter.

Added by Acts 2009, 81st Leg., R.S., Ch. 721 (S.B. 78), Sec. 2.01, eff. September 1, 2009.

SUBCHAPTER B. EMPLOYER ELIGIBILITY; CONTRIBUTIONS

Sec. 1508.051. EMPLOYER ELIGIBILITY TO PARTICIPATE. (a) A small employer may participate in the program if:

(1) during the 12-month period immediately preceding the date of application for a qualifying health benefit plan, the small employer does not offer employees group health benefits on an expense-reimbursed or prepaid basis; and

(2) at least 30 percent of the small employer's eligible employees receive annual wages from the employer in an amount that is equal to or less than 300 percent of the poverty guidelines for an individual, as defined and updated annually by the United States Department of Health and Human Services.

(b) A small employer ceases to be eligible to participate in the program if any health benefit plan that provides employee benefits on an expense-reimbursed or prepaid basis, other than another qualifying health benefit plan, is purchased or otherwise takes effect after the purchase of a qualifying health benefit plan.

Added by Acts 2009, 81st Leg., R.S., Ch. 721 (S.B. 78), Sec. 2.01, eff. September 1, 2009.

Sec. 1508.052. COMMISSIONER ADJUSTMENTS AUTHORIZED. (a) The commissioner by rule may adjust the 12-month period described by Section 1508.051(a)(1) to an 18-month period if the commissioner determines that the 12-month period is insufficient to prevent inappropriate substitution of other health benefit plans for qualifying health benefit plan coverage under this chapter.

(b) The commissioner by rule may adjust the percentage of the poverty guidelines described by Section 1508.051(a)(2) to a higher or lower percentage if the commissioner determines that the adjustment is necessary to fulfill the purposes of this chapter. An adjustment made by the commissioner under this subsection takes effect on the first July 1 following the adjustment.

Added by Acts 2009, 81st Leg., R.S., Ch. 721 (S.B. 78), Sec. 2.01, eff. September 1, 2009.

Sec. 1508.053. MINIMUM EMPLOYER PARTICIPATION REQUIREMENTS. A small employer that meets the eligibility requirements described by

Section 1508.051(a) may apply to purchase a qualifying health benefit plan if 60 percent or more of the employer's eligible employees elect to participate in the plan.

Added by Acts 2009, 81st Leg., R.S., Ch. 721 (S.B. 78), Sec. 2.01, eff. September 1, 2009.

Sec. 1508.054. EMPLOYER CONTRIBUTION REQUIREMENTS. (a) A small employer that purchases a qualifying health benefit plan must:

- (1) pay 50 percent or more of the premium for each employee covered under the qualifying health benefit plan;
- (2) offer coverage to all eligible employees receiving annual wages from the employer in an amount described by Section 1508.051(a)(2) or 1508.052(b), as applicable; and
- (3) contribute the same percentage of premium for each covered employee.

(b) A small employer that purchases a qualifying health benefit plan under the program may elect to pay, but is not required to pay, all or any portion of the premium paid for dependent coverage under the qualifying health benefit plan.

Added by Acts 2009, 81st Leg., R.S., Ch. 721 (S.B. 78), Sec. 2.01, eff. September 1, 2009.

SUBCHAPTER C. PROGRAM PARTICIPATION; REQUIRED COVERAGE AND BENEFITS

Sec. 1508.101. PARTICIPATING PLAN ISSUERS. (a) Subject to Subsection (b), any health benefit plan issuer may participate in the program.

(b) The commissioner by rule may limit which health benefit plan issuers may participate in the program if the commissioner determines that the limitation is necessary to achieve the purposes of this chapter.

(c) If the commissioner limits participation in the program under Subsection (b), the commissioner shall contract on a competitive procurement basis with one or more health benefit plan issuers to provide qualifying health benefit plan coverage under the program.

(d) Nothing in this chapter prohibits a regional or local health care program described by Chapter 75, Health and Safety Code,

from participating in the program. The commissioner by rule shall establish participation requirements applicable to regional and local health care programs that consider the unique plan designs, benefit levels, and participation criteria of each program.

Added by Acts 2009, 81st Leg., R.S., Ch. 721 (S.B. 78), Sec. 2.01, eff. September 1, 2009.

Sec. 1508.102. PREEXISTING CONDITION PROVISION REQUIRED. A health benefit plan offered under the program must include a preexisting condition provision that meets the requirements described by Section 1501.102.

Added by Acts 2009, 81st Leg., R.S., Ch. 721 (S.B. 78), Sec. 2.01, eff. September 1, 2009.

Sec. 1508.103. EXCEPTION FROM MANDATED BENEFIT REQUIREMENTS. Except as expressly provided by this chapter, a small employer health benefit plan issued under the program is not subject to a law of this state that requires coverage or the offer of coverage of a health care service or benefit.

Added by Acts 2009, 81st Leg., R.S., Ch. 721 (S.B. 78), Sec. 2.01, eff. September 1, 2009.

Sec. 1508.104. CERTAIN COVERAGE PROHIBITED OR REQUIRED. (a) A qualifying health benefit plan may only provide coverage for in-plan services and benefits, except for:

- (1) emergency care; or
- (2) other services not available through a plan provider.

(b) In-plan services and benefits provided under a qualifying health benefit plan must include the following:

- (1) inpatient hospital services;
- (2) outpatient hospital services;
- (3) physician services; and
- (4) prescription drug benefits.

(c) The commissioner may approve in-plan benefits other than those required under Subsection (b) or emergency care or other

services not available through a plan provider if the commissioner determines the inclusion to be essential to achieve the purposes of this chapter.

(d) The commissioner may, with respect to the categories of services and benefits described by Subsections (b) and (c):

(1) prepare specifications for a coverage provided under this chapter;

(2) determine the methods and procedures of claims administration;

(3) establish procedures to decide contested cases arising from coverage provided under this chapter;

(4) study, on an ongoing basis, the operation of all coverages provided under this chapter, including gross and net costs, administration costs, benefits, utilization of benefits, and claims administration;

(5) administer the healthy Texas small employer premium stabilization fund established under Subchapter F;

(6) provide the beginning and ending dates of coverages for enrollees in a qualifying health benefit plan;

(7) develop basic group coverage plans applicable to all individuals eligible to participate in the program;

(8) provide for optional group coverage plans in addition to the basic group coverage plans described by Subdivision (7);

(9) provide, as determined to be appropriate by the commissioner, additional statewide optional coverage plans;

(10) develop specific health benefit plans that permit access to high-quality, cost-effective health care;

(11) design, implement, and monitor health benefit plan features intended to discourage excessive utilization, promote efficiency, and contain costs for qualifying health benefit plans;

(12) develop and refine, on an ongoing basis, a health benefit strategy for the program that is consistent with evolving benefits delivery systems;

(13) develop a funding strategy that efficiently uses employer contributions to achieve the purposes of this chapter; and

(14) modify the copayment and deductible amounts for prescription drug benefits under a qualifying health benefit plan, if the commissioner determines that the modification is necessary to achieve the purposes of this chapter.

Added by Acts 2009, 81st Leg., R.S., Ch. 721 (S.B. 78), Sec. 2.01, eff. September 1, 2009.

SUBCHAPTER D. PROGRAM ADMINISTRATION

Sec. 1508.151. EMPLOYER CERTIFICATION. (a) At the time of initial application, a health benefit plan issuer shall obtain from a small employer that seeks to purchase a qualifying health benefit plan a written certification that the employer meets the eligibility requirements described by Section 1508.051 and the minimum employer participation requirements described by Section 1508.053.

(b) Not later than the 90th day before the renewal date of a qualifying health benefit plan, a health benefit plan issuer shall obtain from the small employer that purchased the qualifying health benefit plan a written certification that the employer continues to meet the eligibility requirements described by Section 1508.051 and the minimum employer participation requirements described by Section 1508.053.

(c) A participating health benefit plan issuer may require a small employer to submit appropriate documentation in support of a certification described by Subsection (a) or (b).

Added by Acts 2009, 81st Leg., R.S., Ch. 721 (S.B. 78), Sec. 2.01, eff. September 1, 2009.

Sec. 1508.152. APPLICATION PROCESS. (a) Subject to Subsection (b), a health benefit plan issuer shall accept applications for qualifying health benefit plan coverage from small employers at all times throughout the calendar year.

(b) The commissioner may limit the dates on which a health benefit plan issuer must accept applications for qualifying health benefit plan coverage if the commissioner determines the limitation to be necessary to achieve the purposes of this chapter.

Added by Acts 2009, 81st Leg., R.S., Ch. 721 (S.B. 78), Sec. 2.01, eff. September 1, 2009.

Sec. 1508.153. EMPLOYEE ENROLLMENT; WAITING PERIOD. (a) A qualifying health benefit plan must provide employees with an initial

enrollment period that is 31 days or longer, and annually at least one open enrollment period that is 31 days or longer. The commissioner by rule may require an additional open enrollment period if the commissioner determines that the additional open enrollment period is necessary to achieve the purposes of this chapter.

(b) A small employer may establish a waiting period for employees during which an employee is not eligible for coverage under a qualifying health benefit plan. The last day of a waiting period established under this subsection may not be later than the 90th day after the date on which the employee begins employment with the small employer.

(c) A health benefit plan issuer may not deny coverage under a qualifying health benefit plan to a new employee of a small employer that purchased the qualifying health benefit plan if the health benefit plan issuer receives an application for coverage from the employee not later than the 31st day after the latter of:

- (1) the first day of the employee's employment; or
- (2) the first day after the expiration of a waiting period established under Subsection (b).

(d) Subject to Subsection (e), a health benefit plan issuer may deny coverage under a qualifying health benefit plan to an employee of a small employer who applies for coverage after the period described by Subsection (c).

(e) A health benefit plan issuer that denies an employee coverage under Subsection (d):

- (1) may only deny the employee coverage until the next open enrollment period; and
- (2) may subject the enrollee to a one-year preexisting condition provision, as described by Section 1508.102, if the period during which the preexisting condition provision applies does not exceed 18 months from the date of the initial application for coverage under the qualifying health benefit plan.

Added by Acts 2009, 81st Leg., R.S., Ch. 721 (S.B. 78), Sec. 2.01, eff. September 1, 2009.

Sec. 1508.154. REPORTS. A health benefit plan issuer that participates in the program shall submit reports to the department in the form and at the time the commissioner prescribes.

Added by Acts 2009, 81st Leg., R.S., Ch. 721 (S.B. 78), Sec. 2.01, eff. September 1, 2009.

SUBCHAPTER E. RATING OF QUALIFIED HEALTH BENEFIT PLANS

Sec. 1508.201. RATING; PREMIUM PRACTICES IN GENERAL. (a) A health benefit plan issuer participating in the program must:

(1) use rating practices for qualifying health benefit plans that are consistent with the purposes of this chapter; and

(2) in setting premiums for qualifying health benefit plans, consider the availability of reimbursement from the fund.

(b) A health benefit plan issuer participating in the program shall apply rating factors consistently with respect to all small employers in a class of business.

(c) Differences in premium rates charged for qualifying health benefit plans must be reasonable and reflect objective differences in plan design.

Added by Acts 2009, 81st Leg., R.S., Ch. 721 (S.B. 78), Sec. 2.01, eff. September 1, 2009.

Sec. 1508.202. PREMIUM RATE DEVELOPMENT AND CALCULATION. (a) Rating factors used to underwrite qualifying health benefit plans must produce premium rates for identical groups that:

(1) differ only by the amounts attributable to health benefit plan design; and

(2) do not reflect differences because of the nature of the groups assumed to select a particular health benefit plan.

(b) A health benefit plan issuer shall treat each qualifying health benefit plan that is issued or renewed in a calendar month as having the same rating period.

(c) A health benefit plan issuer may use only age and gender as case characteristics, as defined by Section 1501.201(2), in setting premium rates for a qualifying health benefit plan.

(d) The commissioner by rule may establish additional rating criteria and requirements for qualifying health benefit plans if the commissioner determines that the criteria and requirements are necessary to achieve the purposes of this chapter.

Added by Acts 2009, 81st Leg., R.S., Ch. 721 (S.B. 78), Sec. 2.01,

eff. September 1, 2009.

Sec. 1508.203. FILING; APPROVAL. (a) A health benefit plan issuer shall file with the department, for review and approval by the commissioner, premium rates to be charged for qualifying health benefit plans.

(b) If the commissioner limits health benefit plan issuer participation in the program under Section 1508.101(b), premium rates proposed to be charged for each qualifying health benefit plan will be considered as an element in the contract procurement process required under that section.

Added by Acts 2009, 81st Leg., R.S., Ch. 721 (S.B. 78), Sec. 2.01, eff. September 1, 2009.

**SUBCHAPTER F. HEALTHY TEXAS SMALL EMPLOYER PREMIUM STABILIZATION
FUND**

Sec. 1508.251. ESTABLISHMENT OF FUND. (a) To the extent that funds appropriated to the department are available for this purpose, the commissioner shall establish a fund from which health benefit plan issuers may receive reimbursement for claims paid by the health benefit plan issuers for individuals covered under qualifying group health plans.

(b) The fund established under this section shall be known as the healthy Texas small employer premium stabilization fund.

(c) The commissioner shall adopt rules necessary to implement and administer the fund, including rules that set out the procedures for operation of the fund and distribution of money from the fund.

Added by Acts 2009, 81st Leg., R.S., Ch. 721 (S.B. 78), Sec. 2.01, eff. September 1, 2009.

Sec. 1508.252. OPERATION OF FUND; CLAIM ELIGIBILITY. (a) A health benefit plan issuer is eligible to receive reimbursement in an amount that is equal to 80 percent of the dollar amount of claims paid between \$5,000 and \$75,000 in a calendar year for an enrollee in a qualifying health benefit plan.

(b) A health benefit plan issuer is eligible for reimbursement

from the fund only for the calendar year in which claims are paid.

(c) Once the dollar amount of claims paid on behalf of a covered individual reaches or exceeds \$75,000 in a given calendar year, a health benefit plan issuer may not receive reimbursement for any other claims paid on behalf of the individual in that calendar year.

Added by Acts 2009, 81st Leg., R.S., Ch. 721 (S.B. 78), Sec. 2.01, eff. September 1, 2009.

Sec. 1508.253. REIMBURSEMENT REQUEST SUBMISSION. (a) A health benefit plan issuer seeking reimbursement from the fund shall submit a request for reimbursement in the form prescribed by the commissioner by rule.

(b) A health benefit plan issuer must request reimbursement from the fund annually, not later than the date determined by the commissioner, following the end of the calendar year for which the reimbursement requests are made.

(c) The commissioner may require a health benefit plan issuer participating in the program to submit claims data in connection with reimbursement requests as the commissioner determines to be necessary to ensure appropriate distribution of reimbursement funds and oversee the operation of the fund. The commissioner may require that the data be submitted on a per covered individual, aggregate, or categorical basis.

Added by Acts 2009, 81st Leg., R.S., Ch. 721 (S.B. 78), Sec. 2.01, eff. September 1, 2009.

Sec. 1508.254. FUND AVAILABILITY. (a) The commissioner shall compute the total claims reimbursement amount for all health benefit plan issuers participating in the program for the calendar year for which claims are reported and reimbursement requested.

(b) If the total amount requested by health benefit plan issuers participating in the program for reimbursement for a calendar year exceeds the amount of funds available for distribution for claims paid during that same calendar year, the commissioner shall provide for the pro rata distribution of any available funds. A health benefit plan issuer participating in the program is eligible

to receive a proportional amount of any available funds that is equal to the proportion of total eligible claims paid by all participating health benefit plan issuers that the requesting health benefit plan issuer paid.

(c) If the amount of funds available for distribution for claims paid by all health benefit plan issuers participating in the program during a calendar year exceeds the total amount requested for reimbursement by all participating health benefit plan issuers during that calendar year, the commissioner shall carry forward any excess funds and make those excess funds available for distribution in the next calendar year. Excess funds carried over under this section are added to the fund in addition to any other money appropriated for the fund for the calendar year into which the funds are carried forward.

Added by Acts 2009, 81st Leg., R.S., Ch. 721 (S.B. 78), Sec. 2.01, eff. September 1, 2009.

Sec. 1508.255. PROGRAM REPORTING. (a) Each health benefit plan issuer participating in the program shall provide the department, in the form prescribed by the commissioner, monthly reports of total enrollment under qualifying health benefit plans.

(b) On the request of the commissioner, each health benefit plan issuer participating in the program shall furnish to the department, in the form prescribed by the commissioner, data other than data described by Subsection (a) that the commissioner determines necessary to oversee the operation of the fund.

Added by Acts 2009, 81st Leg., R.S., Ch. 721 (S.B. 78), Sec. 2.01, eff. September 1, 2009.

Sec. 1508.256. CLAIMS EXPERIENCE DATA. (a) Based on available data and appropriate actuarial assumptions, the commissioner shall separately estimate the per covered individual annual cost of total claims reimbursement from the fund for qualifying health benefit plans.

(b) On request, a health benefit plan issuer participating in the program shall furnish to the department claims experience data for use in the estimates described by Subsection (a).

Added by Acts 2009, 81st Leg., R.S., Ch. 721 (S.B. 78), Sec. 2.01, eff. September 1, 2009.

Sec. 1508.257. TOTAL ELIGIBLE ENROLLMENT DETERMINATION. (a) The commissioner shall determine total eligible enrollment under qualifying health benefit plans by dividing the total funds available for distribution from the fund by the estimated per covered individual annual cost of total claims reimbursement from the fund.

(b) At the end of the first year of enrollment and annually thereafter, the commissioner shall submit a report to the governor and the legislature regarding enrollment for the previous year and limitations on future enrollment that ensure that the program does not necessitate a substantial increase in funding to continue the program, as consistent with Section 1508.001.

Added by Acts 2009, 81st Leg., R.S., Ch. 721 (S.B. 78), Sec. 2.01, eff. September 1, 2009.

Sec. 1508.258. EVALUATION AND PROTECTION OF FUND; EMPLOYER ENROLLMENT SUSPENSION. (a) The commissioner shall suspend the enrollment of new employers in qualifying health benefit plans if the commissioner determines that the total enrollment reported by all health benefit plan issuers under qualifying health benefit plans exceeds the total eligible enrollment determined under Section 1508.257 and is likely to result in anticipated annual expenditures from the fund in excess of the total funds available for distribution from the fund.

(b) The commissioner shall provide a health benefit plan issuer participating in the program with notification of any enrollment suspension under Subsection (a) as soon as practicable after:

- (1) receipt of all enrollment data; and
- (2) determination of the need to suspend enrollment.

(c) A suspension of issuance of qualifying health benefit plans to employers under Subsection (a) does not preclude the addition of new employees of an employer already covered under a qualifying health benefit plan or new dependents of employees already covered under a qualifying health benefit plan.

Added by Acts 2009, 81st Leg., R.S., Ch. 721 (S.B. 78), Sec. 2.01,

eff. September 1, 2009.

Sec. 1508.259. EMPLOYER ENROLLMENT REACTIVATION. If, at any point during a suspension of enrollment under Section 1508.258, the commissioner determines that funds are sufficient to provide for the addition of new enrollments, the commissioner:

- (1) may reactivate new enrollments; and
- (2) shall notify all participating group health benefit plan issuers that enrollment of new employers may be resumed.

Added by Acts 2009, 81st Leg., R.S., Ch. 721 (S.B. 78), Sec. 2.01, eff. September 1, 2009.

Sec. 1508.260. FUND ADMINISTRATOR. (a) The commissioner may obtain the services of an independent organization to administer the fund.

(b) The commissioner shall establish guidelines for the submission of proposals by organizations for the purposes of administering the fund and may approve, disapprove, or recommend modification to the proposal of an applicant to administer the fund.

(c) An organization approved to administer the fund shall submit reports to the commissioner, in the form and at the times required by the commissioner, as necessary to facilitate evaluation and ensure orderly operation of the fund, including an annual report of the affairs and operations of the fund. The annual report must also be delivered to the governor, the lieutenant governor, and the speaker of the house of representatives.

(d) An organization approved to administer the fund shall maintain records in the form prescribed by the commissioner and make those records available for inspection by or at the request of the commissioner.

(e) The commissioner shall determine the amount of compensation to be allocated to an approved organization as payment for fund administration. Compensation is payable only from the fund.

(f) The commissioner may remove an organization approved to administer the fund from fund administration. An organization removed from fund administration under this subsection must cooperate in the orderly transition of services to another approved

organization or to the commissioner.

Added by Acts 2009, 81st Leg., R.S., Ch. 721 (S.B. 78), Sec. 2.01, eff. September 1, 2009.

Sec. 1508.261. STOP-LOSS INSURANCE; REINSURANCE. (a) The administrator of the fund, on behalf of and with the prior approval of the commissioner, may purchase stop-loss insurance or reinsurance from an insurance company licensed to write that coverage in this state.

(b) Stop-loss insurance or reinsurance may be purchased to the extent that the commissioner determines funds are available for the purchase of that insurance.

Added by Acts 2009, 81st Leg., R.S., Ch. 721 (S.B. 78), Sec. 2.01, eff. September 1, 2009.

Sec. 1508.262. PUBLIC EDUCATION AND OUTREACH. (a) The commissioner may use an amount of the fund, not to exceed eight percent of the annual amount of the fund, for purposes of developing and implementing public education, outreach, and facilitated enrollment strategies targeted to small employers who do not provide health insurance.

(b) The commissioner shall solicit and accept recommendations concerning the development and implementation of education, outreach, and enrollment strategies under Subsection (a) from agents licensed under Title 13 to write health benefit plans in this state.

(c) The commissioner may contract with marketing organizations to perform or provide assistance with education, outreach, and enrollment strategies described by Subsection (a).

Added by Acts 2009, 81st Leg., R.S., Ch. 721 (S.B. 78), Sec. 2.01, eff. September 1, 2009.

CHAPTER 1509. SHORT-TERM LIMITED-DURATION INSURANCE

Sec. 1509.001. DEFINITION. In this chapter, "short-term limited-duration insurance" has the meaning assigned by 26 C.F.R. Section 54.9801-2.

Added by Acts 2019, 86th Leg., R.S., Ch. 657 (S.B. 1852), Sec. 3, eff. September 1, 2019.

Sec. 1509.002. POLICY DISCLOSURE FORM. (a) The commissioner by rule shall prescribe a disclosure form to be provided with a short-term limited-duration insurance policy and application.

(b) The disclosure form must be in an easily readable font at least 14-point in size and include:

(1) the duration of coverage;

(2) a statement:

(A) of the number of times the policy may be renewed or that the policy may not be renewed, as applicable;

(B) that the expiration of short-term coverage is not a qualifying life event that would make a person eligible for a special enrollment period; and

(C) that the policy may expire outside of the open enrollment period;

(3) to the extent the information is available, the dates of the next three open enrollment periods under the Patient Protection and Affordable Care Act (Pub. L. No. 111-148) following the date the policy expires;

(4) whether the policy contains any limitations or exclusions to preexisting conditions;

(5) the maximum dollar amount payable under the policy;

(6) the deductibles under the policy and the health care services to which the deductibles apply;

(7) whether the following health care services are covered, including:

(A) prescription drug coverage;

(B) mental health services;

(C) substance abuse treatment;

(D) maternity care;

(E) hospitalization;

(F) surgery;

(G) emergency health care; and

(H) preventive health care; and

(8) any other information the commissioner determines is important for a purchaser of a short-term limited-duration insurance policy.

(c) An insurer issuing a short-term limited-duration insurance policy shall adopt procedures in accordance with commissioner rule to obtain a signed form from the insured acknowledging receipt of the disclosure form described by this section. The rule must allow for electronic acknowledgment. The insurer shall retain an acknowledgment form until the fifth anniversary of the date the insurer receives the form, and the insurer shall make the form available to the department on request.

Added by Acts 2019, 86th Leg., R.S., Ch. 657 (S.B. [1852](#)), Sec. 3, eff. September 1, 2019.

SUBTITLE H. HEALTH BENEFITS AND OTHER COVERAGES FOR GOVERNMENTAL EMPLOYEES

CHAPTER 1550. CERTAIN REQUIREMENTS FOR INSURERS CONTRACTING WITH GOVERNMENTAL ENTITIES

SUBCHAPTER B. CERTAIN CONTRACTS WITH MUNICIPALITIES

Sec. 1550.051. DEFINITION OF INSURER. In this subchapter, "insurer" means:

- (1) an insurance company, including a company providing stop-loss or excess loss insurance;
- (2) a health maintenance organization operating under Section 1367.053, Subchapter A, Chapter 1452, Subchapter B, Chapter 1507, Chapter 222, 251, or 258, as applicable to a health maintenance organization, Chapter 843, Chapter 1271, and Chapter 1272;
- (3) an approved nonprofit health corporation that holds a certificate of authority issued under Chapter 844; or
- (4) a third-party administrator that holds a certificate of authority under Chapter 4151.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 1G.002, eff. April 1, 2009.

Sec. 1550.052. BID REQUIREMENTS. (a) Except as provided by Section 1550.054, an insurer that bids on a contract subject to the competitive bidding and competitive proposal requirements adopted under Section 252.021, Local Government Code, may not submit a bid for a contract to provide stop-loss or other insurance coverage that

is subject to any qualification imposed by the insurer that permits the insurer to modify or limit the terms of insurance coverage to be provided after the contract has been made.

(b) An insurer's bid submitted under Section 252.021, Local Government Code, must contain the insurer's entire offer.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1G.002, eff. April 1, 2009.

Sec. 1550.053. CERTAIN EXCLUSIONS AND INCREASED DEDUCTIBLES PROHIBITED. Except as provided by Section 1550.054, an insurer that provides stop-loss or other insurance coverage for health benefits under a contract subject to this subchapter may not, based on an individual's prior medical history:

- (1) exclude from coverage an individual who is otherwise eligible for the health benefits coverage; or
- (2) assign a higher deductible to the individual.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1G.002, eff. April 1, 2009.

Sec. 1550.054. EXCEPTION FOR WRITTEN WAIVER. By executing a written waiver in favor of the insurer, a municipality as defined by Section 1.005, Local Government Code, may waive a requirement of Section 1550.052 or 1550.053(2).

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1G.002, eff. April 1, 2009.

CHAPTER 1551. TEXAS EMPLOYEES GROUP BENEFITS ACT
SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1551.001. SHORT TITLE. This chapter may be cited as the Texas Employees Group Benefits Act.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.002. PURPOSES. The purposes of this chapter are to:

(1) provide uniformity in life, accident, and health benefit coverages for all state officers and employees and their dependents;

(2) enable the state to attract and retain competent and able employees by providing employees and their dependents with life, accident, and health benefit coverages at least equal to those commonly provided in private industry;

(3) foster, promote, and encourage employment by and service to the state as a career profession for individuals of high standards of competence and ability;

(4) recognize and protect the state's investment in each permanent employee by promoting and preserving economic security and good health among employees and their dependents;

(5) foster and develop high standards of employer-employee relationships between the state and its employees;

(6) recognize the long and faithful service and dedication of state officers and employees and encourage them to remain in state service until eligible for retirement by providing health benefits for them and their dependents; and

(7) recognize the service to the state by employees and retired employees of community supervision and corrections departments by extending to them and their dependents the same life, accident, and health benefit coverages as those provided under this chapter to state employees, retired state employees, and their dependents.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1030, Sec. 1.01, eff. Sept. 1, 2003.

Sec. 1551.003. GENERAL DEFINITIONS. In this chapter:

(1) "Administering firm" means a firm designated by the board of trustees to administer coverages, services, benefits, or requirements in accordance with this chapter and the rules adopted by the board of trustees under this chapter.

(2) "Annuitant" means an individual eligible to participate in the group benefits program under Section 1551.102.

(3) "Basic coverage" means the group coverage plans determined by the board of trustees in which each eligible full-time

employee and annuitant participates automatically unless participation is specifically waived.

(4) "Board of trustees" means the board of trustees established under Chapter 815, Government Code, to administer the Employees Retirement System of Texas.

(5) "Cafeteria plan" means a plan defined and authorized by Section 125, Internal Revenue Code of 1986.

(6) "Employee" means an individual eligible to participate in the group benefits program under Section 1551.101.

(7) "Employer" means this state and its agencies.

(8) "Executive director" means the executive director of the Employees Retirement System of Texas.

(9) "Full-time employee" means an employee designated as a full-time employee under Section 1551.319(c) or (d) or an employee designated by the employer as working 30 or more hours a week.

(9-a) "Good cause" means that a person's failure to act was not because of a lack of due diligence the exercise of which would have caused a reasonable person to take prompt and timely action. A failure to act based on ignorance of the law or facts reasonably discoverable through the exercise of due diligence does not constitute good cause.

(10) "Group benefits program" means the state employees group benefits program provided by this chapter.

(10-a) "Participant" means an eligible individual who participates in the group benefits program.

(11) "Part-time employee" means an employee designated by the employer as working less than 30 hours a week. For purposes of this chapter, an individual described by Section 1551.101(e)(2) is considered a part-time employee.

(12) "Serious mental illness" has the meaning assigned by Section 1355.001.

(13) "Service" means personal service to the state creditable in accordance with rules adopted by the board of trustees.

(14) "State agency" means a commission, board, department, division, institution of higher education, or other agency of this state created by the constitution or statutes of this state. The term also includes the Texas Municipal Retirement System and the Texas County and District Retirement System.

(15) "Usual and customary rate" means the relevant allowable amount as described by the applicable master benefit plan

document or policy.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 366, Sec. 2.01, eff. Sept. 1, 2003.

Amended by:

Acts 2005, 79th Leg., Ch. 347 (S.B. 1176), Sec. 24, eff. September 1, 2005.

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2G.018, eff. April 1, 2009.

Acts 2009, 81st Leg., R.S., Ch. 1308 (H.B. 2559), Sec. 31, eff. September 1, 2009.

Acts 2013, 83rd Leg., R.S., Ch. 618 (S.B. 1459), Sec. 21, eff. September 1, 2013.

Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 1.10, eff. September 1, 2019.

Sec. 1551.004. DEFINITION OF DEPENDENT. (a) In this chapter, "dependent" with respect to an individual eligible to participate in the group benefits program means the individual's:

(1) spouse;

(2) unmarried child younger than 26 years of age;

(3) child of any age who the board of trustees determines lives with or has the child's care provided by the individual on a regular basis if the child is mentally or physically incapacitated to the extent that the child is dependent on the individual for care or support, as determined by the board of trustees;

(4) child of any age who is unmarried, for purposes of health benefit coverage under this chapter, on expiration of the child's continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (Pub. L. No. 99-272) and its subsequent amendments; and

(5) ward, as that term is defined by Chapter 1002, Estates Code, who is 26 years of age or younger.

(b) In this section, "child" includes:

(1) a natural child, adopted child, stepchild, foster child, or child in the possession of a participant who is designated as managing conservator of the child under an irrevocable or unrevoked affidavit of relinquishment under Chapter 161, Family Code;

or

(2) a child who is related by blood or marriage and was claimed as a dependent on the federal income tax return of an individual who is eligible to participate in the group benefits program under Section 1551.101 or 1551.102 for the calendar year preceding the plan year in which the child is first enrolled as a dependent under Subchapter D, and for each subsequent year in which the child is enrolled as a dependent.

(c) The requirement in Subsection (b)(2) that a child must be claimed as a dependent on a federal income tax return in the calendar year preceding the child's enrollment does not apply if:

(1) the child is born in the year in which the child is first enrolled; or

(2) the participant can demonstrate good cause for not claiming the child as a dependent in the preceding calendar year.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.401(a), eff. Sept. 1, 2003.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1308 (H.B. [2559](#)), Sec. 32, eff. September 1, 2009.

Acts 2011, 82nd Leg., R.S., Ch. 109 (H.B. [755](#)), Sec. 1, eff. September 1, 2011.

Acts 2011, 82nd Leg., R.S., Ch. 1249 (S.B. [1664](#)), Sec. 17, eff. September 1, 2011.

Acts 2013, 83rd Leg., R.S., Ch. 618 (S.B. [1459](#)), Sec. 22, eff. September 1, 2013.

Acts 2013, 83rd Leg., R.S., Ch. 1285 (H.B. [2155](#)), Sec. 1, eff. June 14, 2013.

Acts 2017, 85th Leg., R.S., Ch. 324 (S.B. [1488](#)), Sec. 22.049, eff. September 1, 2017.

Sec. 1551.005. DEFINITION OF HEALTH BENEFIT PLAN. (a) In this chapter, "health benefit plan" means a plan that provides, pays for, or reimburses expenses for health care services, including comparable health care services for participants who rely solely on spiritual means through prayer for healing in accordance with the teaching of a well-recognized church or denomination.

(b) A health benefit plan shall be provided on a group basis through:

- (1) a policy or contract;
- (2) a medical, dental, or hospital service agreement;
- (3) a membership or subscription contract;
- (4) a salary continuation plan;
- (5) a health maintenance organization agreement;
- (6) a preferred provider arrangement; or
- (7) any other similar group arrangement or a combination of policies, plans, contracts, agreements, or arrangements described by this subsection.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.006. DEFINITION OF INSTITUTION OF HIGHER EDUCATION.

(a) In this chapter, except as provided by Subsection (b), "institution of higher education" means a public junior college, a senior college or university, or any other agency of higher education within the meaning and jurisdiction of Chapter 61, Education Code.

(b) In this chapter, "institution of higher education" does not include:

- (1) an entity in The University of Texas System, as described by Section 65.02, Education Code; and
- (2) an entity in The Texas A&M University System, as described by Subtitle D, Title 3, Education Code, including the Texas Veterinary Medical Diagnostic Laboratory.

(c) Notwithstanding Subsection (b), The Texas A&M University System, including the Texas Veterinary Medical Diagnostic Laboratory, participates in the group benefits program if, not later than November 1, 2004, the system notifies the board of trustees of the system's election to participate. If notice is provided as required by this subsection, the employees and annuitants of the system, including the veterinary medical laboratory, and the dependents of those employees and annuitants, participate in the group benefits program effective not later than September 1, 2005.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Amended by Acts 2003, 78th Leg., ch. 366, Sec. 2.02, eff. Sept. 1, 2003.

Sec. 1551.007. DEFINITION OF CARRIER. In this chapter, "carrier" means:

(1) an insurance company that is authorized by the department under this code or another insurance law of this state to provide any of the types of insurance coverages, benefits, or services provided for in this chapter and that:

(A) has a surplus of \$1 million;

(B) has a successful operating history; and

(C) has had successful experience, as determined by the department, in providing and servicing any of the types of group coverage provided for in this chapter;

(2) a corporation operating under Chapter 842 or 843 that provides any of the types of coverage, benefits, or services provided for in this chapter and that:

(A) has a successful operating history; and

(B) has had successful experience, as determined by the department, in providing and servicing any of the types of group coverage provided for in this chapter; or

(3) any combination of carriers described by Subdivisions (1) and (2) on terms the board of trustees prescribes.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.402, eff. Sept. 1, 2003.

Sec. 1551.008. APPLICABILITY OF DEFINITIONS. The definition of a term defined by this subchapter and the use of the terms "employee" and "annuitant" to refer to individuals eligible to participate in the group benefits program under Sections 1551.101 and 1551.102 apply to this chapter unless a different meaning is plainly required by the context in which the term appears.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.009. BOARD OF TRUSTEES MAY DEFINE OTHER WORDS. The board of trustees may define by rule a word in terms necessary in the administration of this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.010. BOARD OF TRUSTEES APPROVAL FOR PAYROLL DEDUCTIONS OR REDUCTIONS. A state agency may not establish, continue, or authorize payroll deductions or reductions for any benefit or coverage as provided by this chapter without the express approval of the board of trustees.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.011. EXEMPTION FROM EXECUTION. All benefit payments, contributions of employees and annuitants, and optional benefit payments, any rights, benefits, or payments accruing to a person under this chapter, and all money in a fund created by this chapter:

- (1) are exempt from execution, attachment, garnishment, or any other process; and
- (2) may not be assigned, except:
 - (A) for direct payment that a participant may assign to a provider of health care services; and
 - (B) as specifically provided by this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.012. EXEMPTION FROM STATE TAXES AND FEES. Any coverage established under this chapter, including a policy, an insurance contract, a certificate of coverage, an evidence of coverage, and an agreement with a health maintenance organization or a plan administrator, is not subject to any state tax, regulatory fee, or surcharge, including a premium or maintenance tax or fee.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.013. COMBINING OF CARRIERS NOT RESTRAINT OF TRADE. Carriers combining to bid, underwrite, or both bid and underwrite for the group benefits program are not in violation of Chapter 15, Business & Commerce Code.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.014. EXCLUSIVE REMEDIES. The remedies provided under this chapter are the exclusive remedies available to an employee, participant, annuitant, or dependent.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.403(a), eff. Sept. 1, 2003.

Text of section effective until September 1, 2025

Sec. 1551.015. BALANCE BILLING PROHIBITION NOTICE. (a) The administrator of a managed care plan provided under the group benefits program shall provide written notice in accordance with this section in an explanation of benefits provided to the participant and the physician or health care provider in connection with a health care or medical service or supply or transport provided by an out-of-network provider. The notice must include:

(1) a statement of the billing prohibition under Section 1551.228, 1551.229, 1551.230, or 1551.231, as applicable;

(2) the total amount the physician or provider may bill the participant under the participant's managed care plan and an itemization of copayments, coinsurance, deductibles, and other amounts included in that total; and

(3) for an explanation of benefits provided to the physician or provider, information required by commissioner rule advising the physician or provider of the availability of mediation or arbitration, as applicable, under Chapter 1467.

(b) The administrator shall provide the explanation of benefits with the notice required by this section to a physician or health care provider not later than the date the administrator makes a payment under Section 1551.228, 1551.229, 1551.230, or 1551.231, as applicable.

Added by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. [1264](#)), Sec. 1.11, eff. September 1, 2019.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 981 (S.B. [2476](#)), Sec. 9(a), eff. September 1, 2023.

Acts 2023, 88th Leg., R.S., Ch. 981 (S.B. [2476](#)), Sec. 9(b), eff.

September 1, 2025.

Text of section effective on September 1, 2025

Sec. 1551.015. BALANCE BILLING PROHIBITION NOTICE. (a) The administrator of a managed care plan provided under the group benefits program shall provide written notice in accordance with this section in an explanation of benefits provided to the participant and the physician or health care provider in connection with a health care or medical service or supply provided by an out-of-network provider. The notice must include:

(1) a statement of the billing prohibition under Section 1551.228, 1551.229, or 1551.230, as applicable;

(2) the total amount the physician or provider may bill the participant under the participant's managed care plan and an itemization of copayments, coinsurance, deductibles, and other amounts included in that total; and

(3) for an explanation of benefits provided to the physician or provider, information required by commissioner rule advising the physician or provider of the availability of mediation or arbitration, as applicable, under Chapter 1467.

(b) The administrator shall provide the explanation of benefits with the notice required by this section to a physician or health care provider not later than the date the administrator makes a payment under Section 1551.228, 1551.229, or 1551.230, as applicable.

Added by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. [1264](#)), Sec. 1.11, eff. September 1, 2019.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 981 (S.B. [2476](#)), Sec. 9(a), eff. September 1, 2023.

Acts 2023, 88th Leg., R.S., Ch. 981 (S.B. [2476](#)), Sec. 9(b), eff. September 1, 2025.

SUBCHAPTER B. ADMINISTRATION AND IMPLEMENTATION

Sec. 1551.051. ADMINISTRATION AND IMPLEMENTATION. The administration and implementation of this chapter are vested solely in the board of trustees.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.052. AUTHORITY FOR RULES, PLANS, PROCEDURES, AND ORDERS. (a) The board of trustees may adopt rules consistent with this chapter as it considers necessary to implement this chapter and its purposes, including rules that provide standards for determining eligibility for participation in the group benefits program, including standards for determining disability.

(b) The board of trustees may adopt a plan, procedure, or order reasonably necessary to implement this chapter and its purposes.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.053. AUTHORITY TO HIRE EMPLOYEES. (a) The board of trustees may hire employees as the board considers necessary to ensure the proper administration of this chapter and the coverages, services, and benefits provided for or authorized by this chapter.

(b) The board of trustees shall determine and assign the compensation and duties of the employees.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.055. GENERAL POWERS OF BOARD OF TRUSTEES REGARDING COVERAGE PLANS. The board of trustees may:

(1) prepare specifications for a coverage provided under this chapter;

(2) prescribe the time and conditions under which an employee, annuitant, or dependent is eligible for a coverage provided under this chapter;

(3) determine the methods and procedures of claims administration;

(4) determine the amount of payroll deductions and reductions applicable to employees and annuitants and establish procedures to implement those deductions and reductions;

(5) establish procedures for the board of trustees to decide contested cases arising from a coverage provided under this chapter;

(6) study, on an ongoing basis, the operation of all

coverages provided under this chapter, including gross and net costs, administration costs, benefits, utilization of benefits, and claims administration;

(7) administer the employees life, accident, and health insurance and benefits fund;

(8) provide the beginning and ending dates of coverages of participants under all benefit plans;

(9) develop basic group coverage plans applicable to all individuals eligible to participate in the group benefits program under Sections 1551.101 and 1551.102;

(10) provide for optional group coverage plans in addition to the basic group coverage plans;

(11) provide, as the board of trustees determines is appropriate, either additional statewide optional coverage plans or individual agency coverage plans;

(12) develop health benefit plans that permit access to high-quality, cost-effective health care;

(13) design, implement, and monitor health benefit plan features intended to discourage excessive utilization, promote efficiency, and contain costs;

(14) develop and refine, on an ongoing basis, a health benefit strategy consistent with evolving benefit delivery systems;

(15) develop a funding strategy that efficiently uses employer contributions to achieve the purposes of this chapter and that is reasonable and ensures participants a fair choice among health benefit plans as provided by Section 1551.302; and

(16) appoint an advisory committee for the group benefits program under the terms provided by Section 815.509, Government Code.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.406(a), eff. Sept. 1, 2003.

Sec. 1551.056. INDEPENDENT ADMINISTRATOR. (a) The board of trustees may, on a competitive bid basis, contract with an entity to act for the board as an independent administrator or manager of the coverages, services, and benefits authorized under this chapter.

(b) The entity must be a qualified, experienced firm of group insurance specialists or an administering firm and shall assist the

board of trustees in ensuring the proper administration of this chapter and the coverages, services, and benefits provided for or authorized by this chapter.

(c) The board of trustees shall pay an independent administrator selected under this section.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.057. COMPENSATION OF PERSON EMPLOYED BY BOARD OF TRUSTEES. The board of trustees shall pay the compensation and expenses of a person employed by the board at the rate or in the amount approved by the board. The rate or amount may not exceed the rate or amount paid for similar services.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.058. ELECTRONIC AUTHORIZATIONS. (a) The board of trustees may develop a system for a participant to electronically authorize:

- (1) enrollment in a coverage or benefit;
- (2) contributions to a coverage or benefit; and
- (3) deductions or reductions to the participant's

compensation or annuity for participation in a coverage or benefit.

(b) Notwithstanding any other law, the board of trustees may permit or require an authorization covered by Subsection (a) to be made electronically.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.059. CERTIFICATE OF COVERAGE. The board of trustees shall provide for issuance to each employee or annuitant participating in the group benefits program a certificate of coverage that states:

- (1) the benefits to which the participant is entitled;
- (2) to whom the benefits are payable;
- (3) to whom a claim must be submitted; and
- (4) the provisions of the plan document, in summary form,

that principally affect the participant.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.060. IDENTIFICATION CARDS. (a) The board of trustees may issue a single identification card to a participant in a health benefit plan and separately administered coverage under this chapter that offers pharmacy benefits.

(b) The card may contain information regarding both health and pharmacy benefits.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.061. ANNUAL REPORT. The board of trustees shall submit a written report not later than February 1 of each year to the governor, lieutenant governor, speaker of the house of representatives, and Legislative Budget Board concerning the coverages provided and the benefits and services being received by all participants under this chapter. The report must include:

- (1) information about the effectiveness and efficiency of:
 - (A) managed care cost containment practices; and
 - (B) fraud detection and prevention procedures;
- (2) basic information about each group coverage plan provided under this chapter, including the number of participants in each plan and the claims amounts and administrative expenses incurred under each plan;
- (3) a summary of recent changes to the benefits provided under this chapter that highlights any key benefits the board of trustees evaluated but did not implement;
- (4) a discussion of trends in claims under group coverage plans as well as other areas of interest identified by the board of trustees;
- (5) recommendations for any statutory changes the board of trustees determines necessary to achieve its goals for the group benefits program; and
- (6) any other information the board of trustees determines appropriate.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 530 (S.B. 301), Sec. 10, eff.

September 1, 2017.

Sec. 1551.062. INFORMATION ON OPERATION AND ADMINISTRATION OF CHAPTER. (a) The board of trustees shall:

(1) conduct a continuing study of the operation and administration of this chapter, including:

(A) conducting surveys and preparing reports on group coverages and benefits available to participants; and

(B) studying experience relating to group coverages and benefits available to participants; and

(2) maintain statistics on the number, type, and disposition of fraudulent claims for benefits under this chapter.

(b) A contract entered into under this chapter must require a carrier to:

(1) furnish any reasonable report the board of trustees determines is necessary to enable the board to perform its functions under this chapter; and

(2) permit the board and a representative of the state auditor to examine records of the carrier as necessary to accomplish the purposes of this chapter.

(c) Each state agency shall keep records, make certifications, and furnish the board of trustees with information and reports necessary to enable the board to perform its functions under this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.063. CONFIDENTIALITY OF CERTAIN RECORDS. (a) The records of a participant in the group benefits program in the custody of the Employees Retirement System of Texas, or of an administering firm, carrier, or another governmental entity acting on behalf of the retirement system, are confidential and not subject to disclosure, and the retirement system, administering firm, carrier, or governmental entity is not required to accept or comply with a request for a record or information about a record or to seek an opinion from the attorney general, because the records are exempt from the provisions of Chapter 552, Government Code, except as provided by this section.

(b) The records may be released to a participant or to an authorized attorney, family member, or representative acting on behalf of the participant.

(c) To accomplish the purposes of this chapter, the board of trustees may release the records to:

- (1) an administering firm, carrier, agent, or attorney acting on behalf of the board;
- (2) another governmental entity having a legitimate need for the information to perform a function of the board of trustees;
- (3) an authorized medical provider of the participant; or
- (4) a party in response to a subpoena issued under applicable law.

(d) The records of a participant remain confidential after release to a person as authorized by this section.

(d-1) A record released or received by the Employees Retirement System of Texas under this section may be transmitted electronically, including through the use of an electronic signature or certification in a form acceptable to the retirement system. An unintentional disclosure to, or unauthorized access by, a third party related to the transmission or receipt of information under this section is not a violation by the retirement system of any law, including a law or rule relating to the protection of confidential information.

(e) The records of a participant may become part of the public record of an administrative or judicial proceeding related to a contested case under this chapter unless the records are closed to public access by a protective order issued under applicable law. If a participant's records have become part of the public record of a proceeding and the records are not the subject of a protective order, the participant is considered to have waived the privacy of the participant's records.

(f) The Employees Retirement System of Texas has sole discretion in determining if a record is subject to this section. For purposes of this section, a record includes any identifying information about a person, living or deceased, who is or was an employee, annuitant, dependent, or participant in the group benefits program.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1111, Sec. 33, eff. Sept. 1, 2003; Acts 2003, 78th Leg., ch. 1276, Sec. 10A.404(a), eff. Sept. 1,

2003.

Amended by:

Acts 2005, 79th Leg., Ch. 347 (S.B. 1176), Sec. 25, eff. September 1, 2005.

Acts 2009, 81st Leg., R.S., Ch. 1308 (H.B. 2559), Sec. 33, eff. September 1, 2009.

Sec. 1551.064. CERTAIN GROUP HEALTH AND ACCIDENT POLICIES OR CONTRACTS. (a) This section applies only to a group policy or contract described by Section 1251.301. A policy or contract executed under this chapter must provide that:

(1) premium payments must be:

(A) paid directly to the Employees Retirement System of Texas; and

(B) postmarked or received not later than the 10th day of the month for which the premium is due;

(2) the premium for group continuation coverage under Subchapter G, Chapter 1251, may not exceed the level established for other surviving dependents of deceased employees and annuitants;

(3) at the time the group policy or contract is delivered, issued for delivery, renewed, amended, or extended, the Employees Retirement System of Texas shall give notice of the continuation option to each state agency covered by the group benefits program; and

(4) each state agency shall give written notice of the continuation option to each employee and dependent of an employee who is covered by the group benefits program.

(b) A group policy or contract executed under this chapter must provide that, not later than the 15th day after the date of any severance of the family relationship that might activate the continuation option under Subchapter G, Chapter 1251, the group member shall give written notice of the severance to the employing state agency.

(c) On receipt of notice under Subsection (b) or on the death of an employee, the employing state agency shall give written notice of the continuation option to each affected dependent. The notice must state the amount of the premium to be charged and must be accompanied by any necessary enrollment forms.

(d) A covered dependent must exercise the continuation option

not later than the 45th day after the date of:

- (1) the severance of the family relationship; or
- (2) the retirement or death of the group member.

(e) A covered dependent must provide written notice of the exercise of the continuation option to the employing state agency within the time prescribed by Subsection (d). Coverage under the policy or contract remains in effect during the period prescribed by Subsection (d) if the premiums are paid.

(f) Any period of previous coverage under the policy or contract must be used in full or partial satisfaction of any required probationary or waiting periods provided in the policy or contract for dependent coverage.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2G.019, eff. April 1, 2009.

Sec. 1551.065. DISCLOSURE OF SOCIAL SECURITY NUMBER. The board of trustees may require an individual to disclose the individual's social security number as the board considers necessary to properly administer this chapter and any coverage, service, or benefit authorized by this chapter or as otherwise required by state or federal law.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.404(b), eff. Sept. 1, 2003.

Sec. 1551.066. INFORMATION RELATING TO MISCONDUCT. (a) This section applies to:

- (1) the Employees Retirement System of Texas;
- (2) a carrier or other insurance company or health maintenance organization;
- (3) an administering firm or other insurance support organization that provides information or services to the group benefits program or the Employees Retirement System of Texas;
- (4) an agent or third-party administrator authorized under this chapter or licensed under this code;
- (5) a regulatory authority or department; and

(6) a board member, executive director, employee, auditor, or actuary of an entity described by this section.

(b) A person may collect from, furnish to, or exchange with another person information, including medical records or other confidential information, to the extent the person considers necessary to detect or to impose a sanction for a criminal act, a misrepresentation, or nondisclosure that is related to an attempt to obtain coverage, payment, reimbursement, or a benefit under this chapter.

(c) A person who acts under Subsection (b) is immune from suit and criminal or civil liability unless the person acts with malice or intent to defraud.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.405(a), eff. Sept. 1, 2003.

Sec. 1551.067. PHARMACY BENEFIT MANAGER CONTRACTS. (a) In awarding a contract to provide pharmacy benefit manager services under this chapter, the board of trustees is not required to select the lowest bid but must select a contract that meets the criteria established by this section.

(b) The contract must state that:

(1) the board of trustees is entitled to audit the pharmacy benefit manager to verify costs and discounts associated with drug claims, pharmacy benefit manager compliance with contract requirements, and services provided by subcontractors;

(2) the audit must be conducted by an independent auditor in accordance with established auditing standards; and

(3) to conduct the audit, the board of trustees and the independent auditor are entitled access to information related to the services and the costs associated with the services performed under the contract, including access to the pharmacy benefit manager's facilities, records, contracts, medical records, and agreements with subcontractors.

(c) The contract must define the information that the pharmacy benefit manager is required to provide to the board of trustees concerning the audit of the retail, independent, and mail order pharmacies performing services under the contract and describe how the results of these audits must be reported to the board of

trustees, including how often the results must be reported. The contract must state whether the pharmacy benefit manager is required to return recovered overpayments to the board of trustees.

(d) The contract must state that any audit of a mail order pharmacy owned by the pharmacy benefit manager must be conducted by an independent auditor selected by the board of trustees in accordance with established auditing standards.

Added by Acts 2009, 81st Leg., R.S., Ch. 1207 (S.B. 704), Sec. 3, eff. September 1, 2009.

Sec. 1551.068. QUALIFICATION OF GROUP BENEFITS PROGRAM.

Notwithstanding any provision of this chapter or any other law, it is intended that the provisions of this chapter be construed and administered in a manner that coverages under the group benefits program will be considered in compliance with applicable federal law. The board of trustees may adopt rules that modify the coverage provided under the program by adding, deleting, or changing a provision of the program, including rules that modify eligibility and enrollment requirements and the benefits available under the program.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1249 (S.B. 1664), Sec. 18, eff. September 1, 2011.

SUBCHAPTER C. COVERAGE AND PARTICIPATION

Sec. 1551.101. PARTICIPATION ELIGIBILITY: STATE OFFICERS AND EMPLOYEES. (a) An elected or appointed officer or employee who performs service, other than as an independent contractor, for this state, including an institution of higher education, and who is described by this section is eligible to participate in the group benefits program as an employee on the date specified by Section 1551.1055.

(b) An individual is eligible to participate in the group benefits program as provided by Subsection (a) if the individual receives compensation for service performed for this state pursuant to a payroll certified by a state agency, other than an institution of higher education, or by an elected or appointed officer of this state, including a payment made from:

(1) an amount appropriated by the legislature from a state

fund;

(2) a trust fund held by the comptroller; or

(3) money paid under the official budget of a state agency, other than money appropriated under a general appropriations act.

(c), (d) Repealed by Acts 2003, 78th Leg., ch. 366, Sec. 2.14.

(e) An individual is eligible to participate in the group benefits program as provided by Subsection (a) if the individual receives compensation for service performed for an institution of higher education pursuant to a payroll certified by an institution of higher education or by an elected or appointed officer of this state and either:

(1) is eligible to become a member of the Teacher Retirement System of Texas after any waiting period provided by law before membership in that retirement system; or

(2) is employed at least 20 hours a week and is not permitted to be a member of the Teacher Retirement System of Texas because the individual is employed by an institution of higher education only in a position that as a condition of employment requires the individual to be enrolled as a student in the institution in graduate-level courses.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Amended by Acts 2003, 78th Leg., ch. 366, Sec. 2.03, 2.14, eff. Sept. 1, 2003.

Amended by:

Acts 2005, 79th Leg., Ch. 347 (S.B. [1176](#)), Sec. 26, eff. September 1, 2005.

Sec. 1551.102. PARTICIPATION ELIGIBILITY: ANNUITANTS. (a) An individual who has at least 10 years of service credit, as determined by the board of trustees, for which the individual was eligible to participate in the group benefits program under Section 1551.101 or who has at least five years of membership and five years of military service credited in the Employees Retirement System of Texas and who retires in a manner described by this section is eligible, subject to Section 1551.1055, to participate as an annuitant in the group benefits program.

(b) An individual is eligible to participate in the group benefits program as provided by Subsection (a) if:

(1) the individual retires under the jurisdiction of the Employees Retirement System of Texas; and

(2) the individual:

(A) receives or is eligible to receive an annuity under Section 814.104(a)(2), Government Code, and has at least 10 years of eligible service credit;

(B) receives or is eligible to receive an annuity under Chapter 803 or Section 814.104(a)(1), Government Code, has at least 10 years of eligible service credit, and is at least 65 years of age;

(C) receives or is eligible to receive an annuity that is based on eligibility under Section 814.002, 814.102, 814.104(b), 814.107(a), 834.101, or 839.101 or Subchapter B, Chapter 840A, Government Code; or

(D) receives or is eligible to receive an annuity under Subchapter B, Chapter 820, Government Code, and has at least 10 years of eligible service credit.

(c) An individual is eligible to participate in the group benefits program as provided by Subsection (a) if:

(1) the individual retires under the jurisdiction of the Teacher Retirement System of Texas and has at least 10 years of eligible service credit, including not more than five years of military service credited in the Employees Retirement System of Texas, or has five years of eligible service credit and is the sole surviving spouse of military personnel who was killed in action;

(2) the individual:

(A) has accumulated eligible service credit in an amount so that the sum of the person's age and amount of service credit, including months of age and credit, equals or exceeds the number 80; or

(B) is at least 65 years of age; and

(3) the individual was employed, as the last state employment before retirement, including employment by a public junior college, by a state agency whose employees are authorized to participate in the group benefits program.

(c-1) An individual is eligible to participate in the group benefits program as provided by Subsection (a) if:

(1) the individual meets the minimum requirements under Subsection (c) except that the individual does not have at least 10 years of eligible service credit as described by Subsection (c)(1);

(2) the individual has at least 10 years of combined

service in a position for which the individual was eligible to participate in the group benefits program or in the uniform program under Section 1601.101; and

(3) either:

(A) the individual's greatest number of years of state employment was in a position for which the individual was eligible to participate in the group benefits program; or

(B) if the individual's years of employment in positions eligible to participate in the group benefits program and the uniform program are equal, the individual's last state employment before retirement was in a position for which the individual was eligible to participate in the group benefits program.

(c-2) An individual is eligible to participate in the group benefits program as provided by Subsection (a) if the individual:

(1) was employed for at least 10 years by a school district established as specified by Section 19.002, Education Code, as the individual's last position of employment before retirement;

(2) has at least:

(A) 10 years of eligible service credit, including not more than five years of military service credited in the Employees Retirement System of Texas; or

(B) five years of eligible service credit and is the sole surviving spouse of military personnel who was killed in action; and

(3) retires under the jurisdiction of the Teacher Retirement System of Texas and:

(A) has accumulated membership service credit as provided by Section 823.201(a), Government Code, in an amount so that the sum of the person's age and amount of membership service credit, including months of age and credit, equals or exceeds the number 80; or

(B) is at least 65 years of age.

(d) An individual is eligible to participate in the group benefits program as provided by Subsection (a) if:

(1) the individual retires under the optional retirement program established by Chapter 830, Government Code;

(2) the individual has at least 10 years of eligible service credit; and

(3) the individual:

(A) is at least 65 years of age, or would have been

eligible to retire and receive a service or disability retirement annuity from the Teacher Retirement System of Texas or the Employees Retirement System of Texas in an amount such that the sum of the person's age and amount of service credit, including months of age and credit, equals or exceeds the number 80 or would have been eligible to retire and receive a disability retirement annuity from the Teacher Retirement System of Texas or the Employees Retirement System of Texas, if the individual had not elected to participate in the optional retirement program, and is eligible to receive an annuity or periodic distribution of funds from an account under the optional retirement program; or

(B) is disabled as determined by the Employees Retirement System of Texas based on at least 10 years of eligible service credit, and is receiving an annuity or periodic distribution of funds from an account under the optional retirement program.

(e) An individual is eligible to participate in the group benefits program as provided by Subsection (a) if the individual retired under Subtitle C, Title 8, Government Code, before September 1, 1991, with at least five and less than 10 years of service credit.

(f) An individual is eligible to participate in the group benefits program if the individual is certified and qualified as disabled and receives or is eligible to receive an annuity under Section 814.202, 814.207, 824.302, only as to higher education, or 839.201, Government Code.

(g) An individual is eligible to participate in the group benefits program as provided by Subsection (a) if the individual is at least 65 years of age and retires under a federal or state statutory retirement program not described by another provision of this section, to which an institution of higher education has made employer contributions, and the individual has met service requirements, age requirements, and other applicable requirements comparable to the requirements for retirement under the Teacher Retirement System of Texas, based on at least 10 years of service credit.

(h) A person eligible to participate and participating in the group benefits program as an annuitant on September 1, 2003, may continue to participate in the program as an annuitant if a lapse in coverage has not occurred.

(i) Subject to Section 1551.323, an individual and the individual's dependents are eligible to participate in the group

benefits program as an annuitant and the dependents of an annuitant if the individual:

(1) served in a position for which the individual was eligible to participate in the group benefits program under Section 1551.101 on or before August 31, 2003; and

(2) at the time of retirement meets the requirements for eligibility for participation in the program as an annuitant as those requirements existed on August 31, 2003.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 366, Sec. 2.04, 2.05, eff. Sept. 1, 2003; Acts 2003, 78th Leg., ch. 1111, Sec. 34, eff. Sept. 1, 2003; Acts 2003, 78th Leg., ch. 1276, Sec. 10A.401(b), eff. Sept. 1, 2003; Acts 2003, 78th Leg., 3rd C.S., ch. 3, Sec. 16.01, eff. Jan. 11, 2004.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1308 (H.B. [2559](#)), Sec. 34, eff. September 1, 2009.

Acts 2017, 85th Leg., R.S., Ch. 1106 (H.B. [4035](#)), Sec. 2, eff. June 15, 2017.

Acts 2019, 86th Leg., R.S., Ch. 1121 (H.B. [2384](#)), Sec. 33, eff. September 1, 2019.

Acts 2021, 87th Leg., R.S., Ch. 940 (S.B. [321](#)), Sec. 22, eff. September 1, 2021.

Acts 2023, 88th Leg., R.S., Ch. 748 (H.B. [3813](#)), Sec. 1, eff. September 1, 2023.

Acts 2023, 88th Leg., R.S., Ch. 1092 (S.B. [1245](#)), Sec. 17, eff. June 18, 2023.

Sec. 1551.1021. PARTICIPATION ELIGIBILITY: CERTAIN FACULTY OF INSTITUTIONS OF HIGHER EDUCATION. (a) An adjunct faculty member at a public institution of higher education is eligible to participate in the group benefits program as an employee if the faculty member:

(1) receives compensation for services rendered to a public institution of higher education as an adjunct faculty member;

(2) was employed as a faculty member by the same public institution of higher education and taught at least one course in the regular fall and spring semester at the public institution of higher education in the preceding academic year; and

(3) is under contract or is scheduled to teach at least 12 semester credit hours in the academic year of coverage or, if the person is also employed by the public institution of higher education to perform nonteaching duties, is under contract or is scheduled to teach at least six semester credit hours in the academic year of coverage and has been approved by the public institution of higher education to participate in the group benefits program.

(a-1) Notwithstanding Subsection (a)(3), an adjunct faculty member at a public institution of higher education who is a professional librarian is eligible to participate in the group benefits program as an employee if the faculty member receives compensation for services rendered to a public institution of higher education as an adjunct faculty member.

(b) From money appropriated from a fund other than the general revenue fund or from money available from local sources, a public institution of higher education may, for an adjunct faculty member eligible to receive benefits under this section, contribute:

(1) not more than 50 percent of the cost of basic coverage for the employee; and

(2) not more than 25 percent of the cost of dependent coverage.

(c) Subsection (b) does not prohibit a public institution of higher education from contributing, from money other than money appropriated from the general revenue fund, amounts that exceed the amount specified in Subsection (b) to provide coverage for a person employed by a public institution of higher education who meets the criteria for eligibility under Subsection (a).

Added by Acts 2003, 78th Leg., ch. 366, Sec. 4.04, eff. Sept. 1, 2003.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 343 (H.B. [2127](#)), Sec. 1, eff. September 1, 2013.

Sec. 1551.1022. PARTICIPATION ELIGIBILITY: CERTAIN POSTDOCTORAL FELLOWS AND GRADUATE STUDENTS. (a) An individual who is not eligible to participate in the group benefits program under Section 1551.101 is eligible to participate in the group benefits program under this section if the individual, at an institution of

higher education:

(1) holds:

(A) a postdoctoral fellowship; or

(B) one or more graduate student fellowships awarded to the individual on a competitive basis that, either singly or in combination, are valued at not less than \$10,000 per year; and

(2) is currently receiving a stipend from an applicable fellowship.

(b) An individual who is eligible to participate in the group benefits program under this section shall pay all contributions required under this chapter for the coverage selected by the individual, except that an institution of higher education may make contributions for the individual from available funds other than money appropriated to the institution from the general revenue fund.

(c) An institution of higher education shall determine which individuals are eligible to participate in the group benefits program under this section and, at the time of initial eligibility, shall notify each individual of the individual's eligibility to participate in the program.

(d) An individual who participates in the group benefits program under this section is not considered an employee of an institution of higher education solely as a result of the individual's participation in the program.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1198 (S.B. 29), Sec. 1, eff. September 1, 2011.

Sec. 1551.103. RIGHT TO COVERAGE. Subject to Section 1551.351, an individual eligible to participate in the group benefits program under Section 1551.101 or 1551.102 may not be denied any group coverage under this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.104. AUTOMATIC COVERAGE. (a) Subject to Sections 1551.101 and 1551.102, each full-time employee is covered automatically by the basic coverage plan for employees and each annuitant is covered by the basic coverage plan for annuitants unless:

(1) participation is specifically waived as provided by Section 1551.1045;

(2) the employee or annuitant is expelled from the program under Section 1551.351; or

(3) eligibility is otherwise limited by this chapter.

(b) This section does not apply to an employee described by Section 1551.101(e)(2).

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 366, Sec. 2.06, eff. Sept. 1, 2003.

Amended by:

Acts 2005, 79th Leg., Ch. 899 (S.B. 1863), Sec. 4.01, eff. August 29, 2005.

Sec. 1551.1045. WAIVER. (a) Subject to Subsections (b) and (c), an employee or annuitant may waive in writing any coverage provided under this chapter.

(b) To waive coverage under the basic coverage plan for employees, a full-time employee must demonstrate, in the manner required by the board of trustees, that the employee is:

(1) covered by another health benefit plan that provides substantially equivalent coverage, as determined by the board of trustees, to the coverage provided to employees by the basic coverage plan; or

(2) eligible for benefits under the TRICARE Military Health System.

(c) To waive coverage under the basic coverage plan for annuitants for the purpose of eligibility for an incentive payment under Section 1551.222, an annuitant must demonstrate, in the manner required by the board of trustees, that the annuitant is:

(1) covered by another health benefit plan that provides substantially equivalent coverage, as determined by the board of trustees, to the coverage provided to annuitants by the basic coverage plan; or

(2) eligible for benefits under the TRICARE Military Health System.

Added by Acts 2005, 79th Leg., Ch. 899 (S.B. 1863), Sec. 4.02, eff. August 29, 2005.

Sec. 1551.105. DATE AUTOMATIC COVERAGE BEGINS. Automatic coverage under this subchapter begins on the date an employee or annuitant becomes eligible for coverage.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.1055. DATE ELIGIBILITY BEGINS; WAITING PERIOD. (a) Except as provided by Subsection (c), (d), or (e), eligibility under Section 1551.101 begins not later than the 90th day after the date the employee performs services for a state agency or is qualified for and begins to hold elected or appointed office.

(b) Except as provided by Subsection (c), eligibility under Section 1551.102, for an individual who does not retire at the end of the last month for which the individual is on the payroll of a state agency before retirement, begins not later than the 90th day after the date the individual retires.

(c) The waiting period established by Subsections (a) and (b) applies only to the determination of initial eligibility to participate in the group benefits program and does not apply to the determination of initial eligibility to participate in optional and voluntary insurance coverages under the group benefits program.

(d) This subsection applies only to an employee of an institution of higher education or a dependent of the employee. Notwithstanding Subsection (a), eligibility under Section 1551.101 may not begin earlier than the first day that an employee performs services for an institution of higher education if any amount paid for premium incurred before the date specified under Subsection (a) for the employee and any dependents of the employee is paid from money not appropriated from the general revenue fund, in accordance with policies and procedures established by the governing body of the institution of higher education.

(e) Eligibility under Section 1551.101 for an employee reemployed under Chapter 613, Government Code, begins on the first day of reemployment on which the employee performs services for a state agency.

Added by Acts 2003, 78th Leg., ch. 366, Sec. 2.07, eff. Sept. 1, 2003.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 618 (S.B. 1459), Sec. 23, eff. September 1, 2014.

Acts 2015, 84th Leg., R.S., Ch. 150 (H.B. 437), Sec. 1, eff. September 1, 2015.

Sec. 1551.106. GROUP COVERAGE PLAN PURCHASED TO PROVIDE FOR AUTOMATIC COVERAGE. A group coverage plan purchased by the board of trustees must provide for the automatic coverage described by this subchapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.107. CONTINGENT COVERAGE. (a) Each part-time employee or employee eligible to participate in the group benefits program under Section 1551.101(e)(2) may participate in the program on execution of an appropriate application for coverage unless the employee is:

- (1) ineligible for the group benefits program under Section 1551.110; or
- (2) expelled from the group benefits program under Section 1551.351.

(b) An institution of higher education shall, at the time of employment, notify each of the institution's employees eligible to participate in the group benefits program under Section 1551.101(e)(2) of the employee's eligibility to participate.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.108. CONTINUING ELIGIBILITY OF CERTAIN PERSONS WITH LEGISLATIVE SERVICE OR EMPLOYMENT. Subject to Section 1551.351, on application to the board of trustees and on arrangement for payment of contributions and postage:

- (1) an individual who has at least eight years of service credit in the Employees Retirement System of Texas for service as a member of the legislature, on ending the individual's service in the legislature, remains eligible for participation in the group benefits program; and

(2) an individual who has at least 10 years of service credit in the Employees Retirement System of Texas as an employee of the legislature, on ending the individual's service for the legislature, remains eligible for participation in the group benefits program.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.109. CONTINUING ELIGIBILITY OF CERTAIN MEMBERS OF BOARDS, COMMISSIONS, AND INSTITUTIONS OF HIGHER EDUCATION. (a) Subject to Section 1551.351, on application to the board of trustees and arrangement for payment of contributions, an individual participating in the group benefits program on August 31, 2003, as a current or former member of a governing body with administrative responsibility over a state agency created under a statute of this state that has statewide jurisdiction and whose employees are covered by this chapter or as a current or former member of the State Board of Education or the governing body of an institution of higher education remains eligible for participation in a health benefit plan offered under this chapter if a lapse in coverage has not occurred.

(b) A participant described by this section may not receive a state contribution for premiums. The governing body of an institution of higher education may pay from local funds part or all of the contributions the state would pay for similar coverage of other participants in the group benefits program.

(c) The participant's contribution for coverage under a health benefit plan may not be greater than the contribution for continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (Pub. L. No. 99-272).

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 366, Sec. 2.09, eff. Sept. 1, 2003.

Sec. 1551.110. INELIGIBILITY OF CERTAIN JUNIOR COLLEGE EMPLOYEES. (a) Except as provided by Subsections (c) and (d), an employee of a public junior college who is employed to perform services outside this state is not eligible to participate in the group benefits program unless the college elects, under procedures

adopted by the board of trustees, to permit the employee to participate in the group benefits program.

(b) For purposes of this section, an employee is employed to perform services outside this state if 75 percent or more of the services performed by the employee are performed outside this state.

(c) This section does not apply to an individual employed by a public junior college on August 31, 1999. That individual remains eligible to participate in the group benefits program in the same manner as other employees of the college even if the individual's employment by the college is not continuous.

(d) An employee of a public junior college who is employed to perform services outside this state and who is employed after June 18, 1999, is eligible to participate in a group coverage provided under this chapter if the coverage is provided under an insurance policy, contract, or other agreement that:

(1) is in effect on June 18, 1999; and

(2) requires that the employee be eligible to participate in the coverage provided under the agreement.

(e) Eligibility to participate in a coverage under Subsection (d) ends on the date the insurance policy, contract, or other agreement is terminated or renewed.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.111. PARTICIPATION BY CERTAIN RETIREMENT SYSTEMS.

(a) The Texas Municipal Retirement System and the Texas County and District Retirement System shall participate in the group benefits program in the manner described by this section.

(b) Participation is limited to:

(1) an officer or employee of either system who has been an officer or employee of either system following completion of the waiting period described by Section 1551.1055;

(2) an eligible dependent of an officer or employee of either system described by Subdivision (1);

(3) an individual who:

(A) was an officer or employee of either system;

(B) has retired from either system, subject to Section 1551.1055;

(C) receives or is eligible to receive an annuity from

either system or under Chapter 803, Government Code, based on at least 10 years of service credit and is at least 65 years of age; and

(D) has at least 10 years of service credit with a state agency whose employees are authorized to participate in the group benefits program; and

(4) an eligible dependent of a retired officer or employee described by Subdivision (3).

(c) Except as provided by Section 1551.114, participation in the group benefits program does not extend to:

(1) the governing body of either system;

(2) a municipality or subdivision participating in either system; or

(3) a trustee, officer, or employee, or a dependent of a trustee, officer, or employee, of a participating municipality or subdivision.

(d) A participant described by this section may not receive a state contribution for premiums.

(e) Subject to Section 1551.323, an individual and the individual's dependents are eligible to participate in the group benefits program as an annuitant and the dependents of an annuitant as described under this section if the individual:

(1) served as an officer or employee as described by Subsection (b)(1) on or before August 31, 2003; and

(2) at the time of retirement meets the requirements for eligibility for participation in the program as an annuitant as those requirements existed on August 31, 2003.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 366, Sec. 2.10, eff. Sept. 1, 2003; Acts 2003, 78th Leg., ch. 1030, Sec. 1.02, eff. Sept. 1, 2003; Acts 2003, 78th Leg., 3rd C.S., ch. 3, Sec. 16.02, eff. Jan. 11, 2004.

Sec. 1551.112. PARTICIPATION BY TEXAS TURNPIKE AUTHORITY. (a) An individual may participate in the group benefits program as an annuitant, subject to Section 1551.1055, and may obtain coverage for the individual's dependents as any other participating annuitant if the individual:

(1) began employment with, or became an officer of, the Texas Turnpike Authority within the three-year period preceding August 31, 1997;

(2) was an officer or employee of the Texas Turnpike Authority on August 31, 1997;

(3) became an officer or employee of the North Texas Tollway Authority on September 1, 1997; and

(4) retires or is eligible to retire with at least 10 years of service credit under the proportionate retirement program established by Chapter 803, Government Code, or under a public retirement system to which Chapter 803 applies and is at least 65 years of age.

(b) The North Texas Tollway Authority is responsible for payment of the contributions the state would make if the annuitant were a state employee.

(c) Subject to Section 1551.323, an individual and the individual's dependents are eligible to participate in the group benefits program as an annuitant and the dependents of an annuitant as described under this section if the individual:

(1) served in a position described by Subsection (a) on or before August 31, 2003; and

(2) at the time of retirement meets the requirements for eligibility for participation in the program as an annuitant as those requirements existed on August 31, 2003.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003. Amended by Acts 2003, 78th Leg., ch. 366, Sec. 2.11, eff. Sept. 1, 2003; Acts 2003, 78th Leg., 3rd C.S., ch. 3, Sec. 16.03, eff. Jan. 11, 2004.

Sec. 1551.113. PARTICIPATION BY CERTAIN EMPLOYEES WHOSE POSITIONS ARE PRIVATIZED OR ELIMINATED. (a) An individual described by Subsection (b) is entitled to receive state contributions required to provide health benefit plan coverage under the group benefits program for two months after the effective date of the individual's separation from state service.

(b) This section applies only to an individual who separates from state service and receives a cash payment under an incentive program implemented by the Texas Department of Human Services or the

Texas Department of Health for certain employees whose positions are eliminated as a result of privatization or other reductions in services provided by those agencies.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.114. PARTICIPATION BY COMMUNITY SUPERVISION AND CORRECTIONS DEPARTMENTS. (a) In this section, "employee of a community supervision and corrections department" means an employee of a department established under Chapter 76, Government Code.

(b) An employee or retired employee of a community supervision and corrections department shall be treated as an employee or annuitant, as applicable, for purposes of this chapter only as provided by this section.

(c) A community supervision and corrections department of this state participates in the group benefits program administered by the board of trustees under this chapter. Participation under this section is limited to:

(1) active employees of a community supervision and corrections department;

(2) retired employees of a community supervision and corrections department who retire on or after September 1, 2004, and who:

(A) have been employed by one or more community supervision and corrections departments for a total of at least 10 years of creditable service; and

(B) meet all the requirements for retirement benefits prescribed by the Texas County and District Retirement System; and

(3) eligible dependents of the active employees and retired employees described by Subdivisions (1) and (2).

(d) Each full-time active employee of a community supervision and corrections department is automatically covered by the basic coverage for employees unless the employee specifically waives coverage or unless the employee is expelled from the program. Each part-time active employee of a community supervision and corrections department is eligible to participate in the group benefits program on application in the manner provided by the board of trustees, unless the employee has been expelled from the program. Each community supervision and corrections department shall notify each of

its part-time employees of the employee's eligibility for participation.

(e) The state is responsible for payment of the contributions for each of a department's participating active employees and the employees' dependents under Subchapter G.

(f) A retired employee is eligible to participate in the group benefits program on application to the board of trustees. On application, a retired employee is automatically covered by the basic coverage for annuitants unless the retired employee specifically waives coverage or unless the retired employee is expelled from the program. The state is responsible for payment of the contributions for each of a department's retired employees and the retired employees' participating dependents under Subchapter G. The retired employee shall pay contributions required from the retired employee in the manner prescribed by the board of trustees. Each community supervision and corrections department shall notify each of its retired employees of the eligibility for participation and the costs associated with participation.

(g) All contributions received under this section from the state, active employees of community supervision and corrections departments, and retired employees of community supervision and corrections departments for basic, optional, and voluntary coverages under the group benefits program shall be paid into the employees life, accident, and health insurance and benefits fund and shall be used by the board of trustees to provide those coverages as provided by this chapter.

Added by Acts 2003, 78th Leg., ch. 1030, Sec. 1.03, eff. Sept. 1, 2003.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 346 (H.B. [1526](#)), Sec. 2, eff. September 1, 2017.

Sec. 1551.115. PARTICIPATION BY WRONGFULLY IMPRISONED PERSONS. Subject to Section 103.001, Civil Practice and Remedies Code, a person who is entitled to compensation under Chapter 103, Civil Practice and Remedies Code, is eligible to obtain health benefit plan coverage under the group benefits program in the manner and to the extent that an employee of the Texas Department of Criminal Justice

would be entitled to coverage. The person's spouse and dependents may be included in the person's coverage as if the person were an employee of the Texas Department of Criminal Justice.

Added by Acts 2011, 82nd Leg., R.S., Ch. 698 (H.B. 417), Sec. 9, eff. June 17, 2011.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1107 (S.B. 1686), Sec. 4, eff. September 1, 2011.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 315 (H.B. 1455), Sec. 2, eff. September 1, 2023.

SUBCHAPTER D. COVERAGE FOR DEPENDENTS

Sec. 1551.151. ENTITLEMENT TO COVERAGE. An individual who is eligible to participate in the group benefits program under Section 1551.101, 1551.102, or 1551.1022 is entitled to secure for a dependent of the individual any group coverages provided under this chapter, as determined by the board of trustees and subject to the exceptions provided by this subchapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 1198 (S.B. 29), Sec. 2, eff. September 1, 2011.

Sec. 1551.152. ELIGIBILITY OF FOSTER CHILD. A foster child is eligible for health benefit plan coverage only if the child is not covered by another governmental health program.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.153. PARTICIPANT RESIDING OUTSIDE OF SERVICE AREA. An individual who is eligible to participate in the group benefits program under Section 1551.101 or 1551.102 and who resides outside of a health maintenance organization service area is entitled to group coverages for a dependent of the individual without evidence of insurability if the individual applies for the coverage for the dependent during the annual enrollment period.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.154. EMPLOYEE PAYMENTS. In the manner and form the board of trustees determines, payments required of an employee in excess of employer contributions shall be made by:

- (1) a deduction from the employee's monthly pay or retirement benefits; or
- (2) a reduction of the employee's salary.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.155. COVERAGE OPTIONS FOR SURVIVING SPOUSE. (a) A surviving spouse of an individual who is eligible to participate in the group benefits program under Section 1551.101 or 1551.102 and who is entitled to monthly benefits paid by a retirement system named in this chapter may, following the death of the individual, elect to retain:

- (1) the spouse's authorized coverages; and
 - (2) authorized coverages for any dependent of the spouse.
- (b) The coverage is at the group rate for other participants if:
- (1) the coverage was previously secured by the deceased participant for the surviving spouse or dependent; and
 - (2) the surviving spouse directs the applicable retirement system to deduct required contributions from the monthly benefits paid to the spouse by the retirement system.
- (c) A person who is the surviving spouse of an individual described by Subsection (a) may secure group health coverage without evidence of the person's insurability if the individual was eligible to participate in the group benefits program under Section 1551.101 or 1551.102 but was not participating at the time of the individual's death.
- (d) A surviving spouse seeking group coverage under Subsection (c):
- (1) must apply for the coverage not later than the 30th day after the date on which the individual who was eligible to participate in the group benefits program dies; and
 - (2) shall pay for the coverage at the group rate as

provided by Subsection (b).

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1308 (H.B. 2559), Sec. 35, eff. September 1, 2009.

Sec. 1551.156. COVERAGE OPTIONS FOR SURVIVING DEPENDENT. (a) A surviving dependent of an annuitant who was receiving monthly benefits paid by a retirement system named in this chapter may, following the death of the annuitant if there is not a surviving spouse, elect to retain any coverage previously secured by the annuitant until the dependent becomes ineligible for coverage for a reason other than the death of the member of the group.

(b) The coverage is at the group rate for other participants.

(c) A dependent who elects to retain coverage under this section and who is entitled to monthly benefits from a retirement system named in this chapter based on the service of the deceased annuitant must direct the retirement system to deduct required contributions for the coverage from the monthly benefits paid the surviving dependent by the retirement system.

(d) A person who is a surviving dependent of an annuitant may secure group health coverage after the death of the annuitant without evidence of the person's insurability if the annuitant was eligible to participate in the group benefits program of a retirement system named in this chapter but was not participating at the time of the individual's death.

(e) A surviving dependent seeking group coverage under Subsection (d):

(1) must apply for the coverage not later than the 30th day after the date on which the individual who was eligible to participate in the group benefits program dies; and

(2) shall pay for the coverage at the group rate as provided by Subsection (b).

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1308 (H.B. 2559), Sec. 36, eff. September 1, 2009.

Acts 2009, 81st Leg., R.S., Ch. 1308 (H.B. 2559), Sec. 37, eff.

September 1, 2009.

Sec. 1551.157. COVERAGE OPTIONS AFTER EXPIRATION OF ANNUITY OPTION. The surviving spouse or dependent of an employee or annuitant may retain authorized coverages after expiration of a time-certain annuity option selected by the employee or annuitant. To retain the coverages, the surviving spouse or dependent must make advance payment of contributions to the Employees Retirement System of Texas under rules adopted by the board of trustees.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.158. REINSTATEMENT OF HEALTH BENEFIT PLAN COVERAGE BY CERTAIN DEPENDENTS. (a) A dependent child who is unmarried and whose coverage under this chapter ends when the child becomes 26 years of age may, on expiration of continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (Pub. L. No. 99-272), reinstate health benefit plan coverage under this chapter if the child, or the child's participating parent, pays the full cost of the health benefit plan coverage.

(b) A state contribution is not payable for coverage under this section.

(c) Coverage under this section terminates at the end of the month in which the child marries.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 618 (S.B. [1459](#)), Sec. 24, eff. September 1, 2013.

SUBCHAPTER E. GROUP COVERAGES

Sec. 1551.201. ESTABLISHMENT. (a) The board of trustees by rule shall establish group coverage plans for individuals eligible to participate in the group benefits program.

(b) The group coverage plans may, in the board of trustees' discretion, include:

- (1) life coverage;
- (2) accidental death and dismemberment coverage;

- (3) health benefit coverage, including coverage for:
- (A) hospital care and benefits;
 - (B) surgical care and treatment;
 - (C) medical care and treatment;
 - (D) dental care;
 - (E) obstetrical benefits;
 - (F) prescribed drugs, medicines, and prosthetic devices; and
 - (G) supplemental benefits, supplies, and services in accordance with this chapter;
- (4) coverage providing protection against either long-term or short-term loss of salary; and
- (5) any other group coverage that the board of trustees, in consultation with the advisory committee, considers advisable.
- (c) The group coverage plans for annuitants may, at the discretion of the board of trustees, be separate or a part of the group coverage plans for employees. If the trustee establishes separate group coverage plans for annuitants, the separate group coverage plans must include both full benefits and supplemental coverage options.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.412(b), eff. Sept. 1, 2003.

Sec. 1551.2011. EMPLOYEE AWARENESS AND EDUCATION. (a) The board of trustees by rule shall ensure that employees receive information about life coverage, accidental death and dismemberment coverage, and long-term and short-term loss of salary coverage, if those coverages are included in a group coverage plan established under Section 1551.201.

- (b) The information must contain descriptions of:
- (1) probabilities of death and disability; and
 - (2) policy exclusions and limitations, including:
 - (A) limitations based on multiple sources of benefits;
 - (B) preexisting condition exclusions; and
 - (C) required waiting periods for benefits.

(c) The board of trustees by rule may provide the information described by Subsections (a) and (b) in printed materials for new

employees distributed on the first day of employment. The board of trustees may consider using printed materials, online presentations, and educational presentations to ensure the information described by Subsections (a) and (b) is provided to employees.

(d) If applicable, the board of trustees shall annually review the materials and presentations described by Subsection (c) to determine if changes to the contents of the materials or presentations are necessary. If applicable, the department shall adopt rules necessary for considering and making changes to the materials or presentations.

(e) The board of trustees shall publish the information described by Subsections (a) and (b) on the Employees Retirement System of Texas website.

Added by Acts 2013, 83rd Leg., R.S., Ch. 296 (H.B. 1265), Sec. 1, eff. June 14, 2013.

Sec. 1551.202. AUTHORITY TO DEFINE BASIC COVERAGES. (a) The board of trustees may define the basic coverage applicable to each individual for whom coverage is automatic unless participation is specifically waived.

(b) The board of trustees may define different basic coverage plans for individuals eligible to participate in the uniform program under Section 1551.101 and for individuals eligible to participate in the group benefits program under Section 1551.102.

(c) Basic coverage must include basic health coverage. The coverage may be offered through any health benefit plan.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.203. AUTHORITY TO DEFINE OPTIONAL COVERAGES. The board of trustees may define optional coverages for which the board may make available employer contributions under Section 1551.303.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.204. AUTHORITY TO DEFINE VOLUNTARY COVERAGES. Subject to Section 1551.304, the board of trustees may define

voluntary coverages.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.205. LIMITATIONS. The board of trustees may not contract for or provide a coverage plan that:

(1) excludes or limits coverage or services for acquired immune deficiency syndrome, as defined by the Centers for Disease Control and Prevention of the United States Public Health Service, or human immunodeficiency virus infection;

(2) provides coverage for serious mental illness that is less extensive than the coverage provided for any physical illness; or

(3) may provide coverage for prescription drugs to assist in stopping smoking at a lower benefit level than is provided for other prescription drugs.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Amended by Acts 2003, 78th Leg., ch. 213, Sec. 1, eff. Sept. 1, 2003.

Sec. 1551.206. CAFETERIA PLAN. (a) The board of trustees may develop, implement, and administer a cafeteria plan if the board determines that establishment of the plan:

(1) is feasible;

(2) would be beneficial to the state and to employees who would be eligible to participate in the plan; and

(3) would not adversely affect the coverage plans provided under the group benefits program.

(b) The board of trustees may include in the cafeteria plan any benefit that may be included in a cafeteria plan under federal law.

(c) The board of trustees may enter into a contract or agreement with an independent and qualified agency, individual, or entity to:

(1) develop, implement, or administer a cafeteria plan; or

(2) assist in those activities.

(d) The board of trustees may adopt an order terminating the cafeteria plan and providing a procedure for the orderly withdrawal of the state and its employees from the plan if the board determines that a cafeteria plan established under this section is no longer

advantageous to the state or its employees.

(e) The board of trustees may adopt rules for the use of a debit card or other similar technology for claims administration under this section.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.408(a), eff. Sept. 1, 2003.

Sec. 1551.207. PREMIUM CONVERSION BENEFIT PORTION OF CAFETERIA PLAN. Each employee must be enrolled in the premium conversion benefit portion of a cafeteria plan established under Section 1551.206.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.208. DETERMINATION TO SELF-FUND. (a) The board of trustees, in the board's sole discretion, shall determine those coverage plans that the board does not intend to purchase but intends to provide directly from the employees life, accident, and health insurance and benefits fund.

(b) The board of trustees, in the board's sole discretion and under conditions the board approves, may reinsure any coverage the board determines will be provided directly from the employees life, accident, and health insurance and benefits fund under Subsection (a).

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.209. COVERAGE EXEMPT FROM INSURANCE LAW. A coverage plan provided under this chapter is exempt from any other insurance law, including common law, that does not expressly apply to the plan or this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1111, Sec. 35, eff. Sept. 1, 2003.

Sec. 1551.210. ACTUARIAL ADVICE FOR SELF-FUNDED COVERAGE. A qualified actuary selected by the board of trustees shall advise the board regarding an actuarially sound level of contributions required to provide coverage directly from the employees life, accident, and health insurance and benefits fund.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.211. CONTINGENCY RESERVE FUND FOR SELF-FUNDED COVERAGE. (a) Before the first day of each state fiscal biennium, the board of trustees shall estimate for an average 60-day period during the biennium the expenditures from the employees life, accident, and health insurance and benefits fund anticipated for self-funded coverage plans, considering projected claims and administrative expenses for those plans.

(b) The board of trustees shall place the estimated amount in a contingency reserve fund to provide for adverse fluctuations in claims or administrative expenses.

(c) The board of trustees shall include in each request for legislative appropriations to the group benefits program the amount the board determines to be necessary to maintain the contingency reserve fund at the level required by this section.

(d) The board of trustees may invest and reinvest any portion of the contingency reserve fund under the standard of care provided by Section 815.307, Government Code, considering the functional need to provide for adverse fluctuations in claims or administrative expenses.

(e) The interest on, earnings of, and proceeds from the sale of investments of assets in the contingency reserve fund shall be credited to the fund.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.212. FIRMS TO ADMINISTER SELF-FUNDED COVERAGE. (a) For those coverage plans that the board of trustees funds from the employees life, accident, and health insurance and benefits fund, the board may contract with one or more qualified and experienced administering firms to administer the plans in the best interest of the participants in the group benefits program.

(b) The contract may be awarded only after a competitive bid process. The board of trustees is not required to select the lowest bid but shall take into consideration other relevant criteria, including ability to service large group programs and past experience.

(c) If the board of trustees selects a firm whose bid was not the lowest or whose bid differs from that specified, the board shall fully justify and explain the reasons for the action in the minutes of the next meeting of the board.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.213. BIDS FOR PURCHASED COVERAGE. (a) For those coverage plans for which the board of trustees determines to purchase coverage, the board shall notify eligible carriers:

(1) that competitive bidding will be conducted; and

(2) of the date by which an eligible carrier must submit a bid on the contract to the board.

(b) The board of trustees shall submit the group coverages provided by the group benefits program for competitive bidding at least every six years.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.214. SELECTION OF BIDS FOR PURCHASED COVERAGE. (a) An actuary selected by the board of trustees shall advise the board as to the actuarial soundness of the bids received under Section 1551.213.

(b) The board of trustees:

(1) shall select carriers to provide services that will be in the best interest of participants; and

(2) is not required to select the lowest bid but shall take into consideration other relevant criteria, including ability to service contracts, past experience, and financial ability.

(c) If the board of trustees selects a carrier whose bid differs from that advertised, the board shall record the deviation and shall fully justify and explain the reasons for the deviation in the minutes of the next meeting of the board.

(d) The board of trustees shall notify the carriers that

submitted bids of the results of the bidding.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.215. ACCOUNTING BY CARRIER PROVIDING PURCHASED COVERAGE. (a) A carrier providing a coverage purchased under this chapter shall provide an accounting to the board of trustees not later than the 90th day after the end of each plan year.

(b) The accounting must be in a form approved by the board of trustees.

(c) The accounting must state for the period from the coverage's date of issue to the end of the plan year:

(1) the amounts of contributions accrued under the coverage;

(2) the total of mortality and other claims, charges, losses, and expenses incurred; and

(3) the amounts of the carrier's allowance for a reasonable profit and contingencies.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.216. SPECIAL CONTINGENCY RESERVE. (a) A carrier issuing a group coverage plan under this chapter shall hold as a special contingency reserve an amount that equals the amount by which the amount described by Section 1551.215(c)(1) exceeds the sum of the amounts described by Sections 1551.215(c)(2) and (3).

(b) The carrier may use the special contingency reserve only for charges, claims, and expenses under the plan.

(c) The special contingency reserve earns interest at a rate determined before each plan year by the carrier and approved by the board of trustees as consistent with the rates generally used by the carrier for similar funds held under other group coverage plans.

(d) On a determination by the board of trustees that the special contingency reserve has attained an amount estimated by the board to make satisfactory provision for adverse fluctuations in future charges, claims, or expenses under the plan, any further excess shall be deposited to the credit of the employees life, accident, and health insurance and benefits fund.

(e) On discontinuation of a plan, any balance remaining in the

special contingency reserve after all charges have been made shall be deposited to the credit of the employees life, accident, and health insurance and benefits fund. The carrier may make the deposit in equal monthly installments over a period of not more than two years.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.217. USE OF EMPLOYEE'S SALARY IN COMPUTATION OF PREMIUM OR COVERAGE. (a) If the board of trustees establishes a group coverage plan that protects against either long-term or short-term loss of salary, the board may use an employee's annual salary in computing the amount of the employee's premium or coverage, or both, under the plan.

(b) In this section, an employee's annual salary includes benefit replacement pay under Subchapter H, Chapter 659, Government Code, as added by Chapter 417, Acts of the 74th Legislature, Regular Session, 1995.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.218. PRIOR AUTHORIZATION FOR CERTAIN DRUGS. (a) In this section, "drug formulary" means a list of drugs preferred for use and eligible for coverage under a health benefit plan.

(b) A health benefit plan provided under this chapter that uses a drug formulary in providing a prescription drug benefit must require prior authorization for coverage of the following categories of prescribed drugs if the specific drug prescribed is not included in the formulary:

- (1) a gastrointestinal drug;
- (2) a cholesterol-lowering drug;
- (3) an anti-inflammatory drug;
- (4) an antihistamine drug; and
- (5) an antidepressant drug.

(c) Repealed by Acts 2009, 81st Leg., R.S., Ch. 1308, Sec. 41(8), eff. September 1, 2009.

Added by Acts 2003, 78th Leg., ch. 213, Sec. 2, eff. Sept. 1, 2003.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1308 (H.B. [2559](#)), Sec. 41(8),

eff. September 1, 2009.

Sec. 1551.2181. EXEMPTION FROM PREAUTHORIZATION REQUIREMENTS FOR PHYSICIANS AND HEALTH CARE PROVIDERS PROVIDING CERTAIN HEALTH CARE SERVICES. A preauthorization process used by a health benefit plan provided under this chapter is subject to the same limitations and requirements provided by Subchapter N, Chapter 4201, for a preauthorization process used by an insurer.

Added by Acts 2021, 87th Leg., R.S., Ch. 1018 (H.B. 3459), Sec. 1, eff. September 1, 2021.

Sec. 1551.219. DISEASE MANAGEMENT SERVICES. (a) In this section, "disease management services" means services to assist an individual manage a disease or other chronic health condition, such as heart disease, diabetes, respiratory illness, end-stage renal disease, HIV infection, or AIDS, and with respect to which the board of trustees identifies populations requiring disease management.

(b) A group health benefit plan offered under the group benefits program must provide disease management services or coverage for disease management services in the manner required by the board of trustees, including:

- (1) patient self-management education;
- (2) provider education;
- (3) evidence-based models and minimum standards of care;
- (4) standardized protocols and participation criteria; and
- (5) physician-directed or physician-supervised care.

Added by Acts 2003, 78th Leg., ch. 589, Sec. 3, eff. June 20, 2003.

Sec. 1551.220. BENEFICIARY CAUSING DEATH OF PARTICIPANT OR BENEFICIARY OF PARTICIPANT. (a) Any benefits, funds, or account balances payable on the death of a participant or the beneficiary of a participant in the group benefits program may not be paid to a person convicted of or adjudicated as having caused that death but instead are payable as if the convicted person had predeceased the decedent.

(b) The Employees Retirement System of Texas is not required to

change the recipient of any benefits, funds, or account balances under this section unless it receives actual notice of the conviction or adjudication of a beneficiary. However, the retirement system may delay payment of any benefits, funds, or account balances payable on the death of a participant or beneficiary of a participant pending the results of a criminal investigation or civil proceeding and other legal proceedings relating to the cause of death.

(c) For the purposes of this section, a person has been convicted of or adjudicated as having caused the death of a participant or beneficiary of a participant if the person:

(1) pleads guilty or nolo contendere to, or is found guilty by a court or jury in a criminal proceeding of, causing the death of the participant or beneficiary of a participant, regardless of whether sentence is imposed or probated, and no appeal of the conviction is pending and the time provided for appeal has expired; or

(2) is found liable by a court or jury in a civil proceeding for causing the death of the member or annuitant and no appeal of the judgment is pending and the time provided for appeal has expired.

Added by Acts 2005, 79th Leg., Ch. 347 (S.B. [1176](#)), Sec. 27, eff. September 1, 2005.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 1249 (S.B. [1664](#)), Sec. 19, eff. September 1, 2011.

Sec. 1551.222. INCENTIVE PAYMENTS. (a) The board of trustees may allow an incentive payment under this section to an employee or annuitant who elects to waive coverage under the basic coverage plan for employees or annuitants as provided by Section 1551.1045(b) or (c).

(b) The incentive payment authorized by this section is in the amount authorized by the General Appropriations Act and may be used by the employee or annuitant, in the manner prescribed by the board of trustees, only to pay for other group coverage plans provided under the group benefits program, including the supplemental health coverage offered under Section 1551.221.

(c) The board of trustees, at the time of initial enrollment in

the group benefits program and during subsequent open-enrollment periods, shall inform employees and annuitants that they may make an election described by Subsection (a), if eligible, and receive any authorized incentive payment.

Added by Acts 2005, 79th Leg., Ch. 899 (S.B. 1863), Sec. 4.03, eff. August 29, 2005.

Sec. 1551.224. MAIL ORDER REQUIREMENT FOR PRESCRIPTION DRUG COVERAGE PROHIBITED. (a) The board of trustees or a health benefit plan under this chapter that provides benefits for prescription drugs may not require a participant in the group benefits program to purchase a prescription drug through a mail order program.

(b) Except as provided by Subsection (c), the board of trustees or a health benefit plan shall require that a participant who chooses to obtain a prescription drug through a retail pharmacy or other method other than by mail order pay a deductible, copayment, coinsurance, or other cost-sharing obligation to cover the additional cost of obtaining a prescription drug through that method rather than by mail order.

(c) The board of trustees or a health benefit plan may not require a participant who obtains a multiple-month supply of a prescription drug from a retail pharmacy under Section 1560.003 to pay a deductible, copayment, coinsurance, or other cost-sharing obligation that differs from the amount the participant pays for a multiple-month supply of that drug through a mail order program.

Added by Acts 2003, 78th Leg., ch. 213, Sec. 2, eff. Sept. 1, 2003. Renumbered from Insurance Code, Section 1551.219 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 17.001(52), eff. September 1, 2007.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1207 (S.B. 704), Sec. 4, eff. September 1, 2009.

Sec. 1551.225. BARIATRIC SURGERY COVERAGE. (a) The board of trustees shall develop a cost-neutral or cost-positive plan for providing under the group benefits program bariatric surgery coverage for employees eligible to participate in the program under Section

1551.101.

(b) The board of trustees may adopt rules as necessary to implement this section.

Added by Acts 2009, 81st Leg., R.S., Ch. 1270 (H.B. 1290), Sec. 2, eff. September 1, 2009.

Added by Acts 2009, 81st Leg., R.S., Ch. 1399 (S.B. 2577), Sec. 1, eff. September 1, 2009.

Sec. 1551.226. TOBACCO CESSATION COVERAGE. (a) The board of trustees shall develop a plan for providing under any health benefit plan provided under the group benefits program tobacco cessation coverage for participants.

(b) The plan developed under Subsection (a) must include coverage for prescription drugs that aid participants in ceasing the use of tobacco products.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1249 (S.B. 1664), Sec. 20, eff. September 1, 2011.

Sec. 1551.227. TRICARE MILITARY HEALTH SYSTEM SUPPLEMENTAL PLAN. (a) The board of trustees shall make available a TRICARE Military Health System supplemental plan to an employee or annuitant who waives coverage under the basic coverage plan under Section 1551.1045 and is eligible for benefits under the TRICARE Military Health System. The board of trustees may not contribute to the cost of the supplemental plan, including the premium cost.

(b) A plan offered under this section must be considered a permissible offering to TRICARE participants and beneficiaries under 10 U.S.C. Section 1097c.

(c) The board of trustees may adopt rules necessary to implement this section, including rules regarding eligibility for the plan, available insurance products, and enrollment in the plan.

Added by Acts 2015, 84th Leg., R.S., Ch. 807 (H.B. 3307), Sec. 1, eff. June 17, 2015.

Sec. 1551.228. EMERGENCY CARE PAYMENTS. (a) In this section,

"emergency care" has the meaning assigned by Section 1301.155.

(b) The administrator of a managed care plan provided under the group benefits program shall pay for covered emergency care performed by or a covered supply related to that care provided by an out-of-network provider at the usual and customary rate or at an agreed rate. The administrator shall make a payment required by this subsection directly to the provider not later than, as applicable:

(1) the 30th day after the date the administrator receives an electronic claim for those services that includes all information necessary for the administrator to pay the claim; or

(2) the 45th day after the date the administrator receives a nonelectronic claim for those services that includes all information necessary for the administrator to pay the claim.

(c) For emergency care subject to this section or a supply related to that care, an out-of-network provider or a person asserting a claim as an agent or assignee of the provider may not bill a participant in, and the participant does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, and deductible under the participant's managed care plan that:

(1) is based on:

(A) the amount initially determined payable by the administrator; or

(B) if applicable, a modified amount as determined under the administrator's internal appeal process; and

(2) is not based on any additional amount determined to be owed to the provider under Chapter 1467.

Added by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. [1264](#)), Sec. 1.12, eff. September 1, 2019.

Sec. 1551.229. OUT-OF-NETWORK FACILITY-BASED PROVIDER PAYMENTS.

(a) In this section, "facility-based provider" means a physician or health care provider who provides health care or medical services to patients of a health care facility.

(b) Except as provided by Subsection (d), the administrator of a managed care plan provided under the group benefits program shall pay for a covered health care or medical service performed for or a covered supply related to that service provided to a participant by

an out-of-network provider who is a facility-based provider at the usual and customary rate or at an agreed rate if the provider performed the service at a health care facility that is a participating provider. The administrator shall make a payment required by this subsection directly to the provider not later than, as applicable:

(1) the 30th day after the date the administrator receives an electronic claim for those services that includes all information necessary for the administrator to pay the claim; or

(2) the 45th day after the date the administrator receives a nonelectronic claim for those services that includes all information necessary for the administrator to pay the claim.

(c) Except as provided by Subsection (d), an out-of-network provider who is a facility-based provider or a person asserting a claim as an agent or assignee of the provider may not bill a participant receiving a health care or medical service or supply described by Subsection (b) in, and the participant does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, and deductible under the participant's managed care plan that:

(1) is based on:

(A) the amount initially determined payable by the administrator; or

(B) if applicable, a modified amount as determined under the administrator's internal appeal process; and

(2) is not based on any additional amount determined to be owed to the provider under Chapter 1467.

(d) This section does not apply to a nonemergency health care or medical service:

(1) that a participant elects to receive in writing in advance of the service with respect to each out-of-network provider providing the service; and

(2) for which an out-of-network provider, before providing the service, provides a complete written disclosure to the participant that:

(A) explains that the provider does not have a contract with the participant's managed care plan;

(B) discloses projected amounts for which the participant may be responsible; and

(C) discloses the circumstances under which the

participant would be responsible for those amounts.

Added by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. [1264](#)), Sec. 1.12, eff. September 1, 2019.

Sec. 1551.230. OUT-OF-NETWORK DIAGNOSTIC IMAGING PROVIDER OR LABORATORY SERVICE PROVIDER PAYMENTS. (a) In this section, "diagnostic imaging provider" and "laboratory service provider" have the meanings assigned by Section 1467.001.

(b) Except as provided by Subsection (d), the administrator of a managed care plan provided under the group benefits program shall pay for a covered health care or medical service performed for or a covered supply related to that service provided to a participant by an out-of-network provider who is a diagnostic imaging provider or laboratory service provider at the usual and customary rate or at an agreed rate if the provider performed the service in connection with a health care or medical service performed by a participating provider. The administrator shall make a payment required by this subsection directly to the provider not later than, as applicable:

(1) the 30th day after the date the administrator receives an electronic claim for those services that includes all information necessary for the administrator to pay the claim; or

(2) the 45th day after the date the administrator receives a nonelectronic claim for those services that includes all information necessary for the administrator to pay the claim.

(c) Except as provided by Subsection (d), an out-of-network provider who is a diagnostic imaging provider or laboratory service provider or a person asserting a claim as an agent or assignee of the provider may not bill a participant receiving a health care or medical service or supply described by Subsection (b) in, and the participant does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, and deductible under the participant's managed care plan that:

(1) is based on:

(A) the amount initially determined payable by the administrator; or

(B) if applicable, the modified amount as determined under the administrator's internal appeal process; and

(2) is not based on any additional amount determined to be

owed to the provider under Chapter 1467.

(d) This section does not apply to a nonemergency health care or medical service:

(1) that a participant elects to receive in writing in advance of the service with respect to each out-of-network provider providing the service; and

(2) for which an out-of-network provider, before providing the service, provides a complete written disclosure to the participant that:

(A) explains that the provider does not have a contract with the participant's managed care plan;

(B) discloses projected amounts for which the participant may be responsible; and

(C) discloses the circumstances under which the participant would be responsible for those amounts.

Added by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. [1264](#)), Sec. 1.12, eff. September 1, 2019.

For expiration of this section, see Subsection (f).

Sec. 1551.231. OUT-OF-NETWORK EMERGENCY MEDICAL SERVICES PROVIDER PAYMENTS. (a) In this section, "emergency medical services provider" has the meaning assigned by Section 773.003, Health and Safety Code, except that the term does not include an air ambulance.

(b) Except as provided by Subsection (c), the administrator of a managed care plan provided under the group benefits program shall pay for a covered health care or medical service performed for, or a covered supply or covered transport related to that service provided to, a participant by an out-of-network provider who is an emergency medical services provider at:

(1) if the political subdivision has submitted the rate to the department under Section 38.006, the rate set, controlled, or regulated by the political subdivision in which:

(A) the service originated; or

(B) the transport originated if transport is provided;

or

(2) if the political subdivision has not submitted the rate to the department, the lesser of:

(A) the provider's billed charge; or

(B) 325 percent of the current Medicare rate, including any applicable extenders and modifiers.

(c) The administrator shall adjust a payment required by Subsection (b)(1) each plan year by increasing the payment by the lesser of the Medicare Inflation Index or 10 percent of the provider's previous calendar year rates.

(d) The administrator shall make a payment required by this section directly to the provider not later than, as applicable:

(1) the 30th day after the date the administrator receives an electronic claim for those services that includes all information necessary for the administrator to pay the claim; or

(2) the 45th day after the date the administrator receives a nonelectronic claim for those services that includes all information necessary for the administrator to pay the claim.

(e) An out-of-network provider who is an emergency medical services provider or a person asserting a claim as an agent or assignee of the provider may not bill a participant receiving a health care or medical service or supply or transport described by Subsection (b) in, and the participant does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, and deductible under the participant's managed care plan that is based on:

(1) the amount initially determined payable by the administrator; or

(2) if applicable, the modified amount as determined under the administrator's internal appeal process.

(f) This section expires September 1, 2025.

Added by Acts 2023, 88th Leg., R.S., Ch. 981 (S.B. [2476](#)), Sec. 10, eff. September 1, 2023.

SUBCHAPTER F. GROUP LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE COVERAGE PLAN

Sec. 1551.251. GROUP LIFE INSURANCE COVERAGE PLAN. (a) The board of trustees shall administer a group life insurance coverage plan to provide each individual eligible to participate in the group benefits program under Section 1551.101 or 1551.102 group life coverages that provide payments and benefits in an amount and manner the board determines.

(b) The group life insurance coverage plan is subject to the conditions and limitations of:

- (1) this chapter and rules adopted under this chapter; and
- (2) the policy or policies purchased by the board of trustees.

(c) The board of trustees may include the dependents of individuals eligible to participate in the group benefits program under Section 1551.101 or 1551.102 in the group life insurance coverage plan.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.252. ADDITIONAL TERM LIFE INSURANCE. Notwithstanding any other provision of this code, the board of trustees may authorize:

- (1) dependent term life insurance in an amount equal to the term life insurance provided under the basic coverage; and
- (2) optional term life insurance in an amount equal to four times the employee's annual salary plus the amount of term life insurance provided under the basic coverage.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.253. DETERMINATION OF ANNUAL SALARY. (a) To implement this subchapter, the board of trustees shall:

- (1) adopt rules for the conversion of other than annual rates of salary; and
- (2) specify the types of pay included in annual salary and any other matter necessary to implement this subchapter.

(b) For the purpose of determining the amount of an employee's optional term life insurance coverage, an employee's annual salary includes benefit replacement pay under Subchapter H, Chapter 659, Government Code, as added by Chapter 417, Acts of the 74th Legislature, Regular Session, 1995.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.254. ACCELERATED LIFE INSURANCE BENEFITS. (a) In

addition to exercising the authority granted under Subchapter B, Chapter 1111, the board of trustees may adopt rules to provide for payment of accelerated life insurance benefits to a terminally ill, terminally injured, or permanently disabled participant, including an annuitant participating in optional term life insurance coverage, in amounts that benefit the participant without increasing the cost of providing the benefits.

(b) The amount of any payment of an accelerated benefit under a rule adopted under this section must be deducted from the amount that would otherwise be payable as a death benefit.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.255. INCLUSION OF PROVISIONS FOR VIATICAL SETTLEMENTS. (a) In this section, "viatical settlement" has the meaning assigned to "life settlement contract" by Section 1111A.002.

(b) The board of trustees shall adopt rules that require a group life insurance coverage plan established under this chapter to allow a participant in the plan to make, in conjunction with receipt of a viatical settlement, an irrevocable designation of beneficiary for part or all of the group life coverage benefits.

(c) A viatical settlement is not valid for any coverage under the group benefits program unless the participant has a terminal illness or terminal injury, as defined by rules adopted by the board of trustees, at the time application for benefits is made.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 1156 (H.B. [2277](#)), Sec. 16, eff. September 1, 2011.

Sec. 1551.256. OPTIONAL TERM LIFE INSURANCE COVERAGE AFTER RETIREMENT. (a) A participant in the optional group term life insurance coverage plan may maintain optional term life insurance coverage after retirement in addition to basic term life insurance coverage after retirement.

(b) The board of trustees may adopt rules to implement and administer Subsection (a).

(c) Under Subsection (a), the participant may maintain an

amount of optional term life insurance coverage on the participant's life on the date of retirement, not to exceed two times the participant's annual salary on the last September 1 before retirement and subject to benefit reduction factors based on age as determined by the board of trustees.

(d) The board of trustees shall determine the premium rate for optional term life insurance coverage for annuitants under Subsection (a). The rate must be comparable to the premium rate for optional term life insurance coverage for employees of the same age.

(e) As an alternative to the optional term life insurance coverage plan, an annuitant may choose a minimum optional term life insurance coverage amount not subject to benefit reduction factors based on age, with a coverage amount and premium rate determined by the board of trustees.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.257. ELIGIBILITY OF ANNUITANT FOR EXTENDED INSURANCE BENEFITS. An annuitant participating in optional term life insurance coverage is not eligible for premium-waived extended insurance benefits if the total disability begins after the date of retirement.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.258. TERMINATION OF ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE COVERAGE ON RETIREMENT. Without regard to the employee's age, accidental death and dismemberment insurance coverage ends on the employee's date of retirement.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.259. ORDER OF PRECEDENCE OF PAYMENT TO SURVIVORS.
(a) The amount of group life coverage and group accidental death and dismemberment coverage in force for a participant on the date the participant dies shall be paid, on the establishment of a valid claim, to a person surviving the death in the following order of precedence:

(1) to the beneficiary designated by the participant in a

signed and witnessed document mailed before the death of the participant;

(2) if a beneficiary is not designated, to the spouse of the participant;

(3) if Subdivisions (1) and (2) do not apply, to the children of the participant and descendants of the deceased children by representation;

(4) if Subdivisions (1)-(3) do not apply, to the parents of the participant or the survivor of the parents;

(5) if Subdivisions (1)-(4) do not apply, to the executor or administrator of the estate of the participant; or

(6) if Subdivisions (1)-(5) do not apply, to other relatives of the participant entitled under applicable laws of the participant's domicile on the date of the participant's death.

(b) If before the first anniversary of the date of death of the participant a claim for payment has not been filed by a person entitled under the order of precedence in Subsection (a), or if payment to the person within that period is prohibited by any statute or rule, payment may be made in the order of precedence as if the person had predeceased the participant.

(c) If before the second anniversary of the date of death of the participant a claim for payment has not been filed by a person entitled under the order of precedence in Subsection (a), and neither the board of trustees nor the office established by the administering carrier has received notice that the claim will be made, payment may be to a claimant equitably entitled to the payment as determined by the board.

(d) If before the fourth anniversary of the date of death of the participant payment has not been made under this section and a claim for payment by a person entitled under this section is not pending, the amount payable escheats to the credit of the employees life, accident, and health insurance and benefits fund.

(e) The board of trustees shall give effect to a full or partial disclaimer of benefits executed in accordance with Chapter 240, Property Code.

(f) Payment under Subsection (b) or (c) bars recovery by any other person.

(g) For purposes of Subsection (a)(1), a designation, change, or cancellation of a beneficiary in a document, including a will, that is not executed and filed in the manner described by that

subsection is not valid.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Amended by:

Acts 2005, 79th Leg., Ch. 347 (S.B. 1176), Sec. 28, eff. September 1, 2005.

Acts 2015, 84th Leg., R.S., Ch. 562 (H.B. 2428), Sec. 12, eff. September 1, 2015.

SUBCHAPTER G. CONTRIBUTIONS AND COSTS

Sec. 1551.301. FUNDING OF BASIC COVERAGE. The board of trustees shall use the amount appropriated for employer contributions in the manner provided by this subchapter to fund the basic coverage.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.3015. COST ASSESSMENT FOR CERTAIN PARTICIPANTS. Notwithstanding any other provision of law, the board of trustees may impose against an employer whose employees are not paid salaries from amounts appropriated by the General Appropriations Act and whose participation in the group benefits program begins after August 31, 2003, as a condition for participation in the program, a one-time assessment of administrative costs for participation of the employees and annuitants in the program, which may include the actuarial costs of including the group in the program and a participation premium determined by the board. The board of trustees shall deposit all amounts recovered under this section in the employees life, accident, and health insurance and benefits fund.

Added by Acts 2003, 78th Leg., ch. 366, Sec. 2.08, eff. Sept. 1, 2003.

Sec. 1551.302. ALLOCATION OF EMPLOYER CONTRIBUTIONS. (a) The board of trustees may equitably allocate to each health benefit plan the employer contributions that would be required to fund basic health coverage for participants in the plans to the extent funds are available.

(b) In allocating the employer contributions among plans, the

board of trustees shall consider the relevant risk characteristics of each plan's enrollment, including:

(1) demographic variations in the use and cost of health care; and

(2) prevailing cost patterns in the area in which the plan operates.

(c) The allocation must be reasonable and set in a manner that ensures participants a fair choice among health benefit plans providing a basic plan.

(d) The contribution set for each participant must be within the total amount appropriated in the General Appropriations Act.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.303. FUNDING OF OPTIONAL COVERAGES. The board of trustees may allocate any employer contributions remaining after the basic coverage has been funded to fund optional coverages in any manner the board determines is appropriate.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.304. FUNDING OF VOLUNTARY COVERAGES. The board of trustees may not allocate any employer contributions to fund voluntary coverages. Voluntary coverages may be funded only by participant contributions.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.305. COST OF BASIC COVERAGE EXCEEDING EMPLOYER CONTRIBUTIONS. If the cost of the basic coverage for an individual eligible to participate in the group benefits program under Section 1551.101 or 1551.102 exceeds the amount of employer contributions allocated to fund the basic coverage, the state shall deduct from or reduce the monthly compensation of the participant or deduct from the retirement benefits of the participant, as applicable, an amount sufficient to pay the cost of the basic coverage.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.306. PAYMENT OF EXCESS COST OVER BASIC COVERAGE CONTRIBUTION. (a) The board of trustees shall apply the amount of any employer contribution for optional coverages to the excess of the cost of the basic and optional coverages for which an individual eligible to participate in the group benefits program under Section 1551.101 or 1551.102 applies over the basic coverage contribution.

(b) Except as provided by Section 1551.309, if a participant applies for basic and optional coverages for which the cost exceeds the employer contributions for those coverages under this chapter, the participant shall authorize in a form and manner satisfactory to the board of trustees a deduction from the participant's monthly compensation or monthly annuity equal to the difference between:

(1) the cost of basic and optional coverages for which the participant applies; and

(2) the employer contributions for basic and optional coverages.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.307. PAYMENT FOR VOLUNTARY COVERAGES. Except as provided by Section 1551.309, if an individual eligible to participate in the group benefits program under Section 1551.101 or 1551.102 applies for voluntary coverages, the participant shall authorize in a form and manner satisfactory to the board of trustees a deduction from the participant's monthly compensation or monthly annuity equal to the cost of the voluntary coverages.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.3075. TOBACCO USER PREMIUM DIFFERENTIAL. (a) The board of trustees shall assess each participant in a health benefit plan provided under the group benefits program who uses one or more tobacco products a tobacco user premium differential, to be paid in monthly installments. Except as provided by Subsection (b), the board of trustees shall determine the amount of the monthly installments of the premium differential.

(b) If the General Appropriations Act for a state fiscal

biennium sets the amount of the monthly installments of the tobacco user premium differential for that biennium, the board of trustees shall assess the premium differential during that biennium in the amount prescribed by the General Appropriations Act.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1249 (S.B. 1664), Sec. 21, eff. September 1, 2011.

Sec. 1551.3076. EMPLOYER ENROLLMENT FEE. (a) The board of trustees shall assess each employer whose employees participate in the group benefits program an employer enrollment fee in an amount not to exceed a percentage of the employer's total payroll, as determined by the General Appropriations Act.

(b) The board of trustees shall deposit the enrollment fees to the credit of the employees life, accident, and health insurance and benefits fund to be used for the purposes specified by Section 1551.401.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1249 (S.B. 1664), Sec. 22, eff. September 1, 2011.

Sec. 1551.308. NO CONTRIBUTION ON REFUSAL OF COVERAGE. The state and a state agency may not make any contribution to the cost of any coverages or benefits provided under this chapter for an individual who refuses the coverages or benefits in a form and manner satisfactory to the board of trustees.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.309. EMPLOYEE PAYMENTS FOR PARTICIPATION IN CAFETERIA PLAN. (a) If an employee elects to participate in the cafeteria plan, the employee must execute a salary reduction agreement under which the employee's monthly compensation will be reduced in an amount equal to the difference between:

(1) the employer contributions for basic and optional coverages; and

(2) the cost of the cafeteria plan coverages the board of trustees identifies as comparable to the basic and optional coverages

for which the employee is eligible.

(b) The salary reduction agreement must also provide for an additional reduction in the employee's compensation equal to the cost of voluntary coverages for which the employee has applied.

(c) An employee who executes a salary reduction agreement for a group coverage plan included in the cafeteria plan elects to participate in the cafeteria plan and agrees to a salary reduction for the coverages for subsequent plan years unless the employee, during an annual enrollment period specified by the board of trustees, elects in a form and manner satisfactory to the board not to participate for the next plan year in the coverages.

(d) An employee who elects not to participate in the cafeteria plan group coverage plans may reenroll by executing a new salary reduction agreement during a subsequent annual enrollment period.

(e) A salary reduction agreement for cafeteria plan benefits, other than a group coverage plan, must be executed annually during the annual enrollment period.

(f) The employee shall pay any remaining portion of the cost of benefits that is not covered by the contributions for basic and optional coverages and the salary reduction under the cafeteria plan by executing a payroll deduction agreement.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.310. STATE CONTRIBUTION REQUIRED. The state shall contribute to the cost of each participant's group coverages, including dependents' group coverages, the amounts appropriated for the coverages in the General Appropriations Act.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.311. AMOUNT OF STATE CONTRIBUTION. (a) Not later than November 1 preceding each regular session of the legislature, the board of trustees, in coordination with the Legislative Budget Board, shall certify to the budget division of the governor's office for information and review the amount necessary to pay the contributions of the state to the board for the coverages provided under this chapter during the following biennium.

(b) The governor shall include the amount in the budget that

the governor submits to the legislature.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 812 (S.B. 1812), Sec. 4, eff. June 14, 2013.

Sec. 1551.3111. AMOUNT OF STATE CONTRIBUTION FOR CERTAIN JUNIOR COLLEGE EMPLOYEES. (a) In computing the amount to be certified under Section 1551.311, for participants who are employed by public junior colleges or public junior college districts, the board of trustees shall include:

(1) 50 percent of the cost associated with eligible employees who:

(A) otherwise are eligible to participate in the group benefits program; and

(B) are instructional or administrative employees whose salaries may be fully paid from funds appropriated under the General Appropriations Act, regardless of whether such salaries are actually paid from appropriated funds; and

(2) none of the cost associated with employees who:

(A) do not meet the requirements of Subdivision (1)(B) but are otherwise eligible to participate in the group benefits program; or

(B) cannot be included as a qualifying employee under Subdivision (1) by application of Subsection (c).

(b) For qualifying employees under Subsection (a)(1), the board of trustees shall include only the amount payable by the state under Subsection (a)(1) in determining the amount to be certified under Section 1551.311.

(c) In determining the amount described by Subsection (b), the number of qualifying employees under Subsection (a)(1) whose group benefits program costs may be included for each public junior college or public junior college district in each biennium may not be adjusted in a proportion greater than the change in student enrollment at each college during the reporting period except that a college that experiences a decline in student enrollment may petition the Legislative Budget Board to maintain the number of eligible employees up to 98 percent of the level of the prior biennium.

Added by Acts 2013, 83rd Leg., R.S., Ch. 812 (S.B. [1812](#)), Sec. 5, eff. June 14, 2013.

Sec. 1551.313. AMOUNT OF STATE CONTRIBUTION FOR CERTAIN SURVIVING DEPENDENTS. If funds are specifically appropriated for the purpose, this state shall pay the same portion of the cost of the required contributions for a deceased annuitant's surviving spouse or other surviving dependent who elects to retain coverage under Section 1551.156 as this state pays for similar dependent coverage for an employee or annuitant participating in the program.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.314. CERTAIN STATE CONTRIBUTIONS PROHIBITED. A state contribution may not be:

(1) made for coverages under this chapter selected by an individual who receives a state contribution for coverages under a group benefits program provided by another state health plan or by an institution of higher education, as defined by Section 61.003, Education Code; or

(2) made for or used to pay a tobacco user premium differential assessed under Section 1551.3075.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 1249 (S.B. [1664](#)), Sec. 23, eff. September 1, 2011.

Sec. 1551.315. REQUIRED CONTRIBUTIONS BY STATE AGENCIES. (a) The governing board of each state agency participating in the group benefits program shall pay to the board of trustees an amount equal to the amount appropriated by the legislature for each employee's individual group coverages or dependents' group coverages for the agency's employees who are, and annuitants who were, compensated from funds not appropriated in the General Appropriations Act.

(b) The state agency shall:

(1) include the required contributions from funds not appropriated in the General Appropriations Act in its annual

operating budget;

(2) ensure current participant coverages based on the records of the board of trustees;

(3) make timely payments of amounts due the board of trustees from all fund sources under the state agency's control; and

(4) each month reconcile board of trustees and state agency records of coverages and payments.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.316. ALLOCATION TO BOARD OF TRUSTEES OF EMPLOYER CONTRIBUTIONS. From the several funds from which employees receive their respective salaries, all employer contributions computed in accordance with this chapter and rules adopted under this chapter are allocated to the board of trustees as provided by this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.317. PAYMENT OF EMPLOYER CONTRIBUTIONS ALLOCATED BY THE STATE. (a) All money allocated by this state, including by institutions of higher education, to the board of trustees under this chapter shall be paid to the board in monthly installments based on the annual estimate by the board of the contributions to be received for all employees during the year.

(b) At the end of each fiscal year, the board of trustees shall make any adjustments required to cover the difference between:

(1) the annual estimate; and

(2) the actual amount of the employer contributions during the year.

(c) Each monthly installment shall be paid to the appropriate fund created by this chapter in the amount certified by the board of trustees.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.318. PAYMENT OF EMPLOYER CONTRIBUTIONS NOT ALLOCATED BY THE STATE. (a) The board of trustees shall certify to the governing board of each state agency participating in the group

benefits program that provides contributions for its employees' group coverages and dependents' group coverages from operating budgets provided from sources other than the General Appropriations Act the proportionate amounts required to pay its contributions.

(b) The board of trustees shall make the certification not later than the 30th day before the date of the meeting at which the governing board of the state agency adopts its operating budget.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.319. AMOUNT OF CONTRIBUTION FOR FULL-TIME AND PART-TIME EMPLOYEES. (a) A full-time employee receives the benefits of a full state contribution for coverage under this chapter.

(b) A part-time employee receives the benefits of one-half of the amount of the state contribution received by a full-time employee.

(c) The superintendent of the Texas School for the Deaf and the superintendent of the Texas School for the Blind and Visually Impaired shall determine whether an educational professional employee under contract with the school under Section 30.024 or 30.055, Education Code, as applicable, is a full-time employee for purposes of this chapter.

(d) The executive head of the Windham School District shall determine whether an educational professional employee of the school is a full-time employee for purposes of this chapter.

(e) This section does not prohibit an institution of higher education from contributing, from money not appropriated from the general revenue fund, amounts in excess of the state contribution for a part-time employee described by Section 1551.101(e)(2).

(f) Notwithstanding any other provision of this section, if the board of trustees establishes a supplemental health coverage program under Section 1551.221, the amount of the contribution made for an individual who elects to receive supplemental health coverage under the program may be reduced, as provided in the General Appropriations Act, to reflect the reduced cost of the supplemental health coverage.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Amended by Acts 2003, 78th Leg., ch. 366, Sec. 2.12, eff. Sept. 1, 2003.

Amended by:

Acts 2005, 79th Leg., Ch. 178 (H.B. 417), Sec. 2, eff. May 27, 2005.

Sec. 1551.3195. AMOUNT OF CONTRIBUTION FOR ANNUITANTS WHO WERE PART-TIME EMPLOYEES. An annuitant who as an employee received the benefits of a state contribution under Section 1551.319(b) for coverage during any portion of the annuitant's last employment by a state agency is not eligible to receive more than the state contribution provided under Section 1551.319(b) unless the annuitant was designated by the annuitant's employer as a full-time employee during the three-consecutive-month period before retirement.

Added by Acts 2005, 79th Leg., Ch. 347 (S.B. 1176), Sec. 29, eff. January 1, 2006.

Sec. 1551.3196. AMOUNT OF CONTRIBUTION FOR CERTAIN ANNUITANTS.

(a) An annuitant receives the benefits of a state contribution for coverage under this chapter based on the annuitant's eligible service credit, as follows:

(1) for an annuitant with 20 years or more of eligible service credit, a full state contribution;

(2) for an annuitant with at least 15 years but less than 20 years of eligible service credit, 75 percent of a full state contribution; and

(3) for an annuitant with less than 15 years of eligible service credit, 50 percent of a full state contribution.

(b) An annuitant receiving a reduced state contribution under Subsection (a) shall have any state contribution for dependent coverage reduced in an amount proportional to the reduction under Subsection (a).

(c) This section does not apply to an individual who:

(1) receives or is eligible to receive an annuity that is based on eligibility under Section 814.002, 814.102, 834.101, 839.101, or 840A.052, Government Code; or

(2) is eligible to participate in the group benefits program under:

(A) Section 1551.102(d) because of a disability; or

(B) Section 1551.102(f).

Added by Acts 2013, 83rd Leg., R.S., Ch. 618 (S.B. 1459), Sec. 25, eff. September 1, 2014.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 1092 (S.B. 1245), Sec. 18, eff. June 18, 2023.

Sec. 1551.320. CERTAIN COSTS. The Texas Higher Education Coordinating Board shall pay all costs incurred in determining whether an individual is disabled if:

- (1) the individual is an annuitant under the optional retirement program established by Chapter 830, Government Code; and
- (2) the individual's last state employment was as an officer or employee of the coordinating board.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.323. COST OF CERTAIN ANNUITANTS. (a) An annuitant eligible to participate under Section 1551.102(i), 1551.111(e), or 1551.112(c) is, except as provided by this subsection, required to pay the total cost, as determined by the board, attributable to the participation of that individual and the dependents of that individual until the date the individual is 65 years of age. If the General Appropriations Act or other similar legislation addresses the payment of those costs, those costs shall be paid in the manner specified by that legislation.

(b) This section applies only to an individual who is eligible to participate as an annuitant under Section 1551.102(i), 1551.111(e), or 1551.112(c) and who is not eligible to participate under another provision of Section 1551.102, 1551.111, or 1551.112.

Added by Acts 2003, 78th Leg., 3rd C.S., ch. 3, Sec. 16.04, eff. Jan. 11, 2004.

Sec. 1551.324. REDUCTION IN CONTRIBUTION FOR CERTAIN ACTIVE EMPLOYEES AND ANNUITANTS; INCENTIVE PAYMENTS. (a) Notwithstanding any other provision of this subchapter, the state contribution for an employee's coverage or an annuitant's coverage under this chapter may be reduced, as provided in the General Appropriations Act, to reflect

the reduced cost of coverage for an employee or annuitant who elects to waive basic coverage as provided by Section 1551.1045(b) or (c).

(b) Instead of the full state contribution for an employee or annuitant who makes an election described by Subsection (a), the state may contribute, as specified by the General Appropriations Act, an amount for the incentive payment authorized by Section 1551.222.

Added by Acts 2005, 79th Leg., Ch. 899 (S.B. 1863), Sec. 4.04, eff. August 29, 2005.

SUBCHAPTER H. SANCTIONS AND ADJUDICATION OF CLAIMS

Sec. 1551.351. ADMINISTRATIVE PROCESS AND SANCTIONS FOR PROGRAM VIOLATIONS. (a) The Employees Retirement System of Texas may impose one or more sanctions described by this section against any employee, participant, annuitant, or dependent who:

(1) submits a materially false claim or application for coverage under a group coverage plan offered under the group benefits program;

(2) defrauds or attempts to defraud a group coverage plan offered under the group benefits program;

(3) obtains or induces the extension of coverage under any program provided under this chapter by a materially negligent or intentional misrepresentation, a failure to disclose material information, or fraud; or

(4) induces the extension of coverage under any program provided under this chapter by supplying false information on an application for coverage or in related documentation or in any communication.

(b) On receipt of a complaint or on its own motion, if the Employees Retirement System of Texas determines that an employee, participant, annuitant, or dependent has engaged in conduct described by Subsection (a), the retirement system may:

(1) expel from the program the employee, participant, annuitant, or dependent;

(2) impose limitations on the person's participation in the program;

(3) rescind any coverage obtained or extended as a result of the conduct under Subsection (a);

(4) deny a claim arising from coverage; or

(5) require the person to reimburse the employees life, accident, and health insurance and benefits fund for any benefit obtained as a result of the conduct.

(c) An expulsion under Subsection (b) may be permanent or for a specified period. A rescission of coverage under Subsection (b) may be from the date of inception of the coverage or from the date of the prohibited conduct.

(d) A person may appeal a determination made under Subsection (a) or (b) or Section 1551.352 only to the board of trustees. A proceeding under this subsection is a contested case under Chapter 2001, Government Code. This subchapter applies to an appeal to the board of trustees under this subsection. The appellant has the burden of proof on all issues, including issues in the nature of an affirmative defense. Any sanction imposed is not stayed during an appeal under this subsection. An appeal of a decision of the board of trustees under this subsection is under the substantial evidence rule.

(e) An employee, participant, annuitant, or dependent expelled from the group benefits program may not participate in a coverage plan offered by the program for the period determined by the Employees Retirement System of Texas.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1111, Sec. 36, eff. Sept. 1, 2003; Acts 2003, 78th Leg., ch. 1276, Sec. 10A.409(b), eff. Sept. 1, 2003.

Amended by:

Acts 2005, 79th Leg., Ch. 347 (S.B. [1176](#)), Sec. 30, eff. September 1, 2005.

Sec. 1551.352. EXECUTIVE DIRECTOR DETERMINES QUESTIONS RELATING TO ENROLLMENT OR PAYMENT OF CLAIMS. The executive director has exclusive authority to determine all questions relating to enrollment in or payment of a claim arising from group coverages or benefits provided under this chapter other than questions relating to payment of a claim by a health maintenance organization.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.354. DOUBLE OR MULTIPLE LIABILITY. (a) The executive director may determine that a claim arising under any group coverage plan administered by the board of trustees may expose the plan to double or multiple liability.

(b) The executive director may cause the filing of an action for interpleader concerning the claim in a district court in Travis County on behalf of the Employees Retirement System of Texas to protect the group coverage plan from double or multiple liability.

(c) A person may not pursue a counterclaim or other cause of action against the Employees Retirement System of Texas, a trustee, officer, or employee of the retirement system, or a carrier or administering firm for the retirement system in connection with a transaction or occurrence related to the interpleader action.

(d) A person who violates Subsection (c) is liable for the costs and attorney's fees incurred by the Employees Retirement System of Texas, a trustee, officer, or employee of the retirement system, or a carrier or administering firm for the retirement system as a result of the violation.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1308 (H.B. [2559](#)), Sec. 38, eff. September 1, 2009.

Sec. 1551.355. APPEAL OF EXECUTIVE DIRECTOR'S DETERMINATION.

(a) Subject to Subsection (b), an appeal of a determination of the executive director under this subchapter is only to the board of trustees.

(b) On behalf of the board of trustees and notwithstanding any other law, including Section 2003.021, Government Code, the executive director may:

(1) refer an appeal to the State Office of Administrative Hearings for a hearing; or

(2) employ, select, or contract for the services of an administrative law judge or other hearing examiner not affiliated with the State Office of Administrative Hearings to conduct the hearing of an appeal.

(c) The appeal is a contested case under Chapter 2001, Government Code.

(d) The board of trustees shall develop and implement a process to allow an employee, participant, annuitant, or covered dependent affected by a determination described by Section 1551.352 to participate directly in the process of appealing the determination.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1111, Sec. 37, eff. Sept. 1, 2003.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 530 (S.B. 301), Sec. 11, eff. September 1, 2017.

Sec. 1551.356. STANDING. (a) A person has standing to appeal a determination of the executive director under this subchapter only if the person is:

- (1) an employee, participant, annuitant, or covered dependent participating in the group benefits program; or
- (2) after the death of an employee, participant, annuitant, or covered dependent, the person's estate, personal representative, heir at law, or designated beneficiary.

(b) A person has no standing to appeal a determination of the executive director under this subchapter or to pursue a private cause of action against the state, the board of trustees, the retirement system, the executive director, an administering firm, or an employee of any of those persons based on a determination or the implementation by the board or executive director of the type or scope of plan design features under the group benefits program.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1111, Sec. 38, eff. Sept. 1, 2003; Acts 2003, 78th Leg., ch. 1276, Sec. 10A.411(a), eff. Sept. 1, 2003.

Sec. 1551.357. DETERMINATION OF APPEAL BY BOARD OF TRUSTEES.

(a) Notwithstanding any other law, in a proceeding considered to be a contested case under Chapter 2001, Government Code, the board of trustees in its sole discretion may modify, refuse to accept, or delete any proposed finding of fact or conclusion of law contained in a proposal for decision submitted by an administrative law judge or

other hearing examiner, or make alternative findings of fact and conclusions of law.

(b) The board of trustees shall state in writing the specific reason for the board's determination.

(c) The board of trustees may adopt rules to implement this section.

(d) The appellant in a contested case under this subchapter has the burden of proof on all issues, including issues in the nature of an affirmative defense.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1111, Sec. 39, eff. Sept. 1, 2003.

Sec. 1551.358. NEGOTIATION. (a) Notwithstanding any other provision of this subchapter, the board of trustees and a person who has standing to pursue an administrative appeal under this subchapter may at any time informally negotiate an award of benefits.

(b) Negotiated benefits may not exceed the maximum benefits otherwise available or required by law.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.359. JUDICIAL REVIEW. A person aggrieved by a final decision of the Employees Retirement System of Texas in a contested case under this subchapter is entitled to judicial review of the decision. Venue of an appeal under this subchapter is only in a district court in Travis County. The standard of review for the appeal of a determination made by the board of trustees under this subchapter is by substantial evidence.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1111, Sec. 40, eff. Sept. 1, 2003.

Sec. 1551.360. DELEGATION. (a) The board of trustees may delegate its duty to hear an appeal to the executive director.

(b) The executive director may delegate the director's duty

under this subchapter to another employee of the Employees Retirement System of Texas.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.361. DILIGENT PROSECUTION OF SUIT. The plaintiff shall prosecute with reasonable diligence any suit brought under Section 1551.359. If the plaintiff does not secure proper service of process or does not prosecute the suit within one year after it is filed, the court shall presume that the suit has been abandoned. The court shall dismiss the suit on a motion for dismissal made on or behalf of the Employees Retirement System of Texas, unless the plaintiff, after receiving appropriate notice, shows good cause for the delay.

Added by Acts 2005, 79th Leg., Ch. 347 (S.B. 1176), Sec. 31, eff. September 1, 2005.

Sec. 1551.362. SUBPOENA. Notwithstanding any other law, the Employees Retirement System of Texas may issue a subpoena that conforms to Rule 176, Texas Rules of Civil Procedure, including a preappeal investigative subpoena or any subpoena otherwise authorized by the Texas Rules of Civil Procedure, that the retirement system determines necessary to protect the interests of a program or system administered by the retirement system.

Added by Acts 2009, 81st Leg., R.S., Ch. 1308 (H.B. 2559), Sec. 39, eff. September 1, 2009.

Sec. 1551.363. PRECEDENT MANUAL. (a) The board of trustees shall develop and maintain a precedent manual relating to the enrollment and claims determinations under Section 1551.352 and appeals of those determinations. The precedent manual:

- (1) must be composed of precedent-establishing determinations made by the board, executive director, or other staff, initially and on appeal, and include examples of previous determinations that are consistent with the identified precedent; and
- (2) may include other information identified by the board.

(b) The board of trustees shall make the precedent manual available to appropriate staff and to employees, participants, annuitants, and covered dependents.

(c) The board of trustees and staff involved in the claims appeal process are not bound by a decision in the manual.

Added by Acts 2017, 85th Leg., R.S., Ch. 530 (S.B. 301), Sec. 12, eff. September 1, 2017.

SUBCHAPTER I. FUNDS

Sec. 1551.401. EMPLOYEES LIFE, ACCIDENT, AND HEALTH INSURANCE AND BENEFITS FUND. (a) The employees life, accident, and health insurance and benefits fund is in the state treasury.

(b) The board of trustees shall administer the fund.

(c) Contributions of participants and the state provided for under this chapter shall be credited to the fund.

(d) The fund is available:

(1) without fiscal year limitation for all payments for any coverages provided for under this chapter; and

(2) for payment of expenses of administering this chapter within the limitations that may be specified annually by the legislature.

(e) The board of trustees shall regularly set aside in the fund an amount equal to a percentage of the contributions made by participants and the state that the board determines is reasonably adequate to pay the expenses of administering this chapter.

(f) The board of trustees, from time to time and in amounts it considers appropriate, may transfer unused funds for administrative expenses to the contingency reserves to be used by the board only for charges, claims, and expenses under the group benefits program.

(g) Except as provided by Section 1551.259(d), the retirement system may deposit to the credit of the fund any unclaimed money on a finding that a good faith effort has been made to locate the person entitled to the money.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1308 (H.B. 2559), Sec. 40, eff. September 1, 2009.

Sec. 1551.402. STATE EMPLOYEES CAFETERIA PLAN TRUST FUND. (a) The state employees cafeteria plan trust fund is in the state treasury.

(b) The board of trustees shall administer the fund.

(c) The following shall be credited to the fund:

(1) salary reduction payments for benefits included in a cafeteria plan other than group coverage plans under the group benefits program; and

(2) appropriations by the state for the administration of a cafeteria plan.

(d) The trust fund is available without fiscal year limitation:

(1) for all payments for any benefits included in a cafeteria plan other than group coverage plans under the group benefits program; and

(2) for payment of expenses of administering a cafeteria plan.

(e) The board of trustees may establish accounts for money in the fund as the board considers necessary, including accounts for the administration of a cafeteria plan. The board of trustees may transfer assets from one account to another:

(1) to pay benefits if:

(A) the transfer is necessary for financial management purposes; and

(B) adequate arrangements are made to reimburse the account from which the transfer was made; and

(2) to pay administrative expenses.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.403. FEES FOR STATE EMPLOYEES CAFETERIA PLAN TRUST FUND. (a) Subject to Subsection (e), the board of trustees may establish a monthly fee to be paid by each employee who elects to participate in a cafeteria plan for the purpose of paying the expenses of administering the cafeteria plan.

(b) The board of trustees shall establish the amount of the monthly fee and may establish a separate fee for each benefit included in a cafeteria plan.

(c) If the board of trustees establishes a monthly fee, each employee who participates in the cafeteria plan must authorize

payment of the fee by executing a separate payroll deduction agreement or as part of the salary reduction agreement, as determined by the board.

(d) The monthly fee shall be paid into the state employees cafeteria plan trust fund.

(e) The board of trustees may not establish a fee for administering the premium conversion benefit portion of a cafeteria plan.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.404. INSUFFICIENT EARNINGS FOR EMPLOYEE TO PARTICIPATE IN CAFETERIA FUND. (a) If the earnings of an employee who elects to participate in a cafeteria plan are insufficient to pay the cost of the coverages and benefits selected by the employee, the employee is liable to the board of trustees for an amount equal to the difference between:

- (1) the amount received by the board; and
- (2) the cost of the coverages and benefits.

(b) If the employee does not pay the difference within the time specified by the board of trustees, the board may:

- (1) cancel the coverages and benefits retroactive to the last month for which full payment was made; or
- (2) pursue any other available legal remedy.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.405. EMPLOYEES' HEALTH CARE STABILIZATION TRUST FUND. (a) The employees' health care stabilization trust fund is a fund in the state treasury.

(b) The board of trustees shall administer the fund.

(c) The following shall be credited to the fund:

- (1) money transferred to the fund at the direction of the legislature; and
- (2) gifts and grants contributed to the fund.

(d) In administering the fund, the board of trustees shall make investments in a manner that preserves the purchasing power of the fund's assets.

(e) Money in the fund may not be spent for any purpose, except

that the interest and investment returns of the fund may be appropriated only to stabilize the cost of state and participant contributions for health benefit coverage under this chapter by minimizing to the greatest extent possible increases in those contributions.

(f) The fund is exempt from the application of Section 403.095, Government Code.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.406. INVESTMENT OF FUNDS. (a) Under the standard of care provided by Section 815.307, Government Code, the board of trustees may manage and has full power to invest and reinvest the money in:

- (1) the employees life, accident, and health insurance and benefits fund;
- (2) the state employees cafeteria plan trust fund; and
- (3) the employees' health care stabilization trust fund.

(b) The earnings, including interest on money in the fund and proceeds from the sale of any investments, become a part of the fund.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.407. MANAGEMENT OF ASSETS. The board of trustees may commingle for investment purposes the assets of a fund created under this chapter with another fund created under this chapter or any other trust fund administered by the board if the board maintains and credits proportionate ownership records.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

SUBCHAPTER J. STATE CONSUMER-DIRECTED HEALTH PLAN

Sec. 1551.451. DEFINITIONS. In this subchapter:

- (1) "High deductible health plan" means a health benefit plan that complies with Section 223(c), Internal Revenue Code of 1986, and other federal law.
- (2) "Plan enrollee" means an employee or annuitant who is enrolled in the plan established under this subchapter.

(3) "Qualified medical expense" means an expense paid by a plan enrollee for medical care, as defined by Section 213(d), Internal Revenue Code of 1986, for the plan enrollee or the enrollee's dependents as defined by Section 152, Internal Revenue Code of 1986.

Added by Acts 2015, 84th Leg., R.S., Ch. 1015 (H.B. 966), Sec. 1, eff. September 1, 2015.

Sec. 1551.452. ESTABLISHMENT OF STATE CONSUMER-DIRECTED HEALTH PLAN. (a) The state consumer-directed health plan is established for the benefit of individuals eligible to participate in the group benefits program and those individuals' eligible dependents.

(b) The board of trustees may adopt rules necessary to administer this subchapter. In implementing this subchapter the board shall:

(1) establish health savings accounts under this subchapter and administer or select an administrator in accordance with Section 1551.453 for the accounts;

(2) finance a self-funded high deductible health plan that:
(A) is an integral part of the state consumer-directed health plan; and

(B) provides health benefit coverage, including preventive health care, to a plan enrollee in the state consumer-directed health plan and to the dependents of a plan enrollee in accordance with Section 1551.455; and

(3) provide to individuals eligible to participate in the group benefits program information regarding the operation of and option to participate in the state consumer-directed health plan established under this subchapter.

(c) In adopting rules and administering health savings accounts or selecting administrators for health savings accounts under this subchapter, the board of trustees shall ensure that the health savings accounts are qualified for appropriate federal tax exemptions.

Added by Acts 2015, 84th Leg., R.S., Ch. 1015 (H.B. 966), Sec. 1, eff. September 1, 2015.

Sec. 1551.453. ACCOUNT ADMINISTRATOR. (a) The account administrator selected to administer a health savings account established under this subchapter must be a person:

(1) qualified to serve as trustee under Section 223(d)(1)(B), Internal Revenue Code of 1986, and the rules adopted under that section; and

(2) experienced in administering health savings accounts or other similar trust accounts.

(b) An account administrator is the fiduciary of a plan enrollee who has a health savings account established under this subchapter.

Added by Acts 2015, 84th Leg., R.S., Ch. 1015 (H.B. 966), Sec. 1, eff. September 1, 2015.

Sec. 1551.454. PARTICIPATION IN PROGRAM. (a) Each individual eligible to participate in the basic coverage may choose instead to participate in the state consumer-directed health plan if the plan enrollee is an eligible individual under Section 223(c)(1), Internal Revenue Code of 1986. The dependents of a plan enrollee may participate in the state consumer-directed health plan in accordance with Section 1551.455.

(b) Participation in the state consumer-directed health plan qualifies a plan enrollee to receive a contribution to a health savings account under Section 1551.456. An individual who elects not to participate in the plan is not eligible to receive a contribution under that section.

(c) Under this section, the board of trustees has exclusive authority to determine an individual's eligibility to participate in the state consumer-directed health plan and may adopt rules regarding eligibility to participate in the plan.

Added by Acts 2015, 84th Leg., R.S., Ch. 1015 (H.B. 966), Sec. 1, eff. September 1, 2015.

Sec. 1551.455. COVERAGE FOR DEPENDENTS; REQUIRED CONTRIBUTIONS.

(a) A plan enrollee may obtain for the enrollee's dependents coverage in the state consumer-directed health plan in the manner determined by the board of trustees.

(b) If the plan enrollee elects to obtain dependent coverage under Subsection (a), the plan enrollee shall pay any required contribution for the dependent coverage in the state consumer-directed health plan in the manner prescribed by the board of trustees.

(c) Amounts contributed by a plan enrollee under this section may be:

(1) used to pay the cost of coverage in the high deductible health plan not paid by the state under Section 1551.456(b); or

(2) allocated by the board of trustees to an enrollee's health savings account in the manner described by Section 1551.456(c).

Added by Acts 2015, 84th Leg., R.S., Ch. 1015 (H.B. 966), Sec. 1, eff. September 1, 2015.

Sec. 1551.456. STATE CONTRIBUTION. (a) For each plan enrollee, from the state contribution that would otherwise be made for basic coverage for the enrollee, the state shall contribute annually to a high deductible health plan under this subchapter the amount that is necessary to pay the cost of coverage under the high deductible health plan and does not exceed the amount the state annually contributes for a full-time or part-time employee, as applicable, who is covered by the basic coverage.

(b) For each plan enrollee's dependent covered under this subchapter, from the state contribution that would otherwise be made for basic coverage for the dependent, the state shall contribute annually to the high deductible health plan under this subchapter the same percentage of the cost of coverage under the high deductible health plan as the state annually contributes for dependent coverage in the basic coverage.

(c) Before each plan year, the board of trustees may determine the amount of allocation of the state's contribution, if any, to an enrollee's health savings account that would otherwise be made for basic coverage for the enrollee and that remains after payment for coverage under Subsection (a) or (b).

(d) For a calendar year, the amount of any allocations made under Subsection (c) and Section 1551.455(c)(2), in the aggregate, may not exceed the sum of the monthly limitations imposed by federal

law for health savings accounts.

Added by Acts 2015, 84th Leg., R.S., Ch. 1015 (H.B. 966), Sec. 1, eff. September 1, 2015.

Sec. 1551.457. PLAN ENROLLEE CONTRIBUTIONS. (a) Each plan enrollee, in accordance with Section 1551.305, shall contribute any amount required to cover the selected participation in the high deductible health plan that exceeds the state contribution amount under Section 1551.456.

(b) A plan enrollee may contribute any amount allowed under federal law to the enrollee's health savings account in addition to the state contribution under Section 1551.456.

(c) A plan enrollee shall make contributions under this section in the manner prescribed by the board of trustees.

Added by Acts 2015, 84th Leg., R.S., Ch. 1015 (H.B. 966), Sec. 1, eff. September 1, 2015.

Sec. 1551.458. COORDINATION WITH CAFETERIA PLAN. (a) The board of trustees has exclusive authority to determine the eligibility of a plan enrollee to participate in any flexible spending account that is part of a cafeteria plan offered under this chapter.

(b) The board of trustees may adopt rules regarding the eligibility of a plan enrollee to participate in any flexible spending account that is part of a cafeteria plan offered under this chapter.

(c) A plan enrollee may not participate in any flexible spending account that would disqualify the enrollee's health savings account from favorable tax treatment under federal law.

Added by Acts 2015, 84th Leg., R.S., Ch. 1015 (H.B. 966), Sec. 1, eff. September 1, 2015.

Sec. 1551.459. EXEMPTION FROM EXECUTION; UNASSIGNABILITY. A state contribution to a health savings account or a high deductible health plan is exempt from execution and is unassignable in the same

manner and to the same extent as an amount described by Section 1551.011.

Added by Acts 2015, 84th Leg., R.S., Ch. 1015 (H.B. 966), Sec. 1, eff. September 1, 2015.

Sec. 1551.460. SINGLE UNDIVIDED RISK POOL. In implementing and administering the state consumer-directed health plan established under this subchapter, the board of trustees may not divide the self-funded risk pool of the group benefits program provided under this chapter or create a separate self-funded risk pool for that program.

Added by Acts 2015, 84th Leg., R.S., Ch. 1015 (H.B. 966), Sec. 1, eff. September 1, 2015.

CHAPTER 1552. LONG-TERM CARE INSURANCE FOR STATE EMPLOYEES

Sec. 1552.001. DEFINITIONS. In this chapter, "annuitant," "board of trustees," and "employee" have the meanings assigned by Section 1551.003.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1552.002. ESTABLISHMENT OF PROGRAM. (a) The board of trustees may establish a long-term care insurance program to provide long-term care insurance coverage for:

- (1) an individual eligible to participate in the program provided by Chapter 1551 as an employee or annuitant;
- (2) the spouse, parent, or grandparent of an employee or annuitant; and
- (3) a parent of a spouse described by Subdivision (2).

(b) The board of trustees may not implement a long-term care insurance program unless any cost or administrative burden associated with the development of, implementation of, or communications about the program is incidental.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by:

Acts 2019, 86th Leg., R.S., Ch. 158 (H.B. 392), Sec. 2, eff.

September 1, 2019.

Sec. 1552.003. ADMINISTERING FIRM. The board of trustees may select an administering firm to administer the long-term care insurance program under contract with the board.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by:

Acts 2019, 86th Leg., R.S., Ch. 158 (H.B. 392), Sec. 3, eff. September 1, 2019.

Sec. 1552.005. PROGRAM NOT PART OF OTHER GROUP COVERAGES. (a) The long-term care insurance program is not part of the group coverages offered under Chapter 1551.

(b) The state may not contribute any part of the premiums for coverage offered under this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by:

Acts 2019, 86th Leg., R.S., Ch. 158 (H.B. 392), Sec. 4, eff. September 1, 2019.

Sec. 1552.006. RULES. The board of trustees may adopt rules as necessary to implement this chapter, including rules specifying the coverage to be offered under the long-term care insurance program.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by:

Acts 2019, 86th Leg., R.S., Ch. 158 (H.B. 392), Sec. 5, eff. September 1, 2019.

CHAPTER 1560. DELIVERY OF PRESCRIPTION DRUGS BY MAIL

Sec. 1560.001. DEFINITIONS. In this chapter:

(1) "Community retail pharmacy" means a pharmacy that is licensed as a Class A pharmacy under Chapter 560, Occupations Code.

(2) "Mail order pharmacy" means a pharmacy that is licensed under Chapter 560, Occupations Code, and that primarily delivers

prescription drugs to an enrollee through the United States Postal Service or a commercial delivery service.

Added by Acts 2009, 81st Leg., R.S., Ch. 1207 (S.B. 704), Sec. 5, eff. September 1, 2009.

Sec. 1560.002. APPLICABILITY OF CHAPTER. This chapter applies only to a health benefit plan 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 or administered by:

- (1) the Teacher Retirement System of Texas under Chapter 1575 or 1579; or
- (2) the Employees Retirement System of Texas under Chapter 1551.

Added by Acts 2009, 81st Leg., R.S., Ch. 1207 (S.B. 704), Sec. 5, eff. September 1, 2009.

Sec. 1560.003. MULTIPLE-MONTH SUPPLY OF PRESCRIPTION DRUG. (a) In this section, "multiple-month supply" means a supply for 60 or more days.

(b) Notwithstanding any other law, an issuer of a health benefit plan that provides pharmacy benefits to enrollees must allow an enrollee to obtain from a community retail pharmacy a multiple-month supply of any prescription drug under the same terms and conditions applicable when the prescription drug is obtained from a mail order pharmacy, if the community retail pharmacy agrees to accept reimbursement on exactly the same terms and conditions that apply to a mail order pharmacy.

(c) This section does not require:

- (1) the issuer of a health benefit plan to contract with:
 - (A) a retail pharmacy that does not agree to accept reimbursement on exactly the same terms and conditions that apply to a mail order pharmacy; or
 - (B) more than one mail order pharmacy; or
- (2) a community retail pharmacy to:

(A) provide a multiple-month supply of a prescription drug under the same terms and conditions applicable when the prescription drug is obtained from a mail order pharmacy; or

(B) agree to accept reimbursement on exactly the same terms and conditions that apply to a mail order pharmacy.

Added by Acts 2009, 81st Leg., R.S., Ch. 1207 (S.B. 704), Sec. 5, eff. September 1, 2009.

Sec. 1560.004. PRESCRIPTION DRUG REIMBURSEMENT RATES. (a) An issuer of a health benefit plan that provides pharmacy benefits to enrollees shall reimburse pharmacies participating in the health plan using prescription drug reimbursement rates, for both brand name and generic prescription drugs, that are based on a current and nationally recognized benchmark index that includes average wholesale price and maximum allowable cost.

(b) Regardless of whether a pharmacy is a mail order pharmacy or a community retail pharmacy, an issuer of a health benefit plan shall use the same benchmark index, including the same average wholesale price, maximum allowable cost, and national prescription drug codes, to reimburse all pharmacies participating in the health benefit plan.

Added by Acts 2009, 81st Leg., R.S., Ch. 1207 (S.B. 704), Sec. 5, eff. September 1, 2009.

CHAPTER 1575. TEXAS PUBLIC SCHOOL EMPLOYEES GROUP BENEFITS PROGRAM
SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1575.001. SHORT TITLE. This chapter may be cited as the Texas Public School Retired Employees Group Benefits Act.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.413(a), eff. Sept. 1, 2003.

Sec. 1575.002. GENERAL DEFINITIONS. In this chapter:

(1) "Active employee" means a contributing member of the Teacher Retirement System of Texas who:

(A) is employed by a public school; and

(B) is not entitled to coverage under a plan provided under Chapter 1551 or 1601.

(2) "Carrier" means an insurance company or hospital service corporation authorized by the department under this code or another insurance law of this state to provide any of the insurance coverages, benefits, or services provided by this chapter.

(3) "Fund" means the retired school employees group insurance fund.

(4) "Group program" means the Texas Public School Employees Group Insurance Program authorized by this chapter.

(5) "Health benefit plan" means any group arrangement to provide health care benefits or to pay or reimburse expenses for health care services.

(5-a) "Medicare Advantage plan" means a health benefit plan operated under Part C of the Medicare program.

(5-b) "Medicare prescription drug plan" means a health benefit plan operated under Part D of the Medicare program.

(6) "Public school" means:

(A) a school district;

(B) another educational district whose employees are members of the Teacher Retirement System of Texas;

(C) a regional education service center established under Chapter 8, Education Code; or

(D) an open-enrollment charter school established under Subchapter D, Chapter 12, Education Code.

(7) "Trustee" means the Teacher Retirement System of Texas.

(8) "Usual and customary rate" means the relevant allowable amount as described by the applicable master benefit plan document or policy.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Amended by Acts 2003, 78th Leg., ch. 201, Sec. 47, eff. Sept. 1, 2003; Acts 2003, 78th Leg., ch. 366, Sec. 3.01, eff. Sept. 1, 2003; Acts 2003, 78th Leg., ch. 1231, Sec. 1, eff. Sept. 1, 2004; Acts 2003, 78th Leg., ch. 1276, Sec. 10A.414(a), eff. Sept. 1, 2003.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 712 (H.B. [3976](#)), Sec. 1, eff. September 1, 2017.

Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. [1264](#)), Sec. 1.13, eff.

September 1, 2019.

Sec. 1575.0025. REFERENCES TO BASIC PLAN. A reference in this code to a "basic plan" under this chapter means a health benefit plan provided under this chapter other than a Medicare Advantage plan or a Medicare prescription drug plan.

Added by Acts 2017, 85th Leg., R.S., Ch. 712 (H.B. 3976), Sec. 2, eff. September 1, 2017.

Sec. 1575.003. DEFINITION OF DEPENDENT AND RELATED TERMS. In this chapter:

(1) "Dependent" means:

(A) the spouse of a retiree;

(B) a child of a retiree or deceased active member if the child is younger than 26 years of age, including:

(i) an adopted child or child who is lawfully placed for legal adoption;

(ii) a foster child, stepchild, or other child who is in a regular parent-child relationship; or

(iii) a natural child;

(C) a retiree's natural child, adopted child, foster child, stepchild, or other child who is in a regular parent-child relationship and who lives with or has his or her care provided by the retiree or surviving spouse on a regular basis regardless of the child's age, if the child has a mental disability or is physically incapacitated to an extent that the child is dependent on the retiree or surviving spouse for care or support, as determined by the trustee; or

(D) a deceased active member's natural child, adopted child, foster child, stepchild, or other child who is in a regular parent-child relationship, without regard to the age of the child, if, while the active member was alive, the child:

(i) lived with or had the child's care provided by the active member on a regular basis; and

(ii) had a mental disability or was physically incapacitated to an extent that the child was dependent on the active member or surviving spouse for care or support, as determined by the

trustee.

(2) "Surviving dependent child" means:

- (A) the dependent child of a deceased retiree who has survived the deceased retiree and the deceased retiree's spouse; or
- (B) the dependent child of a deceased active member who has survived the deceased member and the deceased member's spouse if the deceased member:
 - (i) had contributions made to the group program at the last place of employment of the deceased member in public education in this state;
 - (ii) had 10 or more years of service credit in the Teacher Retirement System of Texas; and
 - (iii) died on or after September 1, 1986.

(3) "Surviving spouse" means:

- (A) the surviving spouse of a deceased retiree; or
- (B) the surviving spouse of a deceased active member:
 - (i) for whom contributions have been made to the group program at the last place of employment of the deceased member in public education in this state;
 - (ii) who had 10 or more years of service credit in the Teacher Retirement System of Texas; and
 - (iii) who died on or after September 1, 1986.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.414(b), (c), eff. Sept. 1, 2003.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 455 (S.B. 1667), Sec. 21, eff. September 1, 2011.

Acts 2013, 83rd Leg., R.S., Ch. 1078 (H.B. 3357), Sec. 18, eff. June 14, 2013.

Sec. 1575.004. DEFINITION OF RETIREE. (a) In this chapter, "retiree" means:

(1) an individual not eligible for coverage under a plan provided under Chapter 1551 or 1601 who:

- (A) has taken a service retirement under the Teacher Retirement System of Texas after September 1, 2005, with at least 10 years of service credit in the system, which may include up to five

years of military service credit, but which may not include any other service credit purchased for equivalent or special service credit, and either:

(i) the sum of the retiree's age and years of service credit in the retirement system equals or exceeds 80 at the time of retirement, regardless of whether the retiree had a reduction in the retirement annuity for early age; or

(ii) the retiree has 30 or more years of service credit in the retirement system at the time of retirement;

(B) has taken a service retirement under the Teacher Retirement System of Texas after September 1, 2004, but on or before August 31, 2005, and on September 1, 2005, either:

(i) meets the requirements for eligibility for the group program for coverage as a retiree as those requirements existed on August 31, 2004;

(ii) meets the requirements of Paragraph (A); or

(iii) is enrolled in the group program and was enrolled in the group program on August 31, 2005; or

(C) has taken a service retirement under the Teacher Retirement System of Texas on or before August 31, 2004, and who is enrolled in the group program on August 31, 2005;

(2) an individual who:

(A) has taken a disability retirement under the Teacher Retirement System of Texas; and

(B) is entitled to receive monthly benefits from the Teacher Retirement System of Texas; or

(3) an individual who:

(A) has taken a disability retirement under the Teacher Retirement System of Texas;

(B) has at least 10 years of service credit in the Teacher Retirement System of Texas on the date of disability retirement, as determined under Section 824.304, Government Code; and

(C) is not entitled to receive monthly benefits from the Teacher Retirement System of Texas because those benefits have been suspended in accordance with Section 824.310, Government Code.

(b) In this section, "public school" has the meaning assigned by Section 821.001, Government Code.

(c) For purposes of this section, to meet the requirements for eligibility that existed on August 31, 2004, for a service retiree, an individual must not have been eligible to be covered by a plan

provided under Chapter 1551 or 1601 and must have taken a service retirement under the Teacher Retirement System of Texas with either:

- (1) at least 10 years of service credit in the retirement system for actual service in public schools in this state; or
- (2) at least five years of service credit for actual service in the public schools in this state and five years of out-of-state service credit in the Teacher Retirement System of Texas.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 201, Sec. 48, eff. Sept. 1, 2003; Acts 2003, 78th Leg., ch. 1231, Sec. 2, eff. Sept. 1, 2004; Acts 2003, 78th Leg., ch. 1276, Sec. 10A.415, eff. Sept. 1, 2003; Acts 2003, 78th Leg., 3rd C.S., ch. 3, Sec. 16.05, eff. Sept. 1, 2004.

Amended by:

Acts 2005, 79th Leg., Ch. 1359 (S.B. 1691), Sec. 38, eff. September 1, 2005.

Acts 2007, 80th Leg., R.S., Ch. 1230 (H.B. 2427), Sec. 15, eff. September 1, 2007.

Sec. 1575.005. ISSUANCE OF CERTIFICATE OF COVERAGE. At the time and in the circumstances specified by the trustee, a carrier shall issue to each retiree, surviving spouse, or surviving dependent child covered under this chapter a certificate of coverage that:

- (1) states the benefits to which the person is entitled;
- (2) states to whom the benefits are payable;
- (3) states to whom a claim must be submitted; and
- (4) summarizes the provisions of the coverage principally affecting the person.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.416(a), eff. Sept. 1, 2003.

Sec. 1575.006. EXEMPTION FROM PROCESS. (a) The following are exempt from execution, attachment, garnishment, or any other process:

- (1) benefit payments, active employee and state contributions, and retiree, surviving spouse, and surviving dependent child contributions;

(2) any rights, benefits, or payments accruing to any person under this chapter; and

(3) any money in the fund.

(b) The items listed in Subsection (a) may not be assigned except for direct payment to benefit providers as authorized by the trustee by contract, rule, or otherwise.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.417, eff. Sept. 1, 2003.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 712 (H.B. 3976), Sec. 3, eff. September 1, 2017.

Sec. 1575.007. EXEMPTION FROM STATE TAXES AND FEES. A premium or contribution on a policy, insurance contract, or agreement authorized by this chapter is not subject to any state tax, regulatory fee, or surcharge, including a premium or maintenance tax or fee.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1575.008. COVERAGE EXEMPT FROM INSURANCE LAW. A coverage plan provided under this chapter is exempt from any other insurance law, including common law, that does not expressly apply to the plan or this chapter.

Added by Acts 2005, 79th Leg., Ch. 1359 (S.B. 1691), Sec. 39, eff. September 1, 2005.

Text of section effective until September 1, 2025

Sec. 1575.009. BALANCE BILLING PROHIBITION NOTICE. (a) The administrator of a managed care plan provided under the group program shall provide written notice in accordance with this section in an explanation of benefits provided to the enrollee and the physician or health care provider in connection with a health care or medical service or supply or transport provided by an out-of-network provider. The notice must include:

(1) a statement of the billing prohibition under Section 1575.171, 1575.172, 1575.173, or 1575.174, as applicable;

(2) the total amount the physician or provider may bill the enrollee under the enrollee's managed care plan and an itemization of copayments, coinsurance, deductibles, and other amounts included in that total; and

(3) for an explanation of benefits provided to the physician or provider, information required by commissioner rule advising the physician or provider of the availability of mediation or arbitration, as applicable, under Chapter 1467.

(b) The administrator shall provide the explanation of benefits with the notice required by this section to a physician or health care provider not later than the date the administrator makes a payment under Section 1575.171, 1575.172, 1575.173, or 1575.174, as applicable.

Added by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. [1264](#)), Sec. 1.14, eff. September 1, 2019.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 981 (S.B. [2476](#)), Sec. 11(a), eff. September 1, 2023.

Acts 2023, 88th Leg., R.S., Ch. 981 (S.B. [2476](#)), Sec. 11(b), eff. September 1, 2025.

Text of section effective on September 1, 2025

Sec. 1575.009. BALANCE BILLING PROHIBITION NOTICE. (a) The administrator of a managed care plan provided under the group program shall provide written notice in accordance with this section in an explanation of benefits provided to the enrollee and the physician or health care provider in connection with a health care or medical service or supply provided by an out-of-network provider. The notice must include:

(1) a statement of the billing prohibition under Section 1575.171, 1575.172, or 1575.173, as applicable;

(2) the total amount the physician or provider may bill the enrollee under the enrollee's managed care plan and an itemization of copayments, coinsurance, deductibles, and other amounts included in that total; and

(3) for an explanation of benefits provided to the

physician or provider, information required by commissioner rule advising the physician or provider of the availability of mediation or arbitration, as applicable, under Chapter 1467.

(b) The administrator shall provide the explanation of benefits with the notice required by this section to a physician or health care provider not later than the date the administrator makes a payment under Section 1575.171, 1575.172, or 1575.173, as applicable.

Added by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 1.14, eff. September 1, 2019.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 981 (S.B. 2476), Sec. 11(a), eff. September 1, 2023.

Acts 2023, 88th Leg., R.S., Ch. 981 (S.B. 2476), Sec. 11(b), eff. September 1, 2025.

Sec. 1575.010. INFORMATION REGARDING APPEALS. The trustee shall develop and distribute informational materials to individuals enrolled in a health benefit plan offered under the group program regarding:

(1) the enrollee's right to appeal denial of an adverse determination, as defined by Section 4201.002, to an independent review organization;

(2) the procedures for appealing to an independent review organization; and

(3) the assistance available from the trustee in navigating the procedures for appeal.

Added by Acts 2021, 87th Leg., R.S., Ch. 141 (H.B. 1585), Sec. 16, eff. May 26, 2021.

SUBCHAPTER B. ADMINISTRATION

Sec. 1575.051. ADMINISTRATION OF GROUP PROGRAM. The trustee shall take the actions it considers necessary to devise, implement, and administer the group program.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.419, eff. Sept. 1, 2003.

Sec. 1575.052. AUTHORITY TO ADOPT RULES AND PROCEDURES; OTHER AUTHORITY. (a) The trustee may adopt rules, plans, procedures, and orders reasonably necessary to implement this chapter, including:

- (1) minimum benefit and financing standards for group coverage for retirees, dependents, surviving spouses, and surviving dependent children;
- (2) group coverage for retirees, dependents, surviving spouses, and surviving dependent children;
- (3) procedures for contributions and deductions;
- (4) periods for enrollment and selection of coverage and procedures for enrolling and exercising options under the group program;
- (5) procedures for claims administration;
- (6) procedures to administer the fund; and
- (7) a timetable for:
 - (A) developing minimum benefit and financial standards for group coverage;
 - (B) establishing health benefit plans offered under the group program; and
 - (C) taking bids and awarding contracts for health benefit plans offered under the group program.

(b) The trustee may:

- (1) study the operation of all group coverage provided under this chapter; and
- (2) contract for advice and counsel in implementing and administering the group program with independent and experienced group insurance consultants and actuaries.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.420(a), eff. Sept. 1, 2003.

Amended by:

Acts 2005, 79th Leg., Ch. 1359 (S.B. [1691](#)), Sec. 40, eff. September 1, 2005.

Acts 2017, 85th Leg., R.S., Ch. 712 (H.B. [3976](#)), Sec. 4, eff. September 1, 2017.

Sec. 1575.053. PERSONNEL. (a) The trustee may employ persons to assist the trustee in implementing this chapter.

(b) The trustee shall prescribe the duties and compensation of each employee.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.421, eff. Sept. 1, 2003.

Sec. 1575.054. BUDGET. Expenses incurred in developing and administering the group program shall be paid as provided by a budget adopted by the trustee.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.421, eff. Sept. 1, 2003.

Sec. 1575.055. DEPARTMENT ASSISTANCE. The department shall, as requested by the trustee, assist the trustee in implementing and administering this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.421, eff. Sept. 1, 2003.

Sec. 1575.056. TRANSFER OF RECORDS RELATING TO ACTIVE EMPLOYEE PROGRAM. The trustee shall transfer from the program all records relating to active employees participating in the program established under Chapter 1579 not later than the date on which the program established under Chapter 1579 is implemented.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.422(a), eff. Sept. 1, 2003.

SUBCHAPTER C. PROVISION OF BENEFITS

Sec. 1575.101. SYSTEM AS GROUP PLAN HOLDER. The Teacher Retirement System of Texas is the group plan holder of a plan

established under this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.423, eff. Sept. 1, 2003.

Sec. 1575.102. SELF-INSURED PLANS. The trustee may self-insure any plan established under this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.423, eff. Sept. 1, 2003.

Sec. 1575.104. TERMS OF CONTRACT. A contract for group coverage awarded by the trustee must meet the minimum benefit and financial standards adopted by the trustee.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.423, eff. Sept. 1, 2003.

Sec. 1575.105. PLAN COVERAGE SECONDARY TO CERTAIN OTHER COVERAGE. The coverage provided by a plan established under this chapter:

(1) is secondary to Medicare hospital and medical insurance to the extent permitted by federal law if the retiree, dependent, surviving spouse, or surviving dependent child is entitled to receive Medicare hospital insurance benefits without charge; and

(2) may be made secondary to other coverage to which the retiree, dependent, surviving spouse, or surviving dependent child is entitled.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1575.106. COMPETITIVE BIDDING REQUIREMENTS; RULE. (a) A contract to provide group benefits under this chapter may be awarded only through competitive bidding under rules adopted by the trustee.

(b) The trustee shall submit for competitive bidding at least every six years each contract for coverage under this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.424(a), eff. Sept. 1, 2003.

Sec. 1575.107. CONTRACT AWARD; CONSIDERATIONS. (a) In awarding a contract to provide group benefits under this chapter, the trustee is not required to select the lowest bid and may consider any relevant criteria, including the bidder's:

- (1) ability to service contracts;
- (2) past experiences; and
- (3) financial stability.

(b) If the trustee awards a contract to a bidder whose bid deviates from that advertised, the trustee shall record the deviation and fully justify the reason for the deviation in the minutes of the next meeting of the trustee.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.424(b), eff. Sept. 1, 2003.

Sec. 1575.108. USE OF PRIVATE ENTITIES. The trustee may engage a private entity to collect contributions from or to settle claims in connection with a plan established by the trustee under this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.425, eff. Sept. 1, 2003.

Sec. 1575.109. USE OF HEALTH CARE PROVIDER. To provide benefits to participants in the group program, the trustee may contract directly with a health care provider, including a health maintenance organization, a preferred provider organization, a carrier, an administrator, and any other qualified vendor.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.425, eff. Sept. 1, 2003.

Sec. 1575.110. PHARMACY BENEFIT MANAGER CONTRACTS. (a) In awarding a contract to provide pharmacy benefit manager services under this chapter, the trustee is not required to select the lowest bid but must select a contract that meets the criteria established by this section.

(b) The contract must state that:

(1) the trustee is entitled to audit the pharmacy benefit manager to verify costs and discounts associated with drug claims, pharmacy benefit manager compliance with contract requirements, and services provided by subcontractors;

(2) the audit must be conducted by an independent auditor in accordance with established auditing standards; and

(3) to conduct the audit, the trustee and the independent auditor are entitled access to information related to the services and the costs associated with the services performed under the contract, including access to the pharmacy benefit manager's facilities, records, contracts, medical records, and agreements with subcontractors.

(c) The contract must define the information that the pharmacy benefit manager is required to provide to the trustee concerning the audit of the retail, independent, and mail order pharmacies performing services under the contract and describe how the results of these audits must be reported to the trustee, including how often the results must be reported. The contract must state whether the pharmacy benefit manager is required to return recovered overpayments to the trustee.

(d) The contract must state that any audit of a mail order pharmacy owned by the pharmacy benefit manager must be conducted by an independent auditor selected by the trustee in accordance with established auditing standards.

Added by Acts 2009, 81st Leg., R.S., Ch. 1207 (S.B. 704), Sec. 6, eff. September 1, 2009.

SUBCHAPTER D. COVERAGES AND PARTICIPATION

Sec. 1575.151. TYPES OF COVERAGES. The trustee may include in a plan any coverage it considers advisable, including:

- (1) life insurance;
- (2) accidental death and dismemberment coverage;
- (3) coverage for:
 - (A) hospital care and benefits;
 - (B) surgical care and treatment;
 - (C) medical care and treatment;
 - (D) dental care;
 - (E) eye care;
 - (F) obstetrical benefits;
 - (G) long-term care;
 - (H) prescribed drugs, medicines, and prosthetic devices; and
 - (I) supplemental benefits, supplies, and services in accordance with this chapter; and
- (4) protection against loss of salary.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.425, eff. Sept. 1, 2003.

Sec. 1575.152. HEALTH BENEFIT PLAN MUST COVER PREEXISTING CONDITIONS. A health benefit plan offered under the group program, other than a Medicare Advantage plan or a Medicare prescription drug plan, must cover preexisting conditions.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by:

Acts 2017, 85th Leg., R.S., Ch. 712 (H.B. 3976), Sec. 5, eff. September 1, 2017.

For expiration of Subsections (d) and (e), see Subsection (e).

Sec. 1575.153. HEALTH BENEFIT PLAN COVERAGE FOR RETIREES. (a) A retiree who applies for coverage during an enrollment period may not be denied coverage in a health benefit plan provided under this chapter for which the retiree is eligible unless the trustee finds under Subchapter K that the retiree defrauded or attempted to defraud

the group program.

(b) A retiree who has coverage under a health benefit plan offered under the group program shall pay a monthly contribution, as determined by the trustee.

(c) As a condition of electing coverage under a health benefit plan, the retiree must, in writing, authorize the trustee to deduct the amount of the contribution from the retiree's monthly annuity payment. The trustee shall deduct the contribution in the manner and form determined by the trustee.

(d) Notwithstanding Subsection (b), a retiree is not required to pay a monthly contribution under this section until the 2022 plan year if the retiree:

(1) has taken a disability retirement under the Teacher Retirement System of Texas on or before January 1, 2017;

(2) is receiving disability retirement benefits from the Teacher Retirement System of Texas; and

(3) is not eligible to enroll in Medicare.

(e) This subsection and Subsection (d) expire at the end of the 2021 plan year on December 31, 2021.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 201, Sec. 49(a), eff. Sept. 1, 2003; Acts 2003, 78th Leg., ch. 1231, Sec. 3(a), eff. Sept. 1, 2004; Acts 2003, 78th Leg., ch. 1276, Sec. 10A.426(a), eff. Sept. 1, 2003.
Amended by:

Acts 2017, 85th Leg., R.S., Ch. 712 (H.B. 3976), Sec. 6, eff. September 1, 2017.

Sec. 1575.155. COVERAGE FOR DEPENDENTS OF RETIREE. (a) A retiree participating in the group program is entitled to secure for the retiree's dependents group coverage under this chapter for which the dependents are eligible under this chapter or any other law, including requirements established by the trustee.

(b) The additional contribution payments for the dependent coverage shall be deducted from the annuity payments to the retiree in the manner and form determined by the trustee.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.427, eff. Sept. 1, 2003.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 712 (H.B. 3976), Sec. 7, eff. September 1, 2017.

Sec. 1575.156. COVERAGE FOR SURVIVING SPOUSE OR DEPENDENTS OF SURVIVING SPOUSE. (a) A surviving spouse who is entitled to group coverage under this chapter may elect to retain or obtain coverage for which the surviving spouse or dependents of the surviving spouse are eligible.

(b) Repealed by Acts 2017, 85th Leg., R.S., Ch. 712 (H.B. 3976), Sec. 24(2), eff. September 1, 2017.

(c) A surviving spouse who elects under this section to retain or obtain coverage under a health benefit plan offered under the group program for the surviving spouse or dependents of the surviving spouse shall pay a monthly contribution, as determined by the trustee.

(d) As a condition of electing coverage under a health benefit plan, the surviving spouse must, in writing, authorize the trustee to deduct the amount of the contribution from the surviving spouse's monthly annuity payment. The trustee shall deduct the contribution in the manner and form determined by the trustee.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.428, eff. Sept. 1, 2003.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 712 (H.B. 3976), Sec. 8, eff. September 1, 2017.

Acts 2017, 85th Leg., R.S., Ch. 712 (H.B. 3976), Sec. 24(2), eff. September 1, 2017.

Sec. 1575.157. COVERAGE FOR SURVIVING DEPENDENT CHILD. (a) A surviving dependent child, the guardian of the child's estate, or the person having custody of the child may elect to retain or obtain group coverage for which the surviving dependent child is eligible at the applicable rate for a dependent.

(b) A surviving dependent child who has coverage under a health benefit plan offered under the group program shall pay a monthly

contribution, as determined by the trustee. The applicable contributions must be provided by the surviving dependent child in the manner established by the trustee.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003. Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.429, eff. Sept. 1, 2003.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 712 (H.B. 3976), Sec. 9, eff. September 1, 2017.

Sec. 1575.158. GROUP HEALTH BENEFIT PLANS. (a) The trustee shall establish or contract for and make available under the group program a high deductible health plan for retirees, dependents, surviving spouses, or surviving dependent children who are eligible under Section 1575.1582.

(b) Repealed by Acts 2017, 85th Leg., R.S., Ch. 712 (H.B. 3976), Sec. 24(3), eff. September 1, 2017.

(c) The trustee shall establish or contract for and make available under the group program a Medicare Advantage plan and a Medicare prescription drug plan for retirees, dependents, surviving spouses, and surviving dependent children who are eligible under Section 1575.1582.

(d) Notwithstanding Subsection (c), if the trustee determines that a Medicare Advantage plan or a Medicare prescription drug plan is no longer appropriate for the group program, the trustee may establish or contract for and make available under the group program other health benefit plans to provide medical or pharmacy benefits.

(e) To the extent the group program has available funds, the trustee shall consider implementing a plan design for non-Medicare eligible enrollees in the high deductible health plan established or made available under Subsection (a) that provides assistance in the payment of preventive care, including generic preventive maintenance medications, in a manner that is consistent with federal law.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003. Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.430, eff. Sept. 1, 2003.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 1214 (S.B. 1458), Sec. 9, eff.

September 1, 2014.

Acts 2017, 85th Leg., R.S., Ch. 712 (H.B. 3976), Sec. 10, eff. September 1, 2017.

Acts 2017, 85th Leg., R.S., Ch. 712 (H.B. 3976), Sec. 11, eff. September 1, 2017.

Acts 2017, 85th Leg., R.S., Ch. 712 (H.B. 3976), Sec. 24(3), eff. September 1, 2017.

Sec. 1575.1582. ELIGIBILITY FOR GROUP HEALTH BENEFIT PLANS.

(a) A retiree, dependent, surviving spouse, or surviving dependent child who is not eligible to enroll in Medicare is eligible to enroll in a high deductible health plan offered under the group program, subject to any other applicable eligibility requirements, including requirements established by the trustee, but is not eligible to enroll in another health benefit plan offered under the group program.

(b) A retiree, dependent, surviving spouse, or surviving dependent child who is eligible to enroll in Medicare is eligible to enroll in a Medicare Advantage plan or a Medicare prescription drug plan offered under the group program, subject to any other applicable eligibility requirements, including requirements established by the trustee, but is not eligible to enroll in another health benefit plan offered under the group program unless authorized by Subsection (c).

(c) If the trustee makes another health benefit plan available under Section 1575.158(d), any individual otherwise eligible under this section to enroll in a Medicare Advantage plan or Medicare prescription drug plan is eligible to enroll in that health benefit plan.

Added by Acts 2017, 85th Leg., R.S., Ch. 712 (H.B. 3976), Sec. 12, eff. September 1, 2017.

Sec. 1575.159. COVERAGE FOR PROSTATE-SPECIFIC ANTIGEN TEST. A health benefit plan offered under the group program, other than a Medicare Advantage plan or a Medicare prescription drug plan, must provide coverage for a medically accepted prostate-specific antigen test used for the detection of prostate cancer for each male enrolled in the health benefit plan who:

- (1) is at least 50 years of age; or
- (2) is at least 40 years of age and:
 - (A) has a family history of prostate cancer; or
 - (B) exhibits another cancer risk factor.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 712 (H.B. 3976), Sec. 13, eff. September 1, 2017.

Sec. 1575.160. GROUP LIFE OR ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE: PAYMENT OF CLAIM. The amount of group life insurance or group accidental death and dismemberment insurance covering a retiree, dependent, surviving spouse, or surviving dependent child on the date of death shall be paid, on the establishment of a valid claim, only to:

- (1) the beneficiary designated by the person in a signed and witnessed document received before death in the office of the trustee; or
- (2) a person in the order prescribed by Section 824.103(b), Government Code, if a beneficiary is not properly designated or a beneficiary does not exist.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.431(a), eff. Sept. 1, 2003.

Sec. 1575.1601. GROUP BENEFITS FOR DENTAL AND VISION CARE. The trustee shall establish or contract for and make available under the group program the following plans for retirees, dependents, surviving spouses, and surviving dependent children:

- (1) an optional plan that provides coverage for dental care; and
- (2) an optional plan that provides coverage for vision care.

Added by Acts 2023, 88th Leg., R.S., Ch. 955 (S.B. 1854), Sec. 1, eff. September 1, 2023.

For expiration of Subsections (b) and (c), see Subsection (c).

Sec. 1575.161. ENROLLMENT PERIODS. (a) A retiree eligible for coverage under the group program may select for the retiree and the retiree's eligible dependents any coverage provided under this chapter for which each of those individuals is otherwise eligible:

(1) on any date that is on or after the date the retiree retires and on or before the 90th day after that date;

(2) during a period beginning on the date the retiree reaches 65 years of age and ending on a date set by the trustee by rule; and

(3) during any other open enrollment periods for retirees set by the trustee by rule.

(b) Notwithstanding Subsection (a), the trustee by rule shall provide one opportunity to reenroll in a health benefit plan offered under the group program for an otherwise eligible retiree:

(1) who is eligible to enroll in Medicare;

(2) whose initial enrollment was voluntarily terminated on or after January 1, 2017, and on or before December 31, 2019; and

(3) who opts to reenroll on or before December 31, 2023.

(c) Subsection (b) and this subsection expire September 1, 2024.

(d) Repealed by Acts 2017, 85th Leg., R.S., Ch. 712 (H.B. [3976](#)), Sec. 24(5), eff. September 1, 2017.

(e) Repealed by Acts 2017, 85th Leg., R.S., Ch. 712 (H.B. [3976](#)), Sec. 24(5), eff. September 1, 2017.

(f) An individual enrolled in a health benefit plan offered under the group program may remain enrolled in that health benefit plan as long as the individual remains eligible for that health benefit plan. If an individual becomes ineligible for a health benefit plan in which the individual is enrolled, the trustee shall enroll the individual in a health benefit plan for which the individual is eligible, if any, in accordance with procedures established by the trustee.

Added by Acts 2003, 78th Leg., ch. 201, Sec. 50, eff. Sept. 1, 2003; Acts 2003, 78th Leg., ch. 1231, Sec. 4, eff. Sept. 1, 2004. Amended by Acts 2003, 78th Leg., 3rd C.S., ch. 3, Sec. 16.06, eff. Jan. 11, 2004.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 354 (H.B. [1191](#)), Sec. 1, eff.

September 1, 2009.

Acts 2017, 85th Leg., R.S., Ch. 712 (H.B. 3976), Sec. 14, eff. September 1, 2017.

Acts 2017, 85th Leg., R.S., Ch. 712 (H.B. 3976), Sec. 15, eff. September 1, 2017.

Acts 2017, 85th Leg., R.S., Ch. 712 (H.B. 3976), Sec. 24(5), eff. September 1, 2017.

Acts 2021, 87th Leg., R.S., Ch. 681 (H.B. 2022), Sec. 1, eff. June 15, 2021.

Sec. 1575.162. SPECIAL ENROLLMENTS. This chapter does not limit the ability of an individual to enroll in the group program if the individual:

(1) experiences a special enrollment event as provided by the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191, 110 Stat. 1936 (1996)), as amended; and

(2) is otherwise eligible to enroll in the group program.

Added by Acts 2003, 78th Leg., ch. 201, Sec. 50, eff. Sept. 1, 2003; Acts 2003, 78th Leg., ch. 1231, Sec. 4, eff. Sept. 1, 2004.

Sec. 1575.163. LIMITATIONS. The Teacher Retirement System of Texas, as trustee, may not contract for or provide a health benefit plan that excludes from participation in the network a general hospital that:

(1) is located in the geographical service area or areas of the health coverage plan that includes a county that:

(A) has a population of at least 100,000 and not more than 233,500; and

(B) is located in the Texas-Louisiana border region, as that term is defined in Section 2056.002(e), Government Code; and

(2) agrees to provide medical and health care services under the plan subject to the same terms and conditions as other hospital providers under the plan.

Added by Acts 2003, 78th Leg., ch. 201, Sec. 50, eff. Sept. 1, 2003. Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 1163 (H.B. 2702), Sec. 57, eff. September 1, 2011.

Acts 2023, 88th Leg., R.S., Ch. 644 (H.B. 4559), Sec. 117, eff. September 1, 2023.

Sec. 1575.164. DISEASE MANAGEMENT SERVICES. (a) In this section, "disease management services" means services to assist an individual manage a disease or other chronic health condition, such as heart disease, diabetes, respiratory illness, end-stage renal disease, HIV infection, or AIDS, and with respect to which the Teacher Retirement System of Texas identifies populations requiring disease management.

(b) A health benefit plan provided under this chapter, other than a Medicare Advantage plan or a Medicare prescription drug plan, must provide disease management services or coverage for disease management services in the manner required by the Teacher Retirement System of Texas, including:

- (1) patient self-management education;
- (2) provider education;
- (3) evidence-based models and minimum standards of care;
- (4) standardized protocols and participation criteria; and
- (5) physician-directed or physician-supervised care.

Added by Acts 2003, 78th Leg., ch. 589, Sec. 4, eff. June 20, 2003. Renumbered from Insurance Code, Section 1575.162 by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 23.001(62), eff. September 1, 2005. Amended by:

Acts 2017, 85th Leg., R.S., Ch. 712 (H.B. 3976), Sec. 16, eff. September 1, 2017.

Sec. 1575.170. PRIOR AUTHORIZATION FOR CERTAIN DRUGS. (a) In this section, "drug formulary" means a list of drugs preferred for use and eligible for coverage under a health benefit plan.

(b) A health benefit plan provided under this chapter, other than a Medicare Advantage plan or a Medicare prescription drug plan, that uses a drug formulary in providing a prescription drug benefit must require prior authorization for coverage of the following categories of prescribed drugs if the specific drug prescribed is not included in the formulary:

- (1) a gastrointestinal drug;

- (2) a cholesterol-lowering drug;
- (3) an anti-inflammatory drug;
- (4) an antihistamine; and
- (5) an antidepressant drug.

(c) Repealed by Acts 2013, 83rd Leg., R.S., Ch. 1312, Sec. 99(27), eff. September 1, 2013.

Added by Acts 2003, 78th Leg., ch. 213, Sec. 3, eff. Sept. 1, 2003.
Renumbered from Insurance Code Sec. 1575.161 by Acts 2003, 78th Leg., 3rd C.S., ch. 3, Sec. 16.07, eff. Jan. 11, 2004.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 1312 (S.B. 59), Sec. 99(27), eff. September 1, 2013.

Acts 2017, 85th Leg., R.S., Ch. 712 (H.B. 3976), Sec. 17, eff. September 1, 2017.

Sec. 1575.1701. EXEMPTION FROM PREAUTHORIZATION REQUIREMENTS FOR PHYSICIANS AND HEALTH CARE PROVIDERS PROVIDING CERTAIN HEALTH CARE SERVICES. A preauthorization process used by a health benefit plan provided under this chapter is subject to the same limitations and requirements provided by Subchapter N, Chapter 4201, for a preauthorization process used by an insurer.

Added by Acts 2021, 87th Leg., R.S., Ch. 1018 (H.B. 3459), Sec. 2, eff. September 1, 2021.

Sec. 1575.171. EMERGENCY CARE PAYMENTS. (a) In this section, "emergency care" has the meaning assigned by Section 1301.155.

(b) The administrator of a managed care plan provided under the group program shall pay for covered emergency care performed by or a covered supply related to that care provided by an out-of-network provider at the usual and customary rate or at an agreed rate. The administrator shall make a payment required by this subsection directly to the provider not later than, as applicable:

(1) the 30th day after the date the administrator receives an electronic claim for those services that includes all information necessary for the administrator to pay the claim; or

(2) the 45th day after the date the administrator receives a nonelectronic claim for those services that includes all

information necessary for the administrator to pay the claim.

(c) For emergency care subject to this section or a supply related to that care, an out-of-network provider or a person asserting a claim as an agent or assignee of the provider may not bill an enrollee in, and the enrollee does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, and deductible under the enrollee's managed care plan that:

(1) is based on:

(A) the amount initially determined payable by the administrator; or

(B) if applicable, a modified amount as determined under the administrator's internal appeal process; and

(2) is not based on any additional amount determined to be owed to the provider under Chapter 1467.

Added by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. [1264](#)), Sec. 1.15, eff. September 1, 2019.

Sec. 1575.172. OUT-OF-NETWORK FACILITY-BASED PROVIDER PAYMENTS.

(a) In this section, "facility-based provider" means a physician or health care provider who provides health care or medical services to patients of a health care facility.

(b) Except as provided by Subsection (d), the administrator of a managed care plan provided under the group program shall pay for a covered health care or medical service performed for or a covered supply related to that service provided to an enrollee by an out-of-network provider who is a facility-based provider at the usual and customary rate or at an agreed rate if the provider performed the service at a health care facility that is a participating provider. The administrator shall make a payment required by this subsection directly to the provider not later than, as applicable:

(1) the 30th day after the date the administrator receives an electronic claim for those services that includes all information necessary for the administrator to pay the claim; or

(2) the 45th day after the date the administrator receives a nonelectronic claim for those services that includes all information necessary for the administrator to pay the claim.

(c) Except as provided by Subsection (d), an out-of-network

provider who is a facility-based provider or a person asserting a claim as an agent or assignee of the provider may not bill an enrollee receiving a health care or medical service or supply described by Subsection (b) in, and the enrollee does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, and deductible under the enrollee's managed care plan that:

(1) is based on:

(A) the amount initially determined payable by the administrator; or

(B) if applicable, a modified amount as determined under the administrator's internal appeal process; and

(2) is not based on any additional amount determined to be owed to the provider under Chapter 1467.

(d) This section does not apply to a nonemergency health care or medical service:

(1) that an enrollee elects to receive in writing in advance of the service with respect to each out-of-network provider providing the service; and

(2) for which an out-of-network provider, before providing the service, provides a complete written disclosure to the enrollee that:

(A) explains that the provider does not have a contract with the enrollee's managed care plan;

(B) discloses projected amounts for which the enrollee may be responsible; and

(C) discloses the circumstances under which the enrollee would be responsible for those amounts.

Added by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. [1264](#)), Sec. 1.15, eff. September 1, 2019.

Sec. 1575.173. OUT-OF-NETWORK DIAGNOSTIC IMAGING PROVIDER OR LABORATORY SERVICE PROVIDER PAYMENTS. (a) In this section, "diagnostic imaging provider" and "laboratory service provider" have the meanings assigned by Section 1467.001.

(b) Except as provided by Subsection (d), the administrator of a managed care plan provided under the group program shall pay for a covered health care or medical service performed for or a covered

supply related to that service provided to an enrollee by an out-of-network provider who is a diagnostic imaging provider or laboratory service provider at the usual and customary rate or at an agreed rate if the provider performed the service in connection with a health care or medical service performed by a participating provider. The administrator shall make a payment required by this subsection directly to the provider not later than, as applicable:

(1) the 30th day after the date the administrator receives an electronic claim for those services that includes all information necessary for the administrator to pay the claim; or

(2) the 45th day after the date the administrator receives a nonelectronic claim for those services that includes all information necessary for the administrator to pay the claim.

(c) Except as provided by Subsection (d), an out-of-network provider who is a diagnostic imaging provider or laboratory service provider or a person asserting a claim as an agent or assignee of the provider may not bill an enrollee receiving a health care or medical service or supply described by Subsection (b) in, and the enrollee does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, and deductible under the enrollee's managed care plan that:

(1) is based on:

(A) the amount initially determined payable by the administrator; or

(B) if applicable, the modified amount as determined under the administrator's internal appeal process; and

(2) is not based on any additional amount determined to be owed to the provider under Chapter 1467.

(d) This section does not apply to a nonemergency health care or medical service:

(1) that an enrollee elects to receive in writing in advance of the service with respect to each out-of-network provider providing the service; and

(2) for which an out-of-network provider, before providing the service, provides a complete written disclosure to the enrollee that:

(A) explains that the provider does not have a contract with the enrollee's managed care plan;

(B) discloses projected amounts for which the enrollee may be responsible; and

(C) discloses the circumstances under which the enrollee would be responsible for those amounts.

Added by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 1.15, eff. September 1, 2019.

For expiration of this section, see Subsection (f).

Sec. 1575.174. OUT-OF-NETWORK EMERGENCY MEDICAL SERVICES PROVIDER PAYMENTS. (a) In this section, "emergency medical services provider" has the meaning assigned by Section 773.003, Health and Safety Code, except that the term does not include an air ambulance.

(b) Except as provided by Subsection (c), the administrator of a managed care plan provided under the group program shall pay for a covered health care or medical service performed for, or a covered supply or covered transport related to that service provided to, an enrollee by an out-of-network provider who is an emergency medical services provider at:

(1) if the political subdivision has submitted the rate to the department under Section 38.006, the rate set, controlled, or regulated by the political subdivision in which:

(A) the service originated; or

(B) the transport originated if transport is provided;

or

(2) if the political subdivision has not submitted the rate to the department, the lesser of:

(A) the provider's billed charge; or

(B) 325 percent of the current Medicare rate, including any applicable extenders and modifiers.

(c) The administrator shall adjust a payment required by Subsection (b)(1) each plan year by increasing the payment by the lesser of the Medicare Inflation Index or 10 percent of the provider's previous calendar year rates.

(d) The administrator shall make a payment required by this section directly to the provider not later than, as applicable:

(1) the 30th day after the date the administrator receives an electronic claim for those services that includes all information necessary for the administrator to pay the claim; or

(2) the 45th day after the date the administrator receives a nonelectronic claim for those services that includes all

information necessary for the administrator to pay the claim.

(e) An out-of-network provider who is an emergency medical services provider or a person asserting a claim as an agent or assignee of the provider may not bill an enrollee receiving a health care or medical service or supply or transport described by Subsection (b) in, and the enrollee does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, and deductible under the enrollee's managed care plan that is based on:

(1) the amount initially determined payable by the administrator; or

(2) if applicable, the modified amount as determined under the administrator's internal appeal process.

(f) This section expires September 1, 2025.

Added by Acts 2023, 88th Leg., R.S., Ch. 981 (S.B. 2476), Sec. 12, eff. September 1, 2023.

SUBCHAPTER E. CONTRIBUTIONS

Sec. 1575.201. ADDITIONAL STATE CONTRIBUTIONS; CERTAIN CONTRIBUTIONS. (a) The state through the trustee shall contribute from money in the fund an amount prescribed by the General Appropriations Act to cover all or part of the cost for each retiree, surviving spouse, and surviving dependent child enrolled in a health benefit plan offered under the group program.

(b) Repealed by Acts 2017, 85th Leg., R.S., Ch. 712 (H.B. 3976), Sec. 24(6), eff. September 1, 2017.

(c) The trustee may spend a part of the money received for the group program to offset a part of the costs for dependent coverage if the group program is projected to remain financially solvent during the currently funded biennium.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Amended by Acts 2003, 78th Leg., ch. 201, Sec. 51, eff. Sept. 1, 2003; Acts 2003, 78th Leg., ch. 1231, Sec. 5, eff. Sept. 1, 2004; Acts 2003, 78th Leg., ch. 1276, Sec. 10A.432, eff. Sept. 1, 2003.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 712 (H.B. 3976), Sec. 18, eff. September 1, 2017.

Acts 2017, 85th Leg., R.S., Ch. 712 (H.B. 3976), Sec. 24(6), eff.

September 1, 2017.

Sec. 1575.202. STATE CONTRIBUTION BASED ON ACTIVE EMPLOYEE COMPENSATION. (a) Each state fiscal year, the state shall contribute to the fund an amount equal to 1.25 percent of the salary of each active employee.

(b) The state may contribute to the fund an amount in addition to the contribution required by Subsection (a).

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003. Amended by Acts 2003, 78th Leg., ch. 201, Sec. 52, eff. Sept. 1, 2003; Acts 2003, 78th Leg., ch. 1231, Sec. 6, eff. Sept. 1, 2003. Amended by:

Acts 2017, 85th Leg., R.S., Ch. 712 (H.B. 3976), Sec. 19, eff. September 1, 2017.

Sec. 1575.203. ACTIVE EMPLOYEE CONTRIBUTION. (a) Each state fiscal year, each active employee shall, as a condition of employment, contribute to the fund an amount equal to 0.65 percent of the employee's salary.

(b) The employer of an active employee shall monthly:

(1) deduct the employee's contribution from the employee's salary and remit the contribution to the trustee in the manner required by the trustee; or

(2) assume and pay the total contributions due from its active employees.

(c) Contributions to the fund deducted from the salary of an active employee are included in annual compensation for purposes of the Teacher Retirement System of Texas.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003. Amended by Acts 2003, 78th Leg., ch. 201, Sec. 53, eff. Sept. 1, 2003; Acts 2003, 78th Leg., ch. 366, Sec. 3.02, eff. Sept. 1, 2003; Acts 2003, 78th Leg., ch. 1231, Sec. 7, eff. Sept. 1, 2003; Acts 2003, 78th Leg., ch. 1276, Sec. 10A.433, eff. Sept. 1, 2003. Amended by:

Acts 2005, 79th Leg., Ch. 899 (S.B. 1863), Sec. 17.02, eff. September 1, 2005.

Acts 2005, 79th Leg., Ch. 1359 (S.B. 1691), Sec. 41, eff.

September 1, 2005.

Sec. 1575.204. PUBLIC SCHOOL CONTRIBUTION. (a) Each state fiscal year, each public school shall contribute to the fund the amount prescribed by the General Appropriations Act, which may not be less than 0.25 percent or greater than 0.75 percent of the salary of each active employee of the public school. The public school shall make the contributions on a monthly basis and as otherwise prescribed by the trustee.

(b) Each state fiscal year, each employer who reports to the retirement system under Section 824.6022, Government Code, the employment of a retiree who is enrolled in and receiving coverage under the group program shall contribute to the fund an amount established by the trustee. In determining the amount to be contributed by the employer under this subsection, the trustee shall consider the amount a retiree is required to pay for the retiree and any enrolled dependents to participate in the group program and the cost of all retirees' and enrolled dependents' participation in the group program. If more than one employer reports the retiree to the retirement system during a month, the amount of the contribution required by this subsection shall be prorated among the employers. The amounts required to be paid under this subsection are not required to be paid by a reporting employer for a retiree who retired from the retirement system before September 1, 2005.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Amended by Acts 2003, 78th Leg., ch. 201, Sec. 54, eff. Sept. 1, 2003.

Amended by:

Acts 2005, 79th Leg., Ch. 1359 (S.B. 1691), Sec. 42, eff. September 1, 2005.

Acts 2007, 80th Leg., R.S., Ch. 1389 (S.B. 1846), Sec. 4, eff. September 1, 2007.

Acts 2015, 84th Leg., R.S., Ch. 1102 (H.B. 2974), Sec. 8, eff. September 1, 2015.

Sec. 1575.206. CONTRIBUTIONS HELD IN TRUST FOR FUND. An employing public school and its governing body:

- (1) hold contributions required by this subchapter in trust for the fund and its participants; and
- (2) may not divert the contributions for any other purpose.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 455 (S.B. 1667), Sec. 22, eff. September 1, 2011.

Sec. 1575.207. INTEREST ASSESSED ON LATE PAYMENT OF DEPOSITS BY EMPLOYING PUBLIC SCHOOLS. (a) An employing public school that does not remit to the trustee all contributions required by this subchapter before the seventh day after the last day of the month shall pay to the fund:

- (1) the contributions; and
- (2) interest on the unpaid amounts at the annual rate of six percent compounded monthly.

(b) On request, the trustee may grant a waiver of the deadline imposed by this section based on an employing public school's financial or technological resources.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.435(a), eff. Sept. 1, 2003.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 455 (S.B. 1667), Sec. 23, eff. September 1, 2011.

Sec. 1575.208. CERTIFICATION OF AMOUNT NECESSARY TO PAY STATE CONTRIBUTIONS. Not later than October 31 preceding each regular session of the legislature, the trustee shall certify the amount necessary to pay the state contributions to the fund to:

- (1) the Legislative Budget Board; and
- (2) the budget division of the governor's office.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.436, eff. Sept. 1, 2003.

Sec. 1575.209. CERTIFICATION OF AMOUNT OF STATE CONTRIBUTIONS. Not later than August 31 of each year, the trustee shall certify to the comptroller the estimated amount of state contributions to be received by the fund for the next fiscal year under the appropriations authorized by this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003. Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.436, eff. Sept. 1, 2003.

Sec. 1575.210. PAYMENT OF STATE CONTRIBUTIONS; RECONCILIATION.

(a) Contributions allocated and appropriated under this subchapter for a state fiscal year shall be:

- (1) paid in equal monthly installments;
- (2) based on the estimated amount certified by the trustee to the comptroller for that year; and
- (3) subject to any express limitations specified in the Act making the appropriation.

(b) A variation between the certified amount and the actual amount due for the state fiscal year shall be reconciled at the end of the fiscal year, and the annual contributions to the fund shall be adjusted accordingly.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003. Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.437, eff. Sept. 1, 2003.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 712 (H.B. 3976), Sec. 20, eff. September 1, 2017.

Sec. 1575.211. COST SHARING. (a) The total costs for the operation of the group program shall be shared among the state, the public schools, the active employees, the retirees, the surviving spouses, and the surviving dependent children in the manner prescribed by the General Appropriations Act.

(b) Repealed by Acts 2017, 85th Leg., R.S., Ch. 712 (H.B. 3976), Sec. 24(8), eff. September 1, 2017.

(c) Repealed by Acts 2005, 79th Leg., Ch. 1359, Sec. 55(a)(2), eff. September 1, 2005.

Added by Acts 2003, 78th Leg., ch. 201, Sec. 55, eff. Sept. 1, 2003; Acts 2003, 78th Leg., ch. 1231, Sec. 8, eff. Sept. 1, 2004. Amended by Acts 2003, 78th Leg., 3rd C.S., ch. 3, Sec. 16.08, eff. Sept. 1, 2004.

Amended by:

Acts 2005, 79th Leg., Ch. 1359 (S.B. 1691), Sec. 55(a)(2), eff. September 1, 2005.

Acts 2017, 85th Leg., R.S., Ch. 712 (H.B. 3976), Sec. 21, eff. September 1, 2017.

Acts 2017, 85th Leg., R.S., Ch. 712 (H.B. 3976), Sec. 24(8), eff. September 1, 2017.

Sec. 1575.212. PAYMENT BY RETIREES; RANGES. (a) Repealed by Acts 2017, 85th Leg., R.S., Ch. 712 (H.B. 3976), Sec. 24(9), eff. September 1, 2017.

(a-1) The trustee shall establish and collect payments for the share of total costs allocated under Section 1575.211 to retirees, surviving spouses, and surviving dependent children.

(b) In establishing the payments under Subsection (a-1), the trustee may consider various factors, including an enrollee's Medicare status, health benefit plan election, and dependent coverage.

Added by Acts 2003, 78th Leg., ch. 201, Sec. 55, eff. Sept. 1, 2003; Acts 2003, 78th Leg., ch. 1231, Sec. 8, eff. Sept. 1, 2004.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 712 (H.B. 3976), Sec. 22, eff. September 1, 2017.

Acts 2017, 85th Leg., R.S., Ch. 712 (H.B. 3976), Sec. 24(9), eff. September 1, 2017.

Sec. 1575.213. CERTAIN DISABILITY RETIREES. An individual who is eligible as a retiree under Section 1575.004(a)(3) shall pay an additional premium in an amount determined by the trustee. The amount of the premium may not exceed the total cost, as determined by the trustee, attributable to the participation of that retiree and the dependents of that retiree during the period the individual is eligible as a retiree under Section 1575.004(a)(3).

Added by Acts 2007, 80th Leg., R.S., Ch. 1230 (H.B. [2427](#)), Sec. 16, eff. September 1, 2007.

SUBCHAPTER F. FEDERAL OR PRIVATE SOURCE CONTRIBUTIONS

Sec. 1575.251. DEFINITION. In this subchapter, "employer" has the meaning assigned by Section 821.001, Government Code.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1575.252. APPLICATION BY EMPLOYER FOR MONEY TO PAY STATE CONTRIBUTIONS. An employer who applies for money provided by the United States or a privately sponsored source shall:

(1) if any of the money will pay part or all of an active employee's salary, also apply for any legally available money to pay state contributions required by Subchapter E; and

(2) immediately send any money received for state contributions as a result of the application to the trustee for deposit in the fund.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.438, eff. Sept. 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 1223 (H.B. [2358](#)), Sec. 3, eff. September 1, 2007.

Sec. 1575.253. MONTHLY CERTIFICATION. An employer shall monthly certify to the trustee in a form prescribed by the trustee:

(1) the total amount of salary paid from federal funds and private grants; and

(2) the total amount of state contributions provided by the funds and grants.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.438, eff. Sept. 1, 2003.

Sec. 1575.254. MONTHLY MAINTENANCE OF INFORMATION. An employer shall monthly maintain:

- (1) the name of each employee whose salary is paid wholly or partly from a grant;
- (2) the source of the grant;
- (3) the amount of the employee's salary paid from the grant;
- (4) the amount of the money provided by the grant for state contributions for the employee; and
- (5) any other information the trustee determines is necessary to enforce this subchapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.438, eff. Sept. 1, 2003.

Sec. 1575.255. PROOF OF COMPLIANCE. The trustee may:

- (1) require an employer to report an application for federal or private money;
- (2) require evidence that the application includes a request for funds available to pay state contributions for active employees; and
- (3) examine the records of an employer to determine compliance with this subchapter and rules adopted under this subchapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.438, eff. Sept. 1, 2003.

Sec. 1575.256. CRIMINAL OFFENSE: FAILURE OF ADMINISTRATOR TO COMPLY. (a) An administrator of an employer commits an offense if the administrator knowingly fails to comply with this subchapter.

(b) An offense under this section is a Class C misdemeanor.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1575.257. CIVIL SANCTIONS FOR FAILURE OF EMPLOYER TO

COMPLY. (a) An employer who fails to comply with this subchapter may not apply for or spend any money received from a federal or private grant.

(b) The trustee shall report an alleged noncompliance with this subchapter to the attorney general, the Legislative Budget Board, the comptroller, and the governor.

(c) On receipt of a report under Subsection (b), the attorney general shall bring a writ of mandamus against the employer to compel compliance with this subchapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.439, eff. Sept. 1, 2003.

SUBCHAPTER G. RETIRED SCHOOL EMPLOYEES GROUP INSURANCE FUND

Sec. 1575.301. FUND; ADMINISTRATION. (a) The retired school employees group insurance fund is a trust fund with the comptroller, who is custodian of the fund.

(b) The trustee shall administer the fund.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.440(a), eff. Sept. 1, 2003.

Sec. 1575.302. PAYMENTS INTO FUND. The following shall be paid into the fund:

- (1) contributions from active employees and the state;
- (2) investment income;
- (3) appropriations for implementation of the group program;

and

(4) other money required or authorized to be paid into the fund.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by:

Acts 2017, 85th Leg., R.S., Ch. 712 (H.B. [3976](#)), Sec. 23, eff. September 1, 2017.

Sec. 1575.303. PAYMENTS FROM FUND. (a) The following shall, without state fiscal year limitation, be paid from the fund:

- (1) the appropriate premiums to a carrier providing group coverage under a plan under this chapter;
- (2) claims for benefits under the group coverage; and
- (3) money spent by the trustee to administer the group program.

(b) The appropriate portion of the contributions to the fund to provide for incurred but unreported claim reserves and contingency reserves, as determined by the trustee, shall be retained in the fund.

(c) The fund is held in trust for the benefit of participants of the group program and may not be diverted.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.441, eff. Sept. 1, 2003.

Amended by:

Acts 2005, 79th Leg., Ch. 1359 (S.B. 1691), Sec. 43, eff. September 1, 2005.

Sec. 1575.304. TRANSFER OF CERTAIN CONTRIBUTIONS. The trustee shall transfer into the fund the amounts deducted from annuities for contributions.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.441, eff. Sept. 1, 2003.

Sec. 1575.305. INVESTMENT OF FUND. The trustee may invest money in the fund in the manner provided by Subchapter D, Chapter 825, Government Code, for assets of the Teacher Retirement System of Texas.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.441, eff. Sept. 1, 2003.

Sec. 1575.306. EMPLOYEE CONTRIBUTIONS PROPERTY OF FUND ON RECEIPT; NO REFUND. A contribution from an active employee:

(1) is the property of the fund on receipt by the trustee; and

(2) may not be refunded to the active employee under any circumstances, including termination of employment.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.441, eff. Sept. 1, 2003.

Sec. 1575.307. CONTINGENCY RESERVE ACCOUNT. (a) Before the first day of each state fiscal biennium, the trustee shall estimate for an average 60-day period during the biennium the expenditures from the fund anticipated for the group program, considering projected claims and administrative expenses.

(b) The trustee shall place the estimated amount in a contingency reserve account to provide for adverse fluctuations in claims or administrative expenses.

(c) The trustee shall include in each request for legislative appropriations to the group program the amount the trustee determines to be necessary to maintain the contingency reserve account at the level required by this section.

(d) The trustee may invest and reinvest any portion of the contingency reserve account in accordance with Sections 825.103(b) and 825.301, Government Code, considering the functional need to provide for adverse fluctuations in claims or administrative expenses.

(e) The interest on, earnings of, and proceeds from the sale of investments of assets in the contingency reserve account shall be credited to the account.

(f) The trustee, from time to time and in amounts the trustee considers appropriate, may transfer unused money for administrative expenses to the contingency reserve account to be used by the trustee only for charges, claims, and expenses under the group program.

Added by Acts 2019, 86th Leg., R.S., Ch. 445 (S.B. [1682](#)), Sec. 1, eff. June 4, 2019.

SUBCHAPTER H. COORDINATED CARE NETWORK

Sec. 1575.351. DEFINITIONS. In this subchapter:

(1) "Credentialing committee" means a credentialing committee created by the trustee under Section 1575.354.

(2) "Health care provider" means:

(A) an individual licensed as a health care practitioner; or

(B) a health care facility.

(3) "Network" means the coordinated care network implemented and administered by the trustee under this subchapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.442, eff. Sept. 1, 2003.

Sec. 1575.352. IMPLEMENTATION AND ADMINISTRATION. The trustee may implement and administer a coordinated care network for the group program.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.443, eff. Sept. 1, 2003.

Sec. 1575.353. CONTRACTS WITH HEALTH CARE PROVIDERS AND OTHERS. As the trustee determines is necessary to implement and administer the network, the trustee may contract with a health care provider or other individuals or entities.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.443, eff. Sept. 1, 2003.

Sec. 1575.354. CREDENTIALING COMMITTEES. The trustee may establish credentialing committees to evaluate the qualifications of health care providers to participate in the network.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.443, eff. Sept.

1, 2003.

Sec. 1575.355. IMMUNITY FROM LIABILITY ARISING FROM ACTS OR OMISSIONS OF HEALTH CARE PROVIDER. (a) The following are not liable for damages arising from an act or omission of a health care provider participating in the network:

- (1) the trustee and its officers and employees, including the board of trustees of the trustee;
- (2) the group program;
- (3) the fund; and
- (4) a member of an advisory committee to the trustee.

(b) A health care provider participating in the network is an independent contractor and is responsible for the provider's acts or omissions.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.444, eff. Sept. 1, 2003.

Sec. 1575.356. IMMUNITY FROM LIABILITY ARISING FROM EVALUATION OF QUALIFICATIONS OR CARE. The following are not liable for damages arising from an act, including a statement, determination, report of an act, or recommendation, committed without malice in the course of the evaluation of the qualifications of a health care provider or of the patient care provided by a health care provider participating in the network:

- (1) the trustee and its officers and employees, including the board of trustees;
- (2) the group program;
- (3) the fund;
- (4) a member of an advisory committee to the trustee; and
- (5) a member of a credentialing committee.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.445, eff. Sept. 1, 2003.

Sec. 1575.357. IMMUNITY FROM LIABILITY ARISING FROM ACTS

RELATING TO CREDENTIALING COMMITTEE. An individual, a health care provider, or a medical peer review committee is not liable for damages arising from an act committed without malice that consists of:

(1) participating in the activity of a credentialing committee; or

(2) furnishing records, information, or assistance to a credentialing committee.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1575.358. OPEN MEETINGS LAW NOT APPLICABLE TO CREDENTIALING COMMITTEE. The proceedings of a credentialing committee are not subject to Chapter 551, Government Code.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1575.359. RECORDS AND PROCEEDINGS OF CREDENTIALING COMMITTEE NOT SUBJECT TO SUBPOENA. Except to the extent required by the constitution of this state or the United States, the records and proceedings of a credentialing committee and a communication made to a credentialing committee are not subject to court subpoena.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1575.360. CONFIDENTIALITY. Except as otherwise provided by this subchapter:

(1) proceedings and records of a credentialing committee are confidential; and

(2) a communication made to a credentialing committee is privileged.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1575.361. DISCLOSURE TO HEALTH CARE PROVIDER. Disclosure of confidential credentialing committee information that is relevant to the matter under review to an affected health care provider is not

a waiver of the confidentiality requirements under this subchapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1575.362. DISCLOSURE TO CERTAIN ENTITIES. (a) A written or oral communication made to a credentialing committee, or a record or proceeding of the committee, may be disclosed to an appropriate:

(1) state or federal agency, including a state board of registration or licensing;

(2) national accreditation body; or

(3) medical peer review committee.

(b) A disclosure under this section is not a waiver of the confidential and privileged nature of the information.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1575.363. DISCLOSURE TO DEFENDANTS IN CIVIL ACTIONS. (a) Any of the following persons named as a defendant in any civil action filed as a result of participation in the credentialing process may use, including in the person's own defense, otherwise confidential information obtained for legitimate internal business and professional purposes:

(1) the trustee and its officers and employees, including the board of trustees;

(2) a credentialing committee;

(3) a person participating in a credentialing review;

(4) a health care provider;

(5) the group program; and

(6) a member of an advisory committee.

(b) Use of information under this section is not a waiver of the confidential and privileged nature of the information.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.446, eff. Sept. 1, 2003.

SUBCHAPTER I. RETIREES ADVISORY COMMITTEE

Sec. 1575.401. DEFINITION. In this subchapter, "committee"

means the Retirees Advisory Committee.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1575.402. APPOINTMENT OF COMMITTEE MEMBERS. (a) The Retirees Advisory Committee is composed of the following seven members appointed by the trustee:

- (1) one member who is an active school administrator;
- (2) one member who is a retired school administrator;
- (3) two members who are active teachers; and
- (4) three members who are retired teachers.

(b) A person is not eligible for appointment as a member of the committee if the person is required to register as a lobbyist under Chapter 305, Government Code.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.447, eff. Sept. 1, 2003.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 930 (S.B. 1663), Sec. 16, eff. September 1, 2017.

Sec. 1575.403. TERMS. (a) Members of the committee serve staggered four-year terms.

(b) The terms of the active school administrator, one active teacher, and two retired teachers expire February 1, 2002, and every fourth year after that date.

(c) The remaining members' terms expire February 1, 2004, and every fourth year after that date.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by:

Acts 2017, 85th Leg., R.S., Ch. 930 (S.B. 1663), Sec. 17, eff. September 1, 2017.

Sec. 1575.404. VACANCY. The trustee shall fill a vacancy on the committee by appointing a person who meets the qualifications applicable to the vacated position.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.448, eff. Sept. 1, 2003.

Sec. 1575.405. MEETINGS. (a) The committee shall meet:

- (1) at least twice each year; and
- (2) at the call of the trustee.

(b) If there is an emergency, the committee may meet at the call of a majority of the members of the committee.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.449, eff. Sept. 1, 2003.

Sec. 1575.406. DUTIES. The committee shall:

- (1) hold public hearings on group coverage;
- (2) recommend to the trustee minimum standards and features of a plan under the group program that the committee considers appropriate; and
- (3) recommend to the trustee desirable changes in rules and legislation affecting the group program.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.450, eff. Sept. 1, 2003.

Sec. 1575.407. PROCEDURAL RULES. The trustee shall adopt procedural rules for the committee to follow in implementing its powers and duties under this subchapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.450, eff. Sept. 1, 2003.

Sec. 1575.408. REIMBURSEMENT FOR ACTUAL AND REASONABLE EXPENSES. A committee member is entitled to reimbursement for actual and reasonable expenses incurred in performing functions as a

committee member.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

SUBCHAPTER J. ACCOUNTING, REPORTS, AND RECORDS

Sec. 1575.451. ANNUAL ACCOUNTING. (a) In this section, "plan year" means the period beginning on September 1 and ending on the following August 31.

(b) Group coverage purchased under this chapter must provide for an accounting to the trustee by each carrier providing the coverage.

(c) The accounting must be submitted:

(1) not later than the 90th day after the last day of each plan year; and

(2) on a form approved by the trustee.

(d) Each carrier shall prepare any other report that the trustee considers necessary.

(e) A carrier may not assess an extra charge for an accounting report.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.451, eff. Sept. 1, 2003.

Sec. 1575.453. STUDY AND REPORT BY TRUSTEE. (a) The trustee shall study the operation and administration of this chapter, including:

(1) conducting surveys and preparing reports on financing group coverages and health benefit plans available to participants;

(2) studying the experience and projected cost of coverage; and

(3) reviewing the group coverages provided to and the benefits and services being received by individuals covered under this chapter.

(b) The trustee shall report annually to the legislature and the department on the operation and administration of this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.452, eff. Sept.

1, 2003.

Amended by:

Acts 2021, 87th Leg., R.S., Ch. 141 (H.B. 1585), Sec. 17, eff. May 26, 2021.

Sec. 1575.454. REPORTS BY AND EXAMINATION OF CARRIER. Each contract entered into under this chapter between the trustee and a carrier must require the carrier to:

(1) furnish to the trustee in a timely manner reasonable reports that the trustee determines are necessary to implement this chapter; and

(2) permit the trustee and the state auditor to examine records of the carrier as necessary to implement this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.452, eff. Sept. 1, 2003.

Sec. 1575.455. PUBLIC INSPECTION. A report required by this chapter shall be made available for public inspection in a form that protects the identity of individual claimants.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1575.456. CONFIDENTIALITY OF RECORDS. (a) Section 825.507, Government Code, concerning confidentiality and disclosure of records applies to records in the custody of the Teacher Retirement System of Texas or in the custody of an administrator, carrier, agent, attorney, consultant, or governmental body acting in cooperation with or on behalf of the system relating to a retiree, active employee, annuitant, or beneficiary under the group program.

(b) The Teacher Retirement System of Texas may disclose to a health or benefit provider information in the records of an individual that the system determines is necessary to administer the group program.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.453(a), eff.

Sept. 1, 2003.

SUBCHAPTER K. EXPULSION FOR FRAUD

Sec. 1575.501. EXPULSION FOR FRAUD. After notice and hearing as provided by this subchapter, the trustee may expel from participation in the group program a retiree, dependent, surviving spouse, or surviving dependent child who:

(1) submits a fraudulent claim or application for coverage under the group program; or

(2) defrauds or attempts to defraud a health benefit plan offered under the group program.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.454(a), eff. Sept. 1, 2003.

Sec. 1575.502. HEARING. On receipt of a complaint or on its own motion, the trustee may call and hold a hearing to determine whether an individual has acted in the manner described by Section 1575.501.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.455, eff. Sept. 1, 2003.

Sec. 1575.503. CONTESTED CASE. A proceeding under this subchapter is a contested case under Chapter 2001, Government Code.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1575.504. EXPULSION AT CONCLUSION OF HEARING. At the conclusion of the hearing under Section 1575.502, if the trustee determines that the individual acted in the manner described by Section 1575.501, the trustee shall expel the individual from participation in the group program.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.455, eff. Sept. 1, 2003.

Sec. 1575.505. EFFECT OF EXPULSION. An individual expelled from participation in the group program may not be covered by a health benefit plan offered under the group program for a period determined by the trustee, not to exceed five years, beginning on the date the expulsion takes effect.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.455, eff. Sept. 1, 2003.

Sec. 1575.506. APPEAL. An appeal of a determination by the trustee under this subchapter is under the substantial evidence rule.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.455, eff. Sept. 1, 2003.

CHAPTER 1576. GROUP LONG-TERM CARE INSURANCE FOR PUBLIC SCHOOL EMPLOYEES

Sec. 1576.001. DEFINITIONS. In this chapter:

- (1) "Active employee" has the meaning assigned by Section 1575.002.
- (2) "Trustee" means the Teacher Retirement System of Texas.
- (3) "Retiree" has the meaning assigned by Section 1575.004.
- (4) "Surviving spouse" has the meaning assigned by Section 1575.003.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.457, eff. Sept. 1, 2003.

Sec. 1576.002. ESTABLISHMENT OF PROGRAM. (a) The trustee may establish a group long-term care insurance program to provide long-term care insurance coverage for:

- (1) an active employee or retiree;
- (2) the spouse of an active employee or retiree, including a surviving spouse;
- (3) a parent or grandparent of an active employee or retiree; and
- (4) a parent of the spouse of an employee or retiree, including a parent of a surviving spouse.

(b) The trustee may not implement a group long-term care insurance program unless any cost or administrative burden associated with the development of, implementation of, or communications about the program is incidental.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.458, eff. Sept. 1, 2003.

Sec. 1576.003. CONTRACTS TO PROVIDE COVERAGES. The trustee may contract with one or more carriers authorized to provide long-term care insurance to provide that coverage.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.458, eff. Sept. 1, 2003.

Amended by:

Acts 2005, 79th Leg., Ch. 1359 (S.B. [1691](#)), Sec. 44, eff. September 1, 2005.

Sec. 1576.004. PREMIUMS. (a) The trustee shall determine the procedures by which each program participant pays premiums and any other program costs. Each participant is responsible for required payments.

(b) The trustee may authorize any payment method appropriate for the program, including a payment method under which:

- (1) a participating employee is required to pay premiums by payroll deduction remitted by the employee's employer at the times and in the manner determined by the trustee;
- (2) a participating retiree is required to pay premiums by deduction from the retiree's monthly annuity; or
- (3) a carrier with which the trustee has contracted under

Section 1576.003 bills a program participant directly.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Amended by:

Acts 2005, 79th Leg., Ch. 1359 (S.B. 1691), Sec. 44, eff. September 1, 2005.

Sec. 1576.005. PROGRAM NOT PART OF OTHER GROUP COVERAGES. (a) The group long-term care insurance program is not part of the group coverages offered under Chapter 1575 or 1579.

(b) The state may not contribute any part of the premiums for coverage offered under this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Amended by:

Acts 2005, 79th Leg., Ch. 1359 (S.B. 1691), Sec. 45, eff. September 1, 2005.

Sec. 1576.006. RULES. The trustee may adopt rules as necessary to administer this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.458, eff. Sept. 1, 2003.

Amended by:

Acts 2005, 79th Leg., Ch. 1359 (S.B. 1691), Sec. 46, eff. September 1, 2005.

Sec. 1576.007. EXEMPTION FROM STATE TAXES AND FEES. A premium or contribution on a policy, insurance contract, or agreement authorized under this chapter is not subject to any state tax, regulatory fee, or surcharge, including a premium or maintenance tax or fee.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.459(a), eff. Sept. 1, 2003.

Sec. 1576.008. COMPETITIVE BIDDING REQUIREMENTS; RULES. (a) A contract to provide benefits under this chapter may be awarded only through competitive bidding under rules adopted by the trustee.

(b) The rules may provide criteria for determining whether a carrier is qualified.

Added by Acts 2005, 79th Leg., Ch. 1359 (S.B. 1691), Sec. 47, eff. September 1, 2005.

Sec. 1576.009. CONTRACT AWARD; CONSIDERATIONS. (a) In awarding a contract under this chapter, the trustee is not required to select the lowest bid and may consider any relevant criteria, including a bidder's:

- (1) ability to service contracts;
- (2) past experience; and
- (3) financial stability.

(b) If the trustee awards a contract to a bidder whose bid deviates from that advertised, the trustee shall record the deviation and fully justify the reason for the deviation in the minutes of the next meeting of the trustee.

Added by Acts 2005, 79th Leg., Ch. 1359 (S.B. 1691), Sec. 47, eff. September 1, 2005.

Sec. 1576.010. GROUP LONG-TERM CARE INSURANCE PROGRAM FUND.

(a) The group long-term care insurance program fund is a trust fund with the comptroller.

(b) The trustee shall administer the fund on behalf of the participants in the plan of insurance coverage provided under this chapter.

(c) The following shall be credited to the fund:

- (1) money recovered under contracts for providing insurance coverage under this chapter; and
- (2) investment and depository income.

Added by Acts 2005, 79th Leg., Ch. 1359 (S.B. 1691), Sec. 47, eff. September 1, 2005.

Sec. 1576.011. INVESTMENT OF FUND. The trustee may invest the group long-term care insurance program fund in the manner provided by Section 67(a)(3), Article XVI, Texas Constitution.

Added by Acts 2005, 79th Leg., Ch. 1359 (S.B. 1691), Sec. 47, eff. September 1, 2005.

Sec. 1576.012. PAYMENTS FROM FUND. Money in the group long-term care insurance program fund may be used only to cover the cost of administering the program and to provide coverage under this chapter.

Added by Acts 2005, 79th Leg., Ch. 1359 (S.B. 1691), Sec. 47, eff. September 1, 2005.

Sec. 1576.013. COVERAGE EXEMPT FROM INSURANCE LAW. A coverage plan provided under this chapter is exempt from any other insurance law, including common law, that does not expressly apply to the plan or this chapter.

Added by Acts 2005, 79th Leg., Ch. 1359 (S.B. 1691), Sec. 47, eff. September 1, 2005.

CHAPTER 1578. PURCHASE OF INSURANCE BY ASSOCIATION OF TEACHERS AND SCHOOL ADMINISTRATORS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1578.001. APPLICABILITY OF CHAPTER. This chapter applies only to a voluntary association that is:

(1) composed of teachers or school administrators of public or private primary or secondary schools, colleges, or universities; and

(2) incorporated under federal law or a law of this state on a nonprofit membership basis.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1578.002. AUTHORITY TO ISSUE. Notwithstanding any other

law, an insurance company authorized to engage in the business of insurance in this state may issue a group policy to a voluntary association in accordance with this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

SUBCHAPTER B. PURCHASE OF INSURANCE

Sec. 1578.051. AUTHORITY TO OBTAIN INSURANCE. (a) A voluntary association may obtain for any class of the association's membership and for the class's dependents a group policy of:

- (1) life insurance;
- (2) health insurance;
- (3) accident insurance;
- (4) accidental death or dismemberment insurance; or
- (5) hospital, surgical, or medical expense insurance.

(b) The association may obtain a separate policy for each type of insurance listed under Subsection (a).

(c) The association is the policyholder.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1578.052. PAYMENT OF PREMIUM. A voluntary association that obtains a group policy under this chapter shall pay the premium for the policy wholly or partly from money:

- (1) contributed by the association; or
- (2) contributed by the insured association members for that purpose.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1578.053. MINIMUM REQUIREMENTS TO OBTAIN POLICY. (a) A voluntary association may obtain a group policy under this chapter only if the policy will cover at least 25 association members on the date of issue.

(b) If the premium for the group policy is paid wholly or partly from money contributed by association members for that purpose, the policy on the date of issue must cover at least the lesser of 75 percent of the eligible members or 400 members,

excluding any member whose evidence of individual insurability is not satisfactory to the insurer, who elect to make the required contributions and to be insured under the policy.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1578.054. AMOUNT OF INSURANCE. The amount of insurance under a policy issued under this chapter must be based on a plan that precludes individual selection by the voluntary association or an insured association member.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

CHAPTER 1579. TEXAS SCHOOL EMPLOYEES UNIFORM GROUP HEALTH COVERAGE
SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1579.001. SHORT TITLE. This chapter may be cited as the Texas School Employees Uniform Group Health Coverage Act.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.471(a), eff. Sept. 1, 2003.

Sec. 1579.002. GENERAL DEFINITIONS. In this chapter:

(1) "Administering firm" means any entity designated by the trustee to administer any coverages, services, benefits, or requirements under this chapter and the trustee's rules adopted under this chapter.

(2) "Trustee" means the Teacher Retirement System of Texas.

(3) "Charter school" means an open-enrollment charter school established under Subchapter D, Chapter 12, Education Code.

(4) "Health coverage plan" means any group policy or contract, hospital service agreement, health maintenance organization agreement, preferred provider arrangement, or any similar group arrangement or any combination of those policies, contracts, agreements, or arrangements that provides for, pays for, or reimburses expenses for health care services.

(5) "Participating entity" means an entity participating in the uniform group coverage program established under this chapter. The term includes:

(A) a school district;
 (B) another educational district whose employees are members of the Teacher Retirement System of Texas;
 (C) a regional education service center; and
 (D) a charter school that meets the requirements of Section 1579.154.

(6) "Program" means the uniform group coverage program established under this chapter.

(7) "Regional education service center" means a regional education service center established under Chapter 8, Education Code.

(8) "Usual and customary rate" means the relevant allowable amount as described by the applicable master benefit plan document or policy.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.471(a), eff. Sept. 1, 2003.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. [1264](#)), Sec. 1.16, eff. September 1, 2019.

Sec. 1579.003. DEFINITION OF EMPLOYEE. In this chapter, "employee" means a participating member of the Teacher Retirement System of Texas who is employed by a participating entity and who is not receiving coverage from a program under Chapter 1551, 1575, or 1601. The term does not include an individual performing personal services as an independent contractor.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.471(a), eff. Sept. 1, 2003.

Sec. 1579.004. DEFINITION OF DEPENDENT. In this chapter, "dependent" means:

- (1) a spouse of a full-time employee or part-time employee;
- (2) a child of a full-time or part-time employee if the child is younger than 26 years of age, including:
 - (A) an adopted child or child who is lawfully placed for adoption;
 - (B) a foster child, stepchild, or other child who is in a regular parent-child relationship; and

(C) a natural child;

(3) a full-time or part-time employee's natural child, adopted child, foster child, stepchild, or other child who is in a regular parent-child relationship and who lives with or has his or her care provided by the employee or the surviving spouse on a regular basis, regardless of the child's age, if the child has a mental disability or is physically incapacitated to an extent that the child is dependent on the employee or surviving spouse for care or support, as determined by the board of trustees; and

(4) notwithstanding any other provision of this code, any other dependent of a full-time or part-time employee specified by rules adopted by the board of trustees.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.471(a), eff. Sept. 1, 2003.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 455 (S.B. 1667), Sec. 24, eff. September 1, 2011.

Acts 2013, 83rd Leg., R.S., Ch. 1078 (H.B. 3357), Sec. 20, eff. June 14, 2013.

Sec. 1579.005. CONFIDENTIALITY. (a) Section 825.507, Government Code, applies to records relating to an employee or dependent under the program and in the custody of the Teacher Retirement System of Texas or in the custody of an administrator, carrier, agent, attorney, consultant, or governmental body acting in cooperation with or on behalf of the system.

(b) The Teacher Retirement System of Texas may disclose to a health care provider, benefit provider, or claims administrator information in the records of an individual that the system determines is necessary to administer the program.

Added by Acts 2005, 79th Leg., Ch. 1359 (S.B. 1691), Sec. 48, eff. September 1, 2005.

Sec. 1579.006. EXEMPTION FROM PROCESS. (a) The following are exempt from execution, attachment, garnishment, or any other process:

- (1) benefit payments, including optional benefit payments;
- (2) contributions of active employees, the state, and a

participating entity, and any other contributions;

(3) any rights, benefits, or payments accruing to any person under this chapter; and

(4) any money in the Texas school employees uniform group coverage trust fund.

(b) The items listed in Subsection (a) may not be assigned except for direct payment to benefit providers as authorized by the trustee by contract, rule, or otherwise.

Added by Acts 2005, 79th Leg., Ch. 1359 (S.B. 1691), Sec. 48, eff. September 1, 2005.

Sec. 1579.007. EXEMPTION FROM STATE TAXES AND FEES. A premium or contribution on a policy, insurance contract, or agreement authorized by this chapter is not subject to any state tax, regulatory fee, or surcharge, including a premium or maintenance tax or fee.

Added by Acts 2005, 79th Leg., Ch. 1359 (S.B. 1691), Sec. 48, eff. September 1, 2005.

Sec. 1579.008. COVERAGE EXEMPT FROM INSURANCE LAW. A coverage plan provided under this chapter is exempt from any other insurance law, including common law, that does not expressly apply to the plan or this chapter.

Added by Acts 2005, 79th Leg., Ch. 1359 (S.B. 1691), Sec. 48, eff. September 1, 2005.

Text of section effective until September 1, 2025

Sec. 1579.009. BALANCE BILLING PROHIBITION NOTICE. (a) The administrator of a managed care plan provided under this chapter shall provide written notice in accordance with this section in an explanation of benefits provided to the enrollee and the physician or health care provider in connection with a health care or medical service or supply or transport provided by an out-of-network provider. The notice must include:

(1) a statement of the billing prohibition under Section

1579.109, 1579.110, 1579.111, or 1579.112, as applicable;

(2) the total amount the physician or provider may bill the enrollee under the enrollee's managed care plan and an itemization of copayments, coinsurance, deductibles, and other amounts included in that total; and

(3) for an explanation of benefits provided to the physician or provider, information required by commissioner rule advising the physician or provider of the availability of mediation or arbitration, as applicable, under Chapter 1467.

(b) The administrator shall provide the explanation of benefits with the notice required by this section to a physician or health care provider not later than the date the administrator makes a payment under Section 1579.109, 1579.110, 1579.111, or 1579.112, as applicable.

Added by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. [1264](#)), Sec. 1.17, eff. September 1, 2019.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 981 (S.B. [2476](#)), Sec. 13(a), eff. September 1, 2023.

Acts 2023, 88th Leg., R.S., Ch. 981 (S.B. [2476](#)), Sec. 13(b), eff. September 1, 2025.

Text of section effective on September 1, 2025

Sec. 1579.009. BALANCE BILLING PROHIBITION NOTICE. (a) The administrator of a managed care plan provided under this chapter shall provide written notice in accordance with this section in an explanation of benefits provided to the enrollee and the physician or health care provider in connection with a health care or medical service or supply provided by an out-of-network provider. The notice must include:

(1) a statement of the billing prohibition under Section 1579.109, 1579.110, or 1579.111, as applicable;

(2) the total amount the physician or provider may bill the enrollee under the enrollee's managed care plan and an itemization of copayments, coinsurance, deductibles, and other amounts included in that total; and

(3) for an explanation of benefits provided to the physician or provider, information required by commissioner rule

advising the physician or provider of the availability of mediation or arbitration, as applicable, under Chapter 1467.

(b) The administrator shall provide the explanation of benefits with the notice required by this section to a physician or health care provider not later than the date the administrator makes a payment under Section 1579.109, 1579.110, or 1579.111, as applicable.

Added by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 1.17, eff. September 1, 2019.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 981 (S.B. 2476), Sec. 13(a), eff. September 1, 2023.

Acts 2023, 88th Leg., R.S., Ch. 981 (S.B. 2476), Sec. 13(b), eff. September 1, 2025.

Sec. 1579.010. INFORMATION REGARDING APPEALS. The trustee shall develop and distribute informational materials to individuals enrolled in a health coverage plan provided under this chapter regarding:

(1) an enrollee's right to appeal denial of an adverse determination, as defined by Section 4201.002, to an independent review organization;

(2) the procedures for appealing to an independent review organization; and

(3) the assistance available from the trustee in navigating the procedures for appeal.

Added by Acts 2021, 87th Leg., R.S., Ch. 141 (H.B. 1585), Sec. 18, eff. May 26, 2021.

SUBCHAPTER B. ADMINISTRATION

Sec. 1579.051. ADMINISTRATION OF GROUP PROGRAM. The Teacher Retirement System of Texas, as trustee, shall implement and administer the uniform group coverage program described by this chapter.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.471(a), eff. Sept. 1, 2003.

Sec. 1579.052. AUTHORITY TO ADOPT RULES; OTHER AUTHORITY. (a) The trustee may adopt rules relating to the program as considered necessary by the trustee.

(b) The trustee may adopt rules to administer the program, including rules relating to adjudication of claims and expelling participants from the program for cause.

(c) The trustee may contract with independent and experienced group insurance consultants and actuaries for advice and counsel in implementing and administering the program.

(d) The trustee may enter into interagency contracts with any agency of the state, including the Employees Retirement System of Texas and the department, for the purpose of assistance in implementing the program.

(e) The trustee shall take the actions it considers necessary to devise, implement, and administer the program.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.471(a), eff. Sept. 1, 2003.

Amended by:

Acts 2005, 79th Leg., Ch. 1359 (S.B. [1691](#)), Sec. 49, eff. September 1, 2005.

Sec. 1579.053. PERSONNEL. The trustee may hire and compensate employees as necessary to implement the program.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.471(a), eff. Sept. 1, 2003.

Sec. 1579.054. COMPETITIVE BIDDING REQUIREMENTS; RULES. A contract to provide group health coverage under this chapter may be awarded only through competitive bidding under rules adopted by the trustee.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.471(a), eff. Sept. 1, 2003.

Sec. 1579.055. CONTRACT AWARD; CONSIDERATIONS. (a) In awarding a contract to provide group benefits under this chapter, the

trustee is not required to select the lowest bid and may consider also any relevant criteria, including the bidder's:

- (1) ability to service contracts;
- (2) past experiences; and
- (3) financial stability.

(b) If the trustee awards a contract to a bidder whose bid deviates from that advertised, the trustee shall record the deviation and fully justify the reason for the deviation in the minutes of the next board meeting.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.471(a), eff. Sept. 1, 2003.

Sec. 1579.057. PHARMACY BENEFIT MANAGER CONTRACTS. (a) In awarding a contract to provide pharmacy benefit manager services under this chapter, the trustee is not required to select the lowest bid but must select a contract that meets the criteria established by this section.

(b) The contract must state that:

(1) the trustee is entitled to audit the pharmacy benefit manager to verify costs and discounts associated with drug claims, pharmacy benefit manager compliance with contract requirements, and services provided by subcontractors;

(2) the audit must be conducted by an independent auditor in accordance with established auditing standards; and

(3) to conduct the audit, the trustee and the independent auditor are entitled access to information related to the services and the costs associated with the services performed under the contract, including access to the pharmacy benefit manager's facilities, records, contracts, medical records, and agreements with subcontractors.

(c) The contract must define the information that the pharmacy benefit manager is required to provide to the trustee concerning the audit of the retail, independent, and mail order pharmacies performing services under the contract and describe how the results of these audits must be reported to the trustee, including how often the results must be reported. The contract must state whether the pharmacy benefit manager is required to return recovered overpayments to the trustee.

(d) The contract must state that any audit of a mail order pharmacy owned by the pharmacy benefit manager must be conducted by an independent auditor selected by the trustee in accordance with established auditing standards.

Added by Acts 2009, 81st Leg., R.S., Ch. 1207 (S.B. 704), Sec. 7, eff. September 1, 2009.

SUBCHAPTER C. COVERAGES

Sec. 1579.101. PLANS OF GROUP COVERAGES. (a) The trustee by rule shall establish plans of group coverages for employees participating in the program and their dependents.

(b) The plans must include at least two tiers of group coverage, with coverage at different levels in each tier, ranging from the catastrophic care coverage plan to the primary care coverage plan. Each tier must contain a health coverage plan.

(c) The trustee by rule shall define the requirements of each coverage plan and tier of coverage.

(d) Comparable coverage plans of each tier of coverage established must be offered to employees of all participating entities.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.471(a), eff. Sept. 1, 2003.

Sec. 1579.102. CATASTROPHIC CARE COVERAGE PLAN. The coverage provided under the catastrophic care coverage plan shall be prescribed by the trustee by rule and must provide coverage at least as extensive as the coverage provided under the TRS-Care 1 plan operated under Chapter 1575.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.471(a), eff. Sept. 1, 2003.

Amended by:

Acts 2005, 79th Leg., Ch. 1359 (S.B. 1691), Sec. 50, eff. September 1, 2005.

Sec. 1579.104. OPTIONAL COVERAGES. The trustee may not offer

optional coverages, other than optional permanent life insurance, optional long-term care insurance, and optional disability insurance, to employees participating in the program. This section does not affect the right of a participating entity to offer optional coverages to its employees under terms and conditions established by the participating entity.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.471(a), eff. Sept. 1, 2003.

Reenacted by Acts 2005, 79th Leg., Ch. 1359 (S.B. 1691), Sec. 51(a), eff. September 1, 2005.

Sec. 1579.1045. ALTERNATIVE GROUP HEALTH COVERAGE PROHIBITED. Notwithstanding any other law, a participating entity may not offer or make available to the entity's employees or their dependents group health coverage not provided under the program.

Added by Acts 2021, 87th Leg., R.S., Ch. 399 (S.B. 1444), Sec. 1, eff. September 1, 2021.

Sec. 1579.105. PREEXISTING CONDITION LIMITATION. During the initial period of eligibility, coverage provided under the program may not be made subject to a preexisting condition limitation.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.471(a), eff. Sept. 1, 2003.

Sec. 1579.106. PRIOR AUTHORIZATION FOR CERTAIN DRUGS. (a) In this section, "drug formulary" means a list of drugs preferred for use and eligible for coverage by a health coverage plan.

(b) A health coverage plan provided under this chapter that uses a drug formulary in providing a prescription drug benefit must require prior authorization for coverage of the following categories of prescribed drugs if the specific drug prescribed is not included in the formulary:

- (1) a gastrointestinal drug;
- (2) a cholesterol-lowering drug;
- (3) an anti-inflammatory drug;

- (4) an antihistamine drug; and
- (5) an antidepressant drug.

(c) Every 12 months the trustee shall submit to the comptroller and the Legislative Budget Board a report regarding any cost savings achieved in the program through implementation of the prior authorization requirement of this section. The report must cover the previous 12-month period.

(d) In the report under Subsection (c), the trustee:

(1) may include any cost savings achieved in the program for coverage of prescribed drugs that are not included in the categories listed in Subsection (b) for which prior authorization is required by a health coverage plan provided under this chapter; and

(2) considering cost and medical necessity, shall identify any categories of prescribed drugs in addition to the categories listed in Subsection (b) for which requiring prior authorization could achieve cost savings.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1G.003, eff. April 1, 2009.

Amended by:

Acts 2021, 87th Leg., R.S., Ch. 141 (H.B. 1585), Sec. 19, eff. May 26, 2021.

Sec. 1579.1061. EXEMPTION FROM PREAUTHORIZATION REQUIREMENTS FOR PHYSICIANS AND HEALTH CARE PROVIDERS PROVIDING CERTAIN HEALTH CARE SERVICES. A preauthorization process used by a health coverage plan provided under this chapter is subject to the same limitations and requirements provided by Subchapter N, Chapter 4201, for a preauthorization process used by an insurer.

Added by Acts 2021, 87th Leg., R.S., Ch. 1018 (H.B. 3459), Sec. 3, eff. September 1, 2021.

Sec. 1579.107. DISEASE MANAGEMENT SERVICES. (a) In this section, "disease management services" means services to assist an individual manage a disease or other chronic health condition, such as heart disease, diabetes, respiratory illness, end-stage renal disease, HIV infection, or AIDS, and with respect to which the trustee identifies populations requiring disease management.

(b) A health coverage plan provided under this chapter must provide disease management services or coverage for disease management services in the manner required by the trustee, including:

- (1) patient self-management education;
- (2) provider education;
- (3) evidence-based models and minimum standards of care;
- (4) standardized protocols and participation criteria; and
- (5) physician-directed or physician-supervised care.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1G.003, eff. April 1, 2009.

Sec. 1579.108. LIMITATIONS. The trustee may not contract for or provide a health coverage plan that excludes from participation in the network a general hospital that:

(1) is located in the geographical service area or areas of the health coverage plan that includes a county that:

(A) has a population of at least 100,000 and not more than 233,500; and

(B) is located in the Texas-Louisiana border region, as that term is defined in Section 2056.002(e), Government Code; and

(2) agrees to provide medical and health care services under the plan subject to the same terms as other hospital providers under the plan.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1G.003, eff. April 1, 2009.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 1163 (H.B. 2702), Sec. 58, eff. September 1, 2011.

Acts 2023, 88th Leg., R.S., Ch. 644 (H.B. 4559), Sec. 118, eff. September 1, 2023.

Sec. 1579.109. EMERGENCY CARE PAYMENTS. (a) In this section, "emergency care" has the meaning assigned by Section 1301.155.

(b) The administrator of a managed care plan provided under this chapter shall pay for covered emergency care performed by or a covered supply related to that care provided by an out-of-network provider at the usual and customary rate or at an agreed rate. The

administrator shall make a payment required by this subsection directly to the provider not later than, as applicable:

(1) the 30th day after the date the administrator receives an electronic claim for those services that includes all information necessary for the administrator to pay the claim; or

(2) the 45th day after the date the administrator receives a nonelectronic claim for those services that includes all information necessary for the administrator to pay the claim.

(c) For emergency care subject to this section or a supply related to that care, an out-of-network provider or a person asserting a claim as an agent or assignee of the provider may not bill an enrollee in, and the enrollee does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, and deductible under the enrollee's managed care plan that:

(1) is based on:

(A) the amount initially determined payable by the administrator; or

(B) if applicable, a modified amount as determined under the administrator's internal appeal process; and

(2) is not based on any additional amount determined to be owed to the provider under Chapter 1467.

Added by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. [1264](#)), Sec. 1.18, eff. September 1, 2019.

Sec. 1579.110. OUT-OF-NETWORK FACILITY-BASED PROVIDER PAYMENTS.

(a) In this section, "facility-based provider" means a physician or health care provider who provides health care or medical services to patients of a health care facility.

(b) Except as provided by Subsection (d), the administrator of a managed care plan provided under this chapter shall pay for a covered health care or medical service performed for or a covered supply related to that service provided to an enrollee by an out-of-network provider who is a facility-based provider at the usual and customary rate or at an agreed rate if the provider performed the service at a health care facility that is a participating provider. The administrator shall make a payment required by this subsection directly to the provider not later than, as applicable:

(1) the 30th day after the date the administrator receives an electronic claim for those services that includes all information necessary for the administrator to pay the claim; or

(2) the 45th day after the date the administrator receives a nonelectronic claim for those services that includes all information necessary for the administrator to pay the claim.

(c) Except as provided by Subsection (d), an out-of-network provider who is a facility-based provider or a person asserting a claim as an agent or assignee of the provider may not bill an enrollee receiving a health care or medical service or supply described by Subsection (b) in, and the enrollee does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, and deductible under the enrollee's managed care plan that:

(1) is based on:

(A) the amount initially determined payable by the administrator; or

(B) if applicable, a modified amount as determined under the administrator's internal appeal process; and

(2) is not based on any additional amount determined to be owed to the provider under Chapter 1467.

(d) This section does not apply to a nonemergency health care or medical service:

(1) that an enrollee elects to receive in writing in advance of the service with respect to each out-of-network provider providing the service; and

(2) for which an out-of-network provider, before providing the service, provides a complete written disclosure to the enrollee that:

(A) explains that the provider does not have a contract with the enrollee's managed care plan;

(B) discloses projected amounts for which the enrollee may be responsible; and

(C) discloses the circumstances under which the enrollee would be responsible for those amounts.

Added by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. [1264](#)), Sec. 1.18, eff. September 1, 2019.

Sec. 1579.111. OUT-OF-NETWORK DIAGNOSTIC IMAGING PROVIDER OR LABORATORY SERVICE PROVIDER PAYMENTS. (a) In this section, "diagnostic imaging provider" and "laboratory service provider" have the meanings assigned by Section 1467.001.

(b) Except as provided by Subsection (d), the administrator of a managed care plan provided under this chapter shall pay for a covered health care or medical service performed for or a covered supply related to that service provided to an enrollee by an out-of-network provider who is a diagnostic imaging provider or laboratory service provider at the usual and customary rate or at an agreed rate if the provider performed the service in connection with a health care or medical service performed by a participating provider. The administrator shall make a payment required by this subsection directly to the provider not later than, as applicable:

(1) the 30th day after the date the administrator receives an electronic claim for those services that includes all information necessary for the administrator to pay the claim; or

(2) the 45th day after the date the administrator receives a nonelectronic claim for those services that includes all information necessary for the administrator to pay the claim.

(c) Except as provided by Subsection (d), an out-of-network provider who is a diagnostic imaging provider or laboratory service provider or a person asserting a claim as an agent or assignee of the provider may not bill an enrollee receiving a health care or medical service or supply described by Subsection (b) in, and the enrollee does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, and deductible under the enrollee's managed care plan that:

(1) is based on:

(A) the amount initially determined payable by the administrator; or

(B) if applicable, a modified amount as determined under the administrator's internal appeal process; and

(2) is not based on any additional amount determined to be owed to the provider under Chapter 1467.

(d) This section does not apply to a nonemergency health care or medical service:

(1) that an enrollee elects to receive in writing in advance of the service with respect to each out-of-network provider providing the service; and

(2) for which an out-of-network provider, before providing the service, provides a complete written disclosure to the enrollee that:

(A) explains that the provider does not have a contract with the enrollee's managed care plan;

(B) discloses projected amounts for which the enrollee may be responsible; and

(C) discloses the circumstances under which the enrollee would be responsible for those amounts.

Added by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 1.18, eff. September 1, 2019.

For expiration of this section, see Subsection (f).

Sec. 1579.112. OUT-OF-NETWORK EMERGENCY MEDICAL SERVICES PROVIDER PAYMENTS. (a) In this section, "emergency medical services provider" has the meaning assigned by Section 773.003, Health and Safety Code, except that the term does not include an air ambulance.

(b) Except as provided by Subsection (c), the administrator of a managed care plan provided under this chapter shall pay for a covered health care or medical service performed for, or a covered supply or covered transport related to that service provided to, an enrollee by an out-of-network provider who is an emergency medical services provider at:

(1) if the political subdivision has submitted the rate to the department under Section 38.006, the rate set, controlled, or regulated by the political subdivision in which:

(A) the service originated; or

(B) the transport originated if transport is provided;

or

(2) if the political subdivision has not submitted the rate to the department, the lesser of:

(A) the provider's billed charge; or

(B) 325 percent of the current Medicare rate, including any applicable extenders and modifiers.

(c) The administrator shall adjust a payment required by Subsection (b)(1) each plan year by increasing the payment by the lesser of the Medicare Inflation Index or 10 percent of the provider's previous calendar year rates.

(d) The administrator shall make a payment required by this section directly to the provider not later than, as applicable:

(1) the 30th day after the date the administrator receives an electronic claim for those services that includes all information necessary for the administrator to pay the claim; or

(2) the 45th day after the date the administrator receives a nonelectronic claim for those services that includes all information necessary for the administrator to pay the claim.

(e) An out-of-network provider who is an emergency medical services provider or a person asserting a claim as an agent or assignee of the provider may not bill an enrollee receiving a health care or medical service or supply or transport described by Subsection (b) in, and the enrollee does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, and deductible under the enrollee's managed care plan that is based on:

(1) the amount initially determined payable by the administrator; or

(2) if applicable, a modified amount as determined under the administrator's internal appeal process.

(f) This section expires September 1, 2025.

Added by Acts 2023, 88th Leg., R.S., Ch. 981 (S.B. [2476](#)), Sec. 14, eff. September 1, 2023.

SUBCHAPTER D. PARTICIPATING ENTITIES

Sec. 1579.151. REQUIRED PARTICIPATION OF SCHOOL DISTRICTS WITH 500 OR FEWER EMPLOYEES. (a) Each school district with 500 or fewer employees and each regional education service center is required to participate in the program.

(b) Notwithstanding Subsection (a), a school district otherwise subject to Subsection (a) that, on January 1, 2001, was individually self-funded for the provision of health coverage to its employees may elect not to participate in the program.

(c) An educational district described by Section 1579.002(5)(B) that, on January 1, 2001, had 500 or fewer employees may elect not to participate in the program.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.471(a), eff. Sept. 1, 2003.

Sec. 1579.152. PARTICIPATION OF OTHER SCHOOL DISTRICTS. Effective September 1, 2005, a school district with more than 500 employees may elect to participate in the program. A school district that elects to participate under this section shall apply for participation in the manner prescribed by the trustee by rule.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.471(a), eff. Sept. 1, 2003.

Sec. 1579.153. PARTICIPATION BY CERTAIN RISK POOLS. (a) In determining the number of employees of a school district for purposes of Sections 1579.151 and 1579.152, school districts that, on January 1, 2001, were members of a risk pool established under the authority of Chapter 172, Local Government Code, as provided by Section 22.004, Education Code, may elect to be treated as a single unit. A school district shall elect whether to be considered as a member of a risk pool under this section by notifying the trustee not later than September 1, 2001.

(b) A risk pool in existence on January 1, 2001, that, as of that date, provided group health coverage to 500 or fewer school district employees may elect to participate in the program.

(c) A school district with 500 or fewer employees that is a member of a risk pool described by Subsection (a) that provides group health coverage to more than 500 school district employees must elect, not later than September 1, 2001, whether to be treated as a school district with 500 or fewer employees or as part of a unit with more than 500 employees. The school district must notify the trustee of the election, in the manner prescribed by the trustee, not later than September 1, 2001.

(d) For purposes of this section, participation in the program by school districts covered by a risk pool is limited to school districts covered by the risk pool as of January 1, 2001.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.471(a), eff. Sept. 1, 2003.

Sec. 1579.154. PARTICIPATION BY CHARTER SCHOOLS; ELIGIBILITY.

(a) A charter school is eligible to participate in the program if the school agrees:

(1) that all records of the school relating to participation in the program are open to inspection by the trustee, the administering firm, the commissioner of education, or a designee of any of those entities; and

(2) to have the school's accounts relating to participation in the program annually audited by a certified public accountant at the school's expense.

(b) A charter school must notify the trustee of the school's intent to participate in the program in the manner and within the time required by rules adopted by the trustee.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.471(a), eff. Sept. 1, 2003.

Sec. 1579.155. PROGRAM PARTICIPATION: ELECTION. (a) Effective September 1, 2022, a participating entity may elect to discontinue the entity's participation in the program by providing written notice to the trustee not later than December 31 of the year preceding the first day of the plan year in which the election will be effective.

(b) A participating entity that elects to discontinue participation in the program under Subsection (a) may not elect to:

(1) participate in the program until the fifth anniversary of the effective date of the entity's election to discontinue participation; or

(2) discontinue the entity's participation after an election described by Subdivision (1) until the fifth anniversary of the effective date of that election.

(c) Effective September 1, 2022, an entity that elects to participate in the program shall provide written notice to the trustee not later than December 31 of the year preceding the first day of the plan year in which the election will be effective. The entity may not elect to discontinue the entity's participation until the fifth anniversary of the effective date of the entity's election to participate.

(d) The trustee by rule shall prescribe the time and manner for making an election under this section and may adopt rules necessary to administer this section.

Added by Acts 2021, 87th Leg., R.S., Ch. 399 (S.B. 1444), Sec. 2, eff. September 1, 2021.

SUBCHAPTER E. PARTICIPATION BY EMPLOYEE

Sec. 1579.201. DEFINITION. In this subchapter, "full-time employee" and "part-time employee" have the meanings assigned by rules adopted by the trustee.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.471(a), eff. Sept. 1, 2003.

Sec. 1579.202. ELIGIBLE EMPLOYEES. (a) Except as provided by Section 1579.204, participation in the program is limited to employees of participating entities who are full-time employees and to part-time employees who are participating members in the Teacher Retirement System of Texas.

(b) An employee described by Subsection (a) who applies for coverage during an open enrollment period prescribed by the trustee is automatically covered by the catastrophic care coverage plan unless the employee:

- (1) specifically waives coverage under this chapter;
- (2) selects a higher tier coverage plan; or
- (3) is expelled from the program.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.471(a), eff. Sept. 1, 2003.

Sec. 1579.203. SELECTION OF COVERAGE. (a) A participating employee may select coverage in any coverage plan offered by the trustee.

(b) The employee is not required to continue participation in the coverage plan initially selected and may select a higher or lower tier coverage plan than the plan initially selected by the employee in the manner provided by rules adopted by the trustee.

(c) If the combined contributions received from the state and the employing participating entity under Subchapter F exceed the cost of a coverage plan selected by the employee, the employee may use the excess amount of contributions to obtain coverage under a higher tier

coverage plan or to pay all or part of the cost of coverage for the employee's dependents.

(d) A married couple, both of whom are eligible for coverage under the program, may pool the amount of contributions to which the couple are entitled under the program to obtain coverage for themselves and dependent coverage.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.471(a), eff. Sept. 1, 2003.

Sec. 1579.204. CERTAIN PART-TIME EMPLOYEES. A part-time employee of a participating entity who is not a participating member in the Teacher Retirement System of Texas is eligible to participate in the program only if the employee pays all of the premiums and other costs associated with the health coverage plan selected by the employee.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.471(a), eff. Sept. 1, 2003.

Sec. 1579.205. PAYMENT BY PARTICIPATING ENTITY. Notwithstanding Section 1579.204, a participating entity may pay any portion of what otherwise would be the employee share of premiums and other costs associated with the coverage selected by the employee.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.471(a), eff. Sept. 1, 2003.

SUBCHAPTER F. CONTRIBUTIONS

Sec. 1579.251. STATE ASSISTANCE. (a) The state shall assist employees of participating school districts and charter schools in the purchase of group health coverage under this chapter by providing for each covered employee the amount of \$900 each state fiscal year or a greater amount as provided by the General Appropriations Act. The state contribution shall be distributed through the school finance formulas under Chapters 48 and 49, Education Code, and used by school districts and charter schools as provided by Section 48.275, Education Code.

(b) The state shall assist employees of participating regional education service centers and educational districts described by Section 1579.002(5)(B) in the purchase of group health coverage under this chapter by providing to the employing service center or educational district, for each covered employee, the amount of \$900 each state fiscal year or a greater amount as provided by the General Appropriations Act.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.471(a), eff. Sept. 1, 2003.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1328 (H.B. 3646), Sec. 83, eff. September 1, 2009.

Acts 2019, 86th Leg., R.S., Ch. 943 (H.B. 3), Sec. 3.085, eff. September 1, 2019.

Sec. 1579.252. CONTRIBUTION BY PARTICIPATING ENTITIES. A participating entity shall make contributions for the program as provided by Chapter 1581.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.471(a), eff. Sept. 1, 2003.

Sec. 1579.253. CONTRIBUTION BY EMPLOYEE. (a) An employee covered by the program shall pay that portion of the cost of coverage selected by the employee that exceeds the amount of the state contribution under Section 1579.251 and the participating entity contribution under Section 1579.252.

(b) The employee may pay the employee's contribution under this subsection from the amount distributed to the employee under Subchapter D, Chapter 22, Education Code.

(c) Notwithstanding Subsection (a), a participating entity may pay any portion of what otherwise would be the employee share of premiums and other costs associated with the coverage selected by the employee.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.471(a), eff. Sept. 1, 2003.

Amended by:

Acts 2005, 79th Leg., Ch. 899 (S.B. 1863), Sec. 18.04, eff. September 1, 2005.

Acts 2005, 79th Leg., Ch. 1359 (S.B. 1691), Sec. 52, eff. September 1, 2005.

Sec. 1579.254. CONTRIBUTIONS HELD IN TRUST FOR FUND. A participating entity:

(1) shall hold contributions required by this subchapter in trust for the Texas school employees uniform group coverage trust fund and its participants; and

(2) may not divert the contributions for any other purpose.

Added by Acts 2005, 79th Leg., Ch. 1359 (S.B. 1691), Sec. 53, eff. September 1, 2005.

Sec. 1579.255. INTEREST ASSESSED ON LATE PAYMENT OF CONTRIBUTIONS BY PARTICIPATING ENTITIES. (a) A participating entity that does not remit to the trustee all contributions required by this subchapter before the seventh day after the last day of the month shall pay to the Texas school employees uniform group coverage trust fund:

(1) the contributions; and

(2) interest on the unpaid amounts at the annual rate of six percent compounded monthly.

(b) On request, the trustee may grant a waiver of the deadline imposed by this section based on a participating entity's financial or technological resources.

Added by Acts 2005, 79th Leg., Ch. 1359 (S.B. 1691), Sec. 53, eff. September 1, 2005.

SUBCHAPTER G. TEXAS SCHOOL EMPLOYEES UNIFORM GROUP COVERAGE TRUST FUND

Sec. 1579.301. FUND; ADMINISTRATION. The Texas school employees uniform group coverage trust fund is a trust fund with the comptroller.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.471(a), eff. Sept.

1, 2003.

Sec. 1579.302. COMPOSITION OF FUND. The fund is composed of:

- (1) all contributions made to the fund under this chapter from employees, participating entities, and the state;
- (2) contributions made by employees or participating entities for optional coverages;
- (3) investment income;
- (4) any additional amounts appropriated by the legislature for contingency reserves, administrative expenses, or other expenses; and
- (5) any other money required or authorized to be paid into the fund.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.471(a), eff. Sept. 1, 2003.

Sec. 1579.303. PAYMENTS FROM FUND. The trustee may use amounts in the fund only to provide group coverages under this chapter and to pay the expenses of administering the program.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.471(a), eff. Sept. 1, 2003.

Sec. 1579.304. INVESTMENT OF FUND. The trustee may invest assets of the fund in the manner provided by Section 67(a)(3), Article XVI, Texas Constitution.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.471(a), eff. Sept. 1, 2003.

**CHAPTER 1581. EMPLOYER EXPENDITURES FOR SCHOOL EMPLOYEE HEALTH
COVERAGE PLANS**

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1581.001. DEFINITIONS. In this chapter:

- (1) "Participating employee" means an employee of a school district, other educational district whose employees are members of

the Teacher Retirement System of Texas, participating charter school, or regional education service center who participates in a group health coverage plan provided by or through the district, school, or service center.

(2) "Participating charter school" means an open-enrollment charter school established under Subchapter D, Chapter 12, Education Code, that participates in the uniform group coverage program established under Chapter 1579.

(3) "Regional education service center" means a regional education service center established under Chapter 8, Education Code.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.471(a), eff. Sept. 1, 2003.

SUBCHAPTER B. MAINTENANCE OF EFFORT; MINIMUM EFFORT

Sec. 1581.051. MAINTENANCE OF EFFORT FOR 2000-2001 SCHOOL YEAR.

(a) Subject to Sections 1581.052 and 1581.053, and except as provided by Section 1581.054, a school district, other educational district whose employees are members of the Teacher Retirement System of Texas, participating charter school, or regional education service center that, for the 2000-2001 school year, paid amounts to share with employees the cost of coverage under a group health coverage plan shall, for each fiscal year, use to provide health coverage an amount for each participating employee at least equal to the amount computed as provided by this section.

(b) The school district, other educational district, participating charter school, or regional education service center shall divide the amount that the district, school, or service center paid during the 2000-2001 school year for the prior group health coverage plan by the total number of full-time employees of the district, school, or service center in the 2000-2001 school year and multiply the result by the number of full-time employees of the district, school, or service center in the fiscal year for which the computation is made. If, for the 2000-2001 school year, a school district, other educational district, participating charter school, or regional education service center provided group health coverage to its employees through a self-funded insurance plan, the amount the district, school, or service center paid during that school year for the plan includes only the amount of regular contributions made by

the district, school, or service center to the plan.

(c) Amounts used as required by this section shall be deposited, as applicable, in a fund described by Section 1581.052(b).

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.471(a), eff. Sept. 1, 2003.

Sec. 1581.052. REQUIRED MINIMUM EFFORT. (a) A school district, other educational district, participating charter school, or regional education service center shall, for each fiscal year, use to provide health coverage an amount equal to the number of participating employees of the district, school, or service center multiplied by \$1,800.

(b) Amounts used as required by this section shall be deposited, as applicable, in:

(1) the Texas school employees uniform group coverage trust fund established under Subchapter G, Chapter 1579; or

(2) another fund established for the payment of employee health coverage that meets requirements for those funds prescribed by the Texas Education Agency.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.471(a), eff. Sept. 1, 2003.

Sec. 1581.053. USE OF STATE FUNDS. (a) To comply with Section 1581.052, a school district or participating charter school may use state funds received under Chapter 48, Education Code, other than funds that may be used under that chapter only for a specific purpose.

(b) Notwithstanding Subsection (a), amounts a district or school is required to use to pay contributions under a group health coverage plan for district or school employees under Section 48.275, Education Code, other than amounts described by Section 48.275(c)(2), are not used in computing whether the district or school complies with Section 1581.052.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.471(a), eff. Sept. 1, 2003.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1328 (H.B. 3646), Sec. 84, eff. September 1, 2009.

Acts 2019, 86th Leg., R.S., Ch. 943 (H.B. 3), Sec. 3.086, eff. September 1, 2019.

Sec. 1581.054. EXCESS OF MAINTENANCE OF EFFORT. If the amount a school district, other educational district, or participating charter school is required to use to provide health coverage under Section 1581.051 for a fiscal year exceeds the amount necessary for the district or school to comply with Section 1581.052(a) for that year, the district or school may use the excess only to provide employee compensation at a rate greater than the rate of compensation that the district or school paid an employee in the 2000-2001 school year, benefits, or both.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.471(a), eff. Sept. 1, 2003.

**CHAPTER 1601. UNIFORM INSURANCE BENEFITS ACT FOR EMPLOYEES OF THE
UNIVERSITY OF TEXAS SYSTEM AND THE TEXAS A&M UNIVERSITY SYSTEM
SUBCHAPTER A. GENERAL PROVISIONS**

Sec. 1601.001. SHORT TITLE. This chapter may be cited as the State University Employees Uniform Insurance Benefits Act.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.002. PURPOSES. The purposes of this chapter are to:

- (1) provide uniformity in the basic group life, accident, and health benefit coverages for all system employees;
- (2) enable the systems to attract and retain competent and able employees by providing employees with basic life, accident, and health benefit coverages comparable to those commonly provided in private industry and to employees of a state agency other than a system, including a public college or university whose employees are covered under Chapter 1551;
- (3) foster, promote, and encourage employment by and service to the systems as a career profession for individuals of high standards of competence and ability;

(4) recognize and protect the investment of the systems in each employee by promoting and preserving economic security and good health among employees;

(5) foster and develop high standards of employer-employee relationships between the systems and their employees; and

(6) recognize the long and faithful service and dedication of employees and encourage them to remain in service until eligible for retirement by providing health benefits and other group benefits for them.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.003. GENERAL DEFINITIONS. In this chapter:

(1) "Administering carrier" means a carrier or organization that is:

(A) qualified to engage in business in this state; and

(B) designated by a system to administer services, benefits, insurance coverages, or requirements in accordance with this chapter.

(2) "Basic coverage" means coverage, including health benefit coverage, that meets the basic coverage standards required under Section 1601.053(a)(1).

(3) "Cafeteria plan" means a plan defined and authorized by Section 125, Internal Revenue Code of 1986.

(4) "Group life, accident, or health benefit plan" means a group agreement, policy, contract, or arrangement provided by an administering carrier, including:

(A) a group insurance policy or contract;

(B) a life, accident, medical, dental, or hospital service agreement;

(C) a membership or subscription contract; or

(D) any other similar group arrangement.

(5) "Optional coverage" means group coverage other than the basic coverage.

(6) "Service" means personal service to a system for which an employee is credited in accordance with rules adopted by the system.

(7) "System" means The University of Texas System or The Texas A&M University System.

(8) "The Texas A&M University System" means the entities governed under Chapters 85 through 88, Education Code, including the Texas Veterinary Diagnostic Laboratory.

(9) "The University of Texas System" means the entities listed or described by Section 65.02, Education Code.

(10) "Uniform program" means an employees uniform insurance benefits program provided under this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.004. DEFINITION OF DEPENDENT. (a) In this chapter, "dependent," with respect to an individual eligible to participate in the uniform program under Section 1601.101 or 1601.102, means the individual's:

(1) spouse;

(2) unmarried child younger than 25 years of age; and

(3) child of any age who lives with or has the child's care provided by the individual on a regular basis if the child is a person with an intellectual disability or is physically incapacitated to the extent that the child is dependent on the individual for care or support, as determined by the system.

(b) In this section:

(1) "Child" includes:

(A) an adopted child; and

(B) a stepchild, foster child, or other child who is in a parent-child relationship with an individual who is eligible to participate in the uniform program under Section 1601.101 or 1601.102.

(2) "Spouse" has the meaning assigned by the Family Code.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 30 (H.B. 446), Sec. 8.08, eff. September 1, 2023.

Sec. 1601.005. DEFINITION OF CARRIER. In this chapter, "carrier" means:

(1) an insurance company that is authorized by the department to provide under this code any of the types of insurance

coverages, benefits, or services provided for in this chapter, and that:

(A) has an adequate surplus;

(B) has a successful operating history; and

(C) has had successful experience, as determined by the department, in providing and servicing any of the types of group coverage provided for in this chapter;

(2) a corporation operating under Chapter 842 that provides any of the types of coverage, benefits, or services provided for in this chapter and that:

(A) has a successful operating history; and

(B) has had successful experience, as determined by the department, in providing and servicing any of the types of group coverage provided for in this chapter; or

(3) any combination of carriers described by Subdivisions (1) and (2) on terms the system prescribes.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.006. APPLICABILITY OF DEFINITIONS. The definition of a term defined by this subchapter and the use of the terms "employee" and "retired employee" as described by Sections 1601.101 and 1601.102 apply to this chapter unless a different meaning is plainly required by the context in which the term appears.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.007. SYSTEM MAY DEFINE OTHER WORDS. A system may define by rule a word or term necessary in the administration of this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.008. EXEMPTION FROM EXECUTION. All insurance benefits and other payments and transactions made under this chapter to a participant under this chapter are exempt from execution, attachment, garnishment, or any other process.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.009. EXEMPTION FROM TAXATION AND FEES. Premiums on a policy, an insurance contract, or an agreement established under this chapter with a health maintenance organization are not subject to any state tax, regulatory fee, or surcharge, including a premium or maintenance tax or fee.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.010. CERTAIN COMBINING OF CARRIERS NOT RESTRAINT OF TRADE. Carriers combining to bid, underwrite, or both bid and underwrite, a group life, accident, or health benefit plan for the uniform program are not in violation of Chapter 15, Business & Commerce Code.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.011. PARTICIPATION OF THE TEXAS A&M UNIVERSITY SYSTEM. Notwithstanding any other provision of this chapter, if The Texas A&M University System elects to participate in the group benefits program under Section 1551.006(c), that system, including the Texas Veterinary Medical Diagnostic Laboratory, does not participate in a uniform program established under this chapter, effective on the date participation in the group benefits program under Chapter 1551 begins.

Added by Acts 2003, 78th Leg., ch. 366, Sec. 4.01, eff. Sept. 1, 2003.

SUBCHAPTER B. ADMINISTRATION AND IMPLEMENTATION

Sec. 1601.051. ADMINISTRATION AND IMPLEMENTATION. A system shall:

- (1) implement a uniform program for the benefit of its employees and retired employees; and
- (2) determine basic procedural and administrative practices for insurance coverage provided under this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.052. RULEMAKING AUTHORITY. A system shall adopt rules consistent with this chapter as it considers necessary to implement this chapter and its purposes.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.053. GENERAL DUTIES RELATING TO COVERAGE. (a) A system shall:

- (1) determine basic coverage standards that must be comparable to those commonly provided:
 - (A) in private industry; and
 - (B) to employees of another agency or an institution of higher education in this state under Chapter 1551; and
- (2) establish procedures to allow each covered employee and retired employee to obtain prompt action regarding claims pertaining to coverages provided under this chapter.

(b) In designing a coverage plan, a system may consider existing local conditions.

(c) Notwithstanding any other provision of this chapter, a system may adjust a plan and coverage standards as necessary to comply with applicable state and federal law and to provide consistent eligibility for all plans under the program, including eligibility for optional coverages.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 1106 (H.B. 4035), Sec. 3, eff. June 15, 2017.

Sec. 1601.054. COMPETITIVE BIDDING REQUIRED. A system shall submit the uniform program, including any agreement under which a carrier is engaged to administer a self-insured program, for competitive bidding at least every six years.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.055. IDENTIFICATION OF ADMINISTRATIVE COSTS IN BIDS. A system shall include in its respective bid documents for the various coverages a provision calling for each bidder to identify the system's administrative costs as a distinguishable figure and to enumerate the services the bidder will render in exchange for the administrative costs.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.056. INFORMATION ON BIDDERS AND BIDDING CONTRACTS.

(a) The department shall, on request by a system, provide a list of all carriers:

(1) authorized to engage in business in this state; and
(2) eligible to bid on insurance coverage provided under this chapter.

(b) The department shall, on request by a system, examine and evaluate a bidding contract and certify the contract's actuarial soundness to the system not later than the 15th day after the date of the request.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.057. SELECTION OF BIDS. (a) A system is not required to select the lowest bid under Section 1601.054 but shall take into consideration other relevant criteria, such as ability to service contracts, past experience, and financial stability.

(b) If a system selects a carrier whose bid differs from that advertised, the governing board of the system shall fully justify and record the reasons for the deviation in the minutes of the next meeting of the governing board.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.058. SELECTION OF HEALTH MAINTENANCE ORGANIZATIONS. A system shall select and contract for services performed by health maintenance organizations that are approved by this state to offer health care services in specific areas of the state to eligible employees and retired employees.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.059. CERTIFICATE OF COVERAGE. A system shall ensure that each employee and retired employee participating under this chapter is issued a certificate of coverage that states:

- (1) the benefits to which the participant is entitled;
- (2) to whom the benefits are payable;
- (3) to whom a claim must be submitted; and
- (4) the provisions of the plan document, in summary form, that principally affect the participant.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.060. ACCOUNTING BY CARRIER PROVIDING PURCHASED COVERAGE. (a) A carrier providing coverage purchased under this chapter to a system shall provide an accounting for each line of coverage to the system not later than the 120th day after the end of each plan year.

(b) The accounting must be in a form acceptable to the system.

(c) The accounting for each line of coverage must state:

- (1) the cumulative amount of contributions remitted to the carrier under the coverage;
- (2) the total of all mortality and other claims, charges, losses, costs, contingency reserve for pending and unreported claims, and expenses incurred; and
- (3) the amounts of the allowance for a reasonable profit, contingency reserve, and all other administrative charges.

(d) Information provided under Subsection (c) must be provided:

- (1) for the period from the coverage's date of issue to the end of the plan year; and
- (2) for the plan year covered by the report.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.061. SPECIAL RESERVE. (a) A carrier issuing a group coverage plan under this chapter may hold as a special reserve for a system an amount that equals the amount by which the total amount described by Section 1601.060(c)(1) exceeds the sum of the

corresponding amounts described by Sections 1601.060(c)(2) and (3).

(b) The system may use money in the special reserve at its discretion, including for:

- (1) providing additional coverage for participating employees or retired employees;
- (2) offsetting necessary rate increases; or
- (3) reducing contributions to the coverage by participating employees or retired employees.

(c) A special reserve held by a carrier for a system earns interest at a rate determined each plan year by the carrier and approved by the system as consistent with the rate generally used by the carrier for similar funds held under other group coverages.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.062. REPORTS AND RECORDS BY ADMINISTERING CARRIER.

Each contract entered into under this chapter between a system and an administering carrier must:

- (1) require the administering carrier to provide reasonable reports that the system determines are necessary for the system to perform its functions under this chapter; and
- (2) permit the system and representatives of the state auditor to examine records of the administering carrier as necessary to accomplish the purposes of this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.063. ASSISTANCE IN REQUESTING MONEY. The Legislative Budget Board and the Governor's Budget and Planning Office shall:

- (1) establish procedures to ensure that each system requests appropriate money to support its uniform program; and
- (2) present appropriate budget recommendations to the legislature.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.064. PHARMACY BENEFIT MANAGER CONTRACTS. (a) In awarding a contract to provide pharmacy benefit manager services

under this chapter, a system is not required to select the lowest bid but must select a contract that meets the criteria established by this section.

(b) The contract must state that:

(1) the system is entitled to audit the pharmacy benefit manager to verify costs and discounts associated with drug claims, pharmacy benefit manager compliance with contract requirements, and services provided by subcontractors;

(2) the audit must be conducted by an independent auditor in accordance with established auditing standards; and

(3) to conduct the audit, the system and the independent auditor are entitled access to information related to the services and the costs associated with the services performed under the contract, including access to the pharmacy benefit manager's facilities, records, contracts, medical records, and agreements with subcontractors.

(c) The contract must define the information that the pharmacy benefit manager is required to provide to the system concerning the audit of the retail, independent, and mail order pharmacies performing services under the contract and describe how the results of these audits must be reported to the system, including how often the results must be reported. The contract must state whether the pharmacy benefit manager is required to return recovered overpayments to the system.

(d) The contract must state that any audit of a mail order pharmacy owned by the pharmacy benefit manager must be conducted by an independent auditor selected by the system in accordance with established auditing standards.

Added by Acts 2009, 81st Leg., R.S., Ch. 1207 (S.B. 704), Sec. 8, eff. September 1, 2009.

SUBCHAPTER C. COVERAGE AND PARTICIPATION

Sec. 1601.101. PARTICIPATION ELIGIBILITY: EMPLOYEES. (a) An individual who is employed by the governing board of a system, who performs service, other than as an independent contractor, for the system, and who is described by this section is eligible to participate as an employee in the uniform program on the date specified by Section 1601.1045.

(b) An individual is eligible to participate in the uniform program as provided by Subsection (a) if the individual receives compensation for services performed for the system, is eligible to be a member of the Teacher Retirement System of Texas, and either:

- (1) is expected to work at least 20 hours per week and to continue in the employment for a term of at least 4-1/2 months; or
- (2) is appointed for at least 50 percent of a standard full-time appointment.

(c) An individual is eligible to participate in the uniform program as provided by Subsection (a) if the individual:

- (1) receives compensation for services performed for the system;
- (2) is employed at least 20 hours a week; and
- (3) is not permitted to be a member of the Teacher Retirement System of Texas because the individual is solely employed by the system in a position that as a condition of employment requires the individual to be enrolled as a student in the system in graduate-level courses.

(d) Repealed by Acts 2011, 82nd Leg., R.S., Ch. 1198, Sec. 5, eff. January 1, 2012.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 366, Sec. 4.02, eff. Sept. 1, 2003; Acts 2003, 78th Leg., ch. 1266, Sec. 2.11, eff. Sept. 1, 2003.
Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 91 (S.B. 1303), Sec. 14.002, eff. September 1, 2011.

Acts 2011, 82nd Leg., R.S., Ch. 1198 (S.B. 29), Sec. 5, eff. January 1, 2012.

Sec. 1601.102. PARTICIPATION ELIGIBILITY: RETIREES. (a) An individual who retires in a manner described by this section and who meets the requirements of Subsection (f) is eligible to participate, subject to Section 1601.1045, as a retired employee in the uniform program.

(b) An individual is eligible to participate in the uniform program as provided by Subsection (a) if:

- (1) the individual has at least 10 years of service with a system for which the individual was eligible to participate in the

uniform program under Section 1601.101;

(2) the individual's last state employment before retirement was with that system; and

(3) the individual retires under the jurisdiction of:

(A) the Teacher Retirement System of Texas under Subtitle C, Title 8, Government Code;

(B) the Employees Retirement System of Texas; or

(C) subject to Subsection (c):

(i) the optional retirement program established by Chapter 830, Government Code; or

(ii) any other federal or state statutory retirement program to which the system has made employer contributions.

(c) An individual retiring in the manner described by Subsection (b)(3)(C) is a retired employee only if the individual meets all applicable requirements for retirement, including service and age requirements, adopted by the system comparable to the requirements for retirement under the Teachers Retirement System of Texas.

(d) An individual is eligible to participate in the uniform program as provided by Subsection (a) if the individual:

(1) meets the minimum requirements under Subsection (b) except that the last state employment before retirement is not at the employing system; and

(2) does not meet the requirements for an annuitant under Section 1551.102.

(d-1) An individual is eligible to participate in the uniform program as provided by Subsection (a) if:

(1) the individual meets the minimum requirements under Subsection (b) except that the individual does not have at least 10 years of service as described by Subsection (b)(1);

(2) the individual has at least 10 years of combined service in a position for which the individual was eligible to participate in the uniform program or in the group benefits program under Section 1551.101; and

(3) either:

(A) the individual's greatest number of years of state employment was in a position for which the individual was eligible to participate in the uniform program; or

(B) if the individual's years of employment in

positions eligible to participate in the uniform program and the group benefits program are equal, the individual's last state employment before retirement was in a position for which the individual was eligible to participate in the uniform program.

(e) An individual is eligible to participate in the uniform program as provided by Subsection (a) if the individual retired under Subtitle C, Title 8, Government Code, before September 1, 1991, with at least five and less than 10 years of service.

(f) Notwithstanding Subsections (b)-(d), an individual is eligible to participate in the uniform program only if the individual:

(1) has at least 10 years of service credit and the sum of the person's age and amount of service credit, including months of age and credit, equals or exceeds the number 80; or

(2) is at least 65 years old and has at least 10 years of service credit.

(g) A person eligible to participate and participating in the uniform program as an annuitant on September 1, 2003, may continue to participate in the program as an annuitant if a lapse in coverage has not occurred.

(h) Notwithstanding Subsection (b), an individual to whom this subsection applies is eligible to participate in the uniform program as provided by Subsection (a) if:

(1) the individual has at least three years of service with a system for which the individual was eligible to participate in the uniform program under Section 1601.101;

(2) the individual's last state employment before retirement was with that system; and

(3) the individual retires under the jurisdiction of:

(A) the Teacher Retirement System of Texas under Subtitle C, Title 8, Government Code;

(B) the Employees Retirement System of Texas; or

(C) subject to Subsection (c):

(i) the optional retirement program established by Chapter 830, Government Code; or

(ii) any other federal or state statutory retirement program to which the system has made employer contributions.

(i) Subsection (h) applies only to a person who, on August 31, 2003:

(1) was eligible to participate in the uniform program as an employee under Section 1601.101; or

(2) was eligible to participate in the uniform program as a retired employee under this section as this section existed on January 1, 2003.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Amended by Acts 2003, 78th Leg., ch. 366, Sec. 4.03, eff. Sept. 1, 2003; Acts 2003, 78th Leg., ch. 1266, Sec. 2.08, eff. June 20, 2003.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 1106 (H.B. 4035), Sec. 4, eff. June 15, 2017.

Acts 2017, 85th Leg., R.S., Ch. 1106 (H.B. 4035), Sec. 5, eff. June 15, 2017.

Acts 2017, 85th Leg., R.S., Ch. 1106 (H.B. 4035), Sec. 6, eff. June 15, 2017.

Sec. 1601.1021. PARTICIPATION ELIGIBILITY: CERTAIN POSTDOCTORAL FELLOWS AND GRADUATE STUDENTS. (a) An individual who is not eligible to participate in the uniform program under Section 1601.101 is eligible to participate in the uniform program under this section if the individual, at an institution in a system:

(1) holds:

(A) a postdoctoral fellowship; or

(B) one or more graduate student fellowships awarded to the individual on a competitive basis that, either singly or in combination, are valued at not less than \$10,000 per year; and

(2) is currently receiving a stipend from an applicable fellowship.

(b) An individual who is eligible to participate in the uniform program under this section shall pay all contributions required under this chapter for the coverage selected by the individual, except that an institution of higher education may make contributions for the individual from available funds other than money appropriated to the institution from the general revenue fund.

(c) An institution of higher education shall determine which individuals are eligible to participate in the uniform program under this section and, at the time of initial eligibility, shall notify each individual of the individual's eligibility to participate in the

program.

(d) An individual who participates in the uniform program under this section is not considered an employee of an institution of higher education solely as a result of the individual's participation in the program.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1198 (S.B. 29), Sec. 3, eff. September 1, 2011.

Sec. 1601.103. RIGHT TO COVERAGE. An individual eligible to participate in the uniform program under Section 1601.101 or 1601.102 may not be denied enrollment in any coverage provided under this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.104. AUTOMATIC COVERAGE. (a) A system shall automatically provide the basic coverage to each full-time employee unless the employee has:

- (1) waived participation in the basic coverage; or
- (2) selected an optional coverage plan.

(b) An employee or retired employee who is automatically covered under this section may subsequently:

- (1) retain the basic coverage or waive participation in the basic coverage; and
- (2) apply for any other coverage provided under this chapter within applicable standards.

(c) Automatic coverage as described under this section begins on the first date of employment.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.1045. DATE ELIGIBILITY BEGINS; WAITING PERIOD. (a) Except as provided by Subsection (c), (d), or (e), eligibility under Section 1601.101 begins on the first day of the calendar month that begins after the 90th day after the date the employee performs services for a system.

- (b) Except as provided by Subsection (c), eligibility under

Section 1601.102, for an individual who does not retire at the end of the last month for which the individual is on the payroll of a system before retirement, begins on the first day of the calendar month that begins after the 90th day after the date the individual retires.

(c) The waiting period established by Subsections (a) and (b) applies only to the determination of initial eligibility to participate in the group health benefits program and does not apply to the determination of initial eligibility to participate in optional coverages under the uniform program.

(d) Notwithstanding Subsection (a), eligibility under Section 1601.101 may not begin earlier than the first day that an employee performs services for a system if any amount paid for premium incurred before the date specified under Subsection (a) for the employee and any dependents of the employee is paid from money not appropriated from the general revenue fund, in accordance with policies and procedures established by the system.

(e) Eligibility under Section 1601.101 for an employee reemployed under Chapter 613, Government Code, begins on the first day of reemployment on which the employee performs services for a system.

Added by Acts 2003, 78th Leg., ch. 366, Sec. 4.05, eff. Sept. 1, 2003.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 150 (H.B. 437), Sec. 2, eff. September 1, 2015.

Sec. 1601.105. WAIVER. An employee or retired employee may waive in writing any coverage provided under this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.106. OPTIONAL COVERAGE. A system shall provide optional coverage in accordance with Section 1601.201.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.1065. OPTIONAL BASIC COVERAGE PLAN FOR GRADUATE

STUDENTS. The system may design and offer a separate optional basic coverage plan for employees who are graduate students. The system shall determine the participation eligibility, coverage, payments, contributions, and costs of a plan offered under this section.

Added by Acts 2017, 85th Leg., R.S., Ch. 1106 (H.B. 4035), Sec. 7, eff. June 15, 2017.

Sec. 1601.107. COVERAGE FOR DEPENDENTS. An individual who is eligible to participate in the uniform program under Section 1601.101, 1601.102, or 1601.1021 is entitled to secure for a dependent of the individual any group coverages provided under this chapter for dependents under rules adopted by the applicable system.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 1198 (S.B. 29), Sec. 4, eff. September 1, 2011.

Sec. 1601.108. COVERAGE OPTIONS FOR CERTAIN SURVIVING SPOUSES.

(a) This section applies only to the surviving spouse of:

- (1) an individual eligible to participate in the uniform program under Section 1601.101 who had at least five years of service on the date of the individual's death, including at least three years of service as an eligible employee with the employing system; or
- (2) an individual eligible to participate in the uniform program under Section 1601.102.

(b) A surviving spouse to whom this section applies may elect to retain any of the following coverages in effect on the date of the participant's death:

- (1) the surviving spouse's authorized coverages; and
- (2) authorized coverages for any eligible dependent of the deceased participant.

(c) The coverage is at the group rate for other participants.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.109. COVERAGE FOR AIDS, HIV, OR SERIOUS MENTAL

ILLNESS. (a) In this section, "serious mental illness" has the meaning assigned by Section 1355.001.

(b) A system may not contract for or provide for group insurance or HMO coverage or provide self-insured coverage, that:

(1) excludes or limits coverage or services for acquired immune deficiency syndrome, as defined by the Centers for Disease Control and Prevention of the United States Public Health Service, or human immunodeficiency virus infection; or

(2) provides coverage for serious mental illness that is less extensive than the coverage provided for any other physical illness.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2G.020, eff. April 1, 2009.

Sec. 1601.110. DISEASE MANAGEMENT SERVICES. (a) In this section, "disease management services" means services to assist an individual manage a disease or other chronic health condition, such as heart disease, diabetes, respiratory illness, end-stage renal disease, HIV infection, or AIDS, and with respect to which the governing board of a system identifies populations requiring disease management.

(b) A health benefit plan provided under this chapter must provide disease management services or coverage for disease management services in the manner required by the governing board of a system, including:

- (1) patient self-management education;
- (2) provider education;
- (3) evidence-based models and minimum standards of care;
- (4) standardized protocols and participation criteria; and
- (5) physician-directed or physician-supervised care.

Added by Acts 2003, 78th Leg., ch. 589, Sec. 5, eff. June 20, 2003.

Sec. 1601.111. PROGRAMS PROMOTING DISEASE PREVENTION, WELLNESS, AND HEALTH. A system may establish premium discounts, surcharges, rebates, or a revision in otherwise applicable copayments,

coinsurance, or deductibles, or any combination of those incentives, for an individual who participates in system-approved programs promoting disease prevention, wellness, and health.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1049 (S.B. 5), Sec. 3.02, eff. June 17, 2011.

SUBCHAPTER D. GROUP COVERAGES

Sec. 1601.151. AUTHORITY TO SELF-INSURE; EXEMPTION FROM OTHER INSURANCE LAWS. (a) Notwithstanding any other provisions of this chapter, the governing board of a system may:

(1) self-insure a plan provided under this chapter; and
 (2) hire a carrier to administer the system's uniform program.

(b) A plan for which a system provides coverage on a self-insured basis is exempt from any other insurance law of this state that does not expressly apply to that plan or this chapter.

(c) Expenses for the administration of a self-insured plan may come from the contributions of employees and the state after payments for any coverage provided under this chapter have been made.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.152. CAFETERIA PLAN. (a) The governing board of a system may develop, implement, and administer a cafeteria plan.

(b) The governing board may include in the cafeteria plan any benefit that may be included in a cafeteria plan under federal law.

(c) The governing board may cooperate and work with and enter into a necessary contract or agreement with an independent and qualified agency, person, or entity to:

(1) develop, implement, or administer a cafeteria plan; or
 (2) assist in those activities.

(d) The governing board may adopt an order terminating the cafeteria plan and providing a procedure for the orderly withdrawal of the system and its employees from the cafeteria plan if the governing board determines that a cafeteria plan adopted under this section is no longer advantageous to the system and its employees.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.153. SYSTEMS MAY JOIN IN PROCURING INSURANCE. The systems may join together to procure one or more group contracts with an insurance company authorized to engage in business in this state to insure the employees and retired employees of each participating system.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.154. LONG-TERM CARE COVERAGE. (a) A system may join with a board of trustees that administers the uniform program established under Chapter 1551 or the group program established under Chapter 1575 to provide long-term care insurance coverage.

(b) Each participating board of trustees and the governing board of the system must mutually agree to join together for this purpose, subject to terms that are beneficial to all participants.

(c) A system may not participate in an agreement under this section unless any cost or administrative burden associated with the development or implementation of or communications about the long-term care coverage plan is incidental.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.155. REINSURANCE. A system may arrange with an administering carrier issuing a policy under this chapter for the reinsurance of portions of the total amount of insurance under the policy with other carriers that elect to participate in the reinsurance.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

SUBCHAPTER E. PAYMENTS, CONTRIBUTIONS, AND COSTS

Sec. 1601.201. PAYMENT FOR COVERAGE. (a) A system may not contribute more than the amounts specified by this section for coverages provided under the uniform program.

(b) For an employee designated by the system as working 40 or more hours a week, the system may contribute:

(1) the full cost of basic coverage for the employee; and
(2) not more than 50 percent of the cost of dependent coverage.

(c) For an employee designated by the system as working less than 40 hours a week, including an individual employed by the system in a position that as a condition of employment requires the individual to be enrolled as a student in the system in graduate-level courses, the system, from money appropriated from the general revenue fund, may contribute:

(1) not more than 50 percent of the cost of basic coverage for the employee; and

(2) not more than 25 percent of the cost of dependent coverage.

(d) Subsection (c) does not prohibit a system from contributing, from money not appropriated from the general revenue fund, amounts in excess of the amount specified by that subsection for:

(1) an individual employed by the system in a position that as a condition of employment requires the individual to be enrolled as a student in the system in graduate level courses; or

(2) an individual who is a tenured faculty member with whom the system has entered into a phased retirement agreement under which the individual will work less than 40 hours a week for a specified period of time at the end of which the individual will retire.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 366, Sec. 4.06, eff. Sept. 1, 2003.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 1049 (S.B. 5), Sec. 3.03, eff. June 17, 2011.

Sec. 1601.202. FEES FOR CAFETERIA PLAN. (a) The governing board of a system may establish a monthly fee in an amount set by the board to be paid by each employee who elects to participate in a cafeteria plan for the purpose of paying the expenses of administering the cafeteria plan.

(b) If the governing board establishes a monthly fee, each employee who participates in the cafeteria plan must authorize

payment of the fee by executing a separate payroll deduction agreement or as part of a salary reduction agreement, as determined by the governing board.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.203. PAYMENT FOR COVERAGE FOR DEPENDENTS.

Contributions for coverages for a dependent of an individual eligible to participate in the uniform program under Section 1601.101 or 1601.102 required of the participant that exceed the amount of system contributions shall be paid:

- (1) by a deduction from the monthly compensation of the participant;
- (2) by a reduction of the monthly compensation of the participant in the appropriate amount; or
- (3) in the form and manner the system determines.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.204. AUTHORIZATION OF EMPLOYEE DEDUCTION. (a)

Except for a participant who participates in a cafeteria plan, each individual eligible to participate in the uniform program under Section 1601.101 must authorize a deduction from the participant's monthly compensation in an amount equal to the difference between:

- (1) the total cost for coverages for which the participant applies; and
 - (2) the amount contributed by the system.
- (b) The authorization must be:
- (1) in writing or performed electronically; and
 - (2) in a form satisfactory to the system.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.2041. EMPLOYEE DEDUCTION FOR AUTOMATIC COVERAGE.

Each individual automatically enrolled in a uniform program under Section 1601.104 is considered to have authorized a deduction from the participant's monthly compensation in an amount equal to the difference between:

- (1) the total cost of the employee's basic coverage; and
- (2) the amount contributed by the system for the employee's basic coverage.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1049 (S.B. 5), Sec. 3.04, eff. June 17, 2011.

Sec. 1601.2042. COMPENSATION INSUFFICIENT TO COVER DEDUCTION. If a participant's monthly compensation from which the participant's contribution is deducted is insufficient to pay the participant's contribution for coverage, the system may adopt rules under which the system considers the coverage to have terminated after the last full month for which the contribution was paid in full, as determined by the system.

Added by Acts 2017, 85th Leg., R.S., Ch. 1106 (H.B. 4035), Sec. 8, eff. June 15, 2017.

Sec. 1601.205. EMPLOYEE PAYMENTS FOR PARTICIPATION IN CAFETERIA PLAN. (a) If an employee elects to participate in a cafeteria plan, the employee must execute a salary reduction agreement under which the employee's monthly compensation will be reduced in an amount equal to the difference between:

- (1) the amount appropriated for that purpose in the General Appropriations Act or the system's budget; and
- (2) the cost of the employee's selected coverages for which the employee is eligible to pay under the cafeteria plan.

(b) The employee must execute a salary reduction agreement for any portion of the cost that is not covered by state or system appropriations and cafeteria plan contributions.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.206. PAYMENT BY RETIRED EMPLOYEE. An individual eligible to participate in the uniform program under Section 1601.102 must execute an agreement and make appropriate contributions in a manner analogous to the requirements adopted under Sections 1601.204 and 1601.205 for an individual eligible to participate in the uniform

program under Section 1601.101.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.207. SYSTEM CONTRIBUTIONS. A system shall contribute monthly to the cost of each participant's coverage provided under this chapter an amount:

(1) if the participants are compensated from amounts appropriated in the General Appropriations Act, equal to or greater than the amount appropriated for that purpose in the Act; or

(2) if the participants are compensated from amounts appropriated by the governing board of the system in its official operating budget, an amount equal to the amount appropriated for a participant under the General Appropriations Act.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.208. AMOUNT OF SYSTEM CONTRIBUTION. Not later than November 1 preceding each regular session of the legislature, each system shall certify to the Legislative Budget Board and the budget division of the Governor's Budget and Planning Office the amount necessary to pay the contributions of the system for the coverages provided under this chapter to each employee and retired employee of the system.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.209. ORDER OF PRECEDENCE OF PAYMENT TO SURVIVORS.

(a) The amount of group life coverages and group accidental death and dismemberment coverages in force for a participant on the date the participant dies shall be paid, on the establishment of a valid claim, to a person surviving the death in the following order of precedence:

(1) to the beneficiary designated by the participant in a signed and witnessed writing received before death by the appropriate office of the applicable system; or

(2) if a beneficiary is not designated under Subdivision (1), in accordance with the death benefit provisions of Subtitle C,

Title 8, Government Code.

(b) For purposes of Subsection (a)(1), a designation, change, or cancellation of a beneficiary in a document, including a will, that is not executed and filed in the manner described by that subsection is not valid.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.210. PROVISION OF NECESSARY INFORMATION. The Teacher Retirement System of Texas, Optional Retirement Program carriers, and Employees Retirement System of Texas shall provide to each system information the system considers necessary to provide retired employees with the coverages and system contributions provided under this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.211. LIABILITY FOR BACK CONTRIBUTIONS FOR DROPPED COVERAGE. (a) This section applies to a participant in the uniform program for whom appropriate contributions were not made during the entire plan year because of nonpayment of premiums.

(b) As a condition of enrollment in the same coverage for a subsequent plan year, the participant must make a contribution equal to the contributions not made for the plan year for which appropriate contributions were not made during the entire plan year, unless the nonpayment of premiums was related to a qualified change in status, as determined by the system. The payment shall be made in the form and manner determined by the system.

Added by Acts 2017, 85th Leg., R.S., Ch. 1106 (H.B. 4035), Sec. 8, eff. June 15, 2017.

SUBCHAPTER F. CAFETERIA PLAN FUND

Sec. 1601.251. SYSTEM CAFETERIA PLAN FUND. (a) The governing board of each system may establish and administer a cafeteria plan fund.

(b) The following shall be credited to the cafeteria plan fund of a system:

(1) salary reduction payments for benefits included in a cafeteria plan adopted under this chapter, other than group coverage plans under the uniform program;

(2) appropriations by the state for the administration of a cafeteria plan; and

(3) a monthly fee established under Section 1601.202.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.252. USE OF FUND. The cafeteria plan fund of a system is available without fiscal year limitation:

(1) for all payments for any benefits included in a cafeteria plan adopted by the system under this chapter other than group coverage plans under the uniform program; and

(2) for payment of expenses of administering the cafeteria plan.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.253. INVESTMENT OF MONEY IN FUND. (a) The governing board of a system may invest the money in the system's cafeteria plan fund.

(b) The earnings, including interest, and the proceeds from the sale of the investments become a part of the fund.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

SUBCHAPTER G. ADVISORY COMMITTEE

Sec. 1601.301. ADVISORY COMMITTEE. An advisory committee for each system shall be selected, serve, and perform duties as provided by this subchapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.302. ELECTION OF MEMBERS. One member of the advisory committee shall be elected from each of the components, units, or agencies of the system:

- (1) at times designated by the system; and
- (2) in accordance with general guidelines for the election provided by the system.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.303. QUALIFICATIONS OF MEMBERS. (a) A member of a system's advisory committee must be an employee of the system.

(b) A member must:

- (1) demonstrate mature judgment, special abilities, and sincere interest in employee coverage plans; and
- (2) be able to represent the needs of all employees of the component, unit, or agency the member represents with respect to an action of the advisory committee.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.304. TERMS. A member of the advisory committee is elected for a two-year term, subject to reelection.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.305. OFFICERS. Annually, the members of a system's advisory committee shall elect a presiding officer and other necessary officers.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.306. VACANCY. The chief executive officer of a component, unit, or agency of a system shall appoint to the system's advisory committee an employee of the component, unit, or agency to fill the remainder of a vacated term of a member who is an employee of the component, unit, or agency.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.307. DUTIES OF COMMITTEE. (a) The advisory committee of a system shall cooperate and work with the governing board of the system in coordinating and correlating the administration of the uniform program among the various components, units, and agencies of the system.

(b) Members of the advisory committee shall cooperate and work with the governing board of the system as advisors in the development, implementation, coordination, and administration of the uniform program among the various components, units, and agencies of the system.

(c) The advisory committee shall provide a channel for open communication of ideas and suggestions regarding coverages, eligibility, claims, procedures, bidding, administration, and any other aspect of employee plan benefits.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.308. EXPENSES. (a) A member's service on the advisory committee of a system is in addition to the duties of the member's state office or employment.

(b) An expense incurred by an advisory committee member in performing a duty as a member of the committee shall be paid from money made available for that purpose to the system of which the member is an employee or officer.

(c) Employees may not be required to pay from the amount of employer contributions due the employees or from the amount of additional contributions due for selected coverages under this chapter the expenses of an advisory committee established under this subchapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 87 (S.B. 1969), Sec. 14.017(a), eff. September 1, 2009.

CHAPTER 1625. TRANSFER BETWEEN CERTAIN GOVERNMENTAL PROGRAMS

Sec. 1625.001. DEFINITIONS. In this chapter:

(1) "Board of trustees" has the meaning assigned by Section 1551.003.

(2) "Institution of higher education" means a senior college or university, medical or dental unit, technical institute, or agency of higher education under the policy direction of a single governing board. The term does not include a public junior college.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1625.002. INAPPLICABILITY OF PREEXISTING CONDITIONS REQUIREMENT. A person, including a covered dependent, who obtains insurance, benefits, or any type of health care services coverage under Chapter 1551 or 1601 may transfer from an institution of higher education or other state agency to which either law applies to another institution of higher education or state agency to which either law applies without being required to comply with any preexisting conditions requirement.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1625.003. RULES. The board of trustees and the governing boards of institutions of higher education may adopt rules necessary to implement this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1625.004. MEMORANDUM OF UNDERSTANDING. The board of trustees and the governing boards of institutions of higher education may enter into memoranda of understanding with one another to implement this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1625.005. UNIFORM PROCEDURES. The governing board of an institution of higher education and the board of trustees may:

(1) adopt uniform procedures to implement a transfer under this chapter; and

(2) impose conditions necessary to ensure the efficient operation of the programs over which each has jurisdiction.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

SUBTITLE I. SPECIALIZED COVERAGES
CHAPTER 1651. LONG-TERM CARE BENEFIT PLANS
SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1651.001. APPLICABILITY OF CHAPTER. (a) Notwithstanding Section 101.053(b)(5) and subject to Subsection (b), this chapter applies only to:

- (1) an individual long-term care benefit plan that is delivered or issued for delivery in this state;
- (2) a group long-term care benefit plan that is:
 - (A) delivered or issued for delivery in this state;

and

- (B) issued to an eligible group as described by Subchapter B, Chapter 1251;

- (3) a certificate issued under a group long-term care benefit plan issued to an eligible group as described by Subchapter B, Chapter 1251, if the certificate is delivered or issued for delivery in this state, regardless of the place where the plan is delivered or issued for delivery; and

- (4) an evidence of coverage delivered or issued for delivery in this state for long-term care.

(b) This chapter applies only to a policy, certificate, or evidence of coverage that is issued by:

- (1) a capital stock insurance company, including a life, health and accident, or general casualty insurance company;
- (2) a mutual life insurance company;
- (3) a mutual assessment life insurance company, including a statewide mutual assessment corporation, local mutual aid association, and burial association;
- (4) a mutual or mutual assessment association, including an association subject to Section 887.101;
- (5) a mutual insurance company other than a life insurance company;
- (6) a mutual or natural premium life or casualty insurance company;
- (7) a fraternal benefit society;
- (8) a Lloyd's plan insurer;
- (9) a reciprocal or interinsurance exchange;

- (10) a nonprofit medical, hospital, or dental service corporation, including a company subject to Chapter 842;
 - (11) a stipulated premium company;
 - (12) a health maintenance organization under Chapter 843;
- or
- (13) another insurer required to be licensed by the department.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 4, eff. April 1, 2005.

Sec. 1651.002. EXEMPTIONS. This chapter does not apply to:

- (1) a certificate that is delivered or issued for delivery in this state under a single employer or labor union group policy that is delivered or issued for delivery outside this state; or
- (2) a benefit plan that is not advertised, marketed, or offered as a long-term care benefit plan or nursing home benefit plan.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 4, eff. April 1, 2005.

Sec. 1651.003. LONG-TERM CARE BENEFIT PLAN DEFINED. (a) In this chapter, "long-term care benefit plan" means an insurance policy or group certificate, or rider to the policy or certificate, or evidence of coverage issued by a health maintenance organization subject to Chapter 843, that is advertised or marketed as providing, or offered or designed to provide, coverage for not less than 12 consecutive months for each covered individual on an expense-incurred, indemnity, prepaid, or other basis for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services provided in a setting other than an acute care unit of a hospital.

(b) The term includes a plan or rider, other than a group or individual annuity or life insurance policy, that provides for payment of benefits based on cognitive impairment or the loss of functional capacity.

(c) The term does not include an insurance policy, group certificate, or evidence of coverage that is offered primarily to provide:

- (1) basic Medicare supplement coverage, basic hospital

expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident-only coverage, specified disease or specified accident coverage, or limited benefit health coverage; or

(2) basic or single health care services.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 4, eff. April 1, 2005.

Sec. 1651.004. RULES. (a) In addition to other rules required or authorized by this chapter, the department may adopt reasonable rules that are necessary and proper to carry out this chapter.

(b) Rules adopted under this section must include requirements no less favorable than the minimum standards for long-term care benefit plans adopted in any model laws or regulations relating to minimum standards for benefits for long-term care benefit plans and in accordance with all applicable federal law.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 4, eff. April 1, 2005.

Sec. 1651.005. CONSTRUCTION OF CHAPTER. This chapter may not be construed to enlarge the powers of an entity listed in Section 1651.001.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 4, eff. April 1, 2005.

Sec. 1651.006. CONFLICTS WITH OTHER PROVISIONS. This chapter prevails to the extent of any conflict with another provision of this code.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 4, eff. April 1, 2005.

SUBCHAPTER B. BENEFIT PLAN STANDARDS

Sec. 1651.051. MINIMUM STANDARDS. (a) The commissioner by rule shall establish:

(1) specific standards for provisions of long-term care benefit plans; and

(2) standards for full and fair disclosure setting forth the manner, content, and required disclosures for the marketing and sale of those benefit plans.

(b) The standards are in addition to and must be in accordance with:

(1) applicable laws of this state, including Chapter 1201;
 (2) applicable federal law; and
 (3) any rules, regulations, and standards required by federal law.

(c) The standards must address:

(1) terms of renewability;
 (2) initial and subsequent conditions of eligibility;
 (3) nonduplication of coverage;
 (4) coverage of dependents;
 (5) coverage of parents of the insured or enrollee and parents of the spouse of the insured or enrollee;
 (6) preexisting conditions;
 (7) termination of insurance;
 (8) continuation or conversion;
 (9) probationary periods;
 (10) benefit limitations, exceptions, and reductions;
 (11) elimination periods;
 (12) requirements for replacement;
 (13) recurrent conditions;
 (14) definitions of terms; and
 (15) inflation protection.

(d) The standards may:

(1) establish standard claim forms;
 (2) establish standard benefits for:
 (A) skilled nursing care;
 (B) intermediate nursing care;
 (C) custodial care; and
 (D) home health care;
 (3) require coverage for skilled nursing care, intermediate nursing care, and custodial care to facilitate comparison among long-term care products;
 (4) require long-term care benefit plan issuers to offer coverage for home health care benefits;
 (5) require that rates may not be increased for a covered individual unless:

(A) the covered individual requests and receives a change of benefits; or

(B) the increase applies to all members of the class to which the individual has been assigned by the benefit plan issuer; or

(6) require a benefit plan issuer to pay for a service covered by the benefit plan that is provided by an institution licensed to provide that service under Chapter 242, Health and Safety Code.

(e) Rules adopted under this section must include requirements no less favorable than the minimum standards of benefits for long-term care benefit plans adopted in any model laws or regulations relating to minimum standards for benefits for long-term care benefit plans and required by federal law.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 4, eff. April 1, 2005.

Sec. 1651.052. PREEXISTING CONDITIONS. (a) A long-term care benefit plan may not contain a provision that denies coverage for a claim for losses incurred more than six months after the effective date of coverage for a preexisting condition.

(b) A long-term care benefit plan may not define a preexisting condition more restrictively than as a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage.

(c) The commissioner by rule may:

(1) establish additional reasonable regulation of preexisting conditions consistent with this section and Section 1651.051; and

(2) extend a limitation period specified in this section as to a specific age group category in a specific benefit plan form if the commissioner finds that the extension is in the best interest of the public.

(d) Rules adopted under this section must comply with Section 1651.051(e).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 4, eff. April 1, 2005.

Sec. 1651.053. LOSS RATIO STANDARDS. (a) A long-term care

benefit plan must provide a benefit plan holder with benefits that are reasonable in relation to the rates charged.

(b) The commissioner shall adopt reasonable rules to establish minimum standards for loss ratios of long-term care benefit plans on the basis of:

- (1) incurred claims experience;
- (2) earned premiums;
- (3) the period for which rates are computed to provide coverage;
- (4) experienced and projected trends;
- (5) concentration of experience within early benefit plan duration;
- (6) expected claim fluctuations;
- (7) experience refunds;
- (8) adjustments;
- (9) dividends;
- (10) renewability features;
- (11) all relevant expense factors;
- (12) interest;
- (13) reserves;
- (14) mix of business by risk classification; and
- (15) product features otherwise affecting claims experience.

(c) Annually, each entity providing a long-term care benefit plan in this state shall:

- (1) file its rates, rating schedule, and supporting documentation to demonstrate compliance with the applicable loss ratio standards of this state; and
- (2) comply with any other filing requirement adopted by the commissioner relating to loss ratios.

(d) Rules adopted under this section shall be no less favorable to the holders of long-term care benefit plans than any model laws, rules, and regulations adopted in connection with minimum standards for benefits for long-term care benefit plans.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 4, eff. April 1, 2005.

Sec. 1651.054. NOTICE OF RIGHT TO REFUND. (a) In this section, "applicant" means:

(1) in the case of an individual long-term care benefit plan, the individual who seeks to contract for insurance or other health benefits; and

(2) in the case of a group long-term care benefit plan, the proposed certificate holder.

(b) A long-term care benefit plan must have a notice prominently printed on the first page of or attached to the benefit plan document.

(c) The notice must state in substance that, if the applicant is not satisfied for any reason after examining the benefit plan document, the applicant is entitled to:

(1) return the document not later than the 30th day after the date of its delivery; and

(2) have any premium refunded.

(d) The long-term care benefit plan issuer shall pay in a timely manner the refund directly to the individual or entity that paid the premium.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 4, eff. April 1, 2005.

Sec. 1651.055. RATE STABILIZATION. (a) The commissioner shall adopt rules to stabilize long-term care premium rates by:

(1) ensuring that:

(A) initial rates for long-term care benefit plan forms are adequate; and

(B) any rate schedule increases for long-term care benefit plans made after issuance of the plans are justified, adequate, and reasonable in relation to benefits provided to plan holders;

(2) requiring any appropriate plan terms;

(3) imposing penalties on insurers or other entities subject to this chapter that violate a rule adopted under this section; and

(4) protecting plan holders affected by a rate schedule increase.

(b) Repealed by Acts 2017, 85th Leg., R.S., Ch. 432 (S.B. [1492](#)), Sec. 1, eff. September 1, 2017.

(c) In adopting rules under this section, the commissioner may exempt long-term care benefit plans from the requirements of Sections

1651.053(a), (b), and (d).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 4, eff. April 1, 2005.
Amended by:

Acts 2017, 85th Leg., R.S., Ch. 432 (S.B. 1492), Sec. 1, eff.
September 1, 2017.

Sec. 1651.056. REVIEW; APPROVAL OR DISAPPROVAL OF PREMIUM RATES. (a) A long-term care premium rate may not be used until the rate has been filed with the department and approved by the commissioner.

(b) The commissioner may disapprove a long-term care premium rate that is not actuarially justified or does not comply with standards established under this chapter or adopted by rule by the commissioner.

(c) An insurer who obtains the commissioner's approval of an increase of a long-term care premium rate under Subsection (a) shall:

(1) notify policyholders of the scheduled rate increase at least 45 days prior to the date that the policyholder is required to make a premium payment at the increased rate; and

(2) provide contingent nonforfeiture benefits consistent with nationally recognized models and rules adopted by the commissioner.

Added by Acts 2009, 81st Leg., R.S., Ch. 1374 (S.B. 963), Sec. 1, eff. September 1, 2009.

SUBCHAPTER C. PARTNERSHIP FOR LONG-TERM CARE PROGRAM

Sec. 1651.101. DEFINITIONS. In this subchapter:

(1) "Approved plan" means a long-term care benefit plan that is approved by the department under this subchapter.

(2) "Dollar-for-dollar asset disregard" and "asset protection" have the meanings assigned by Section 32.251, Human Resources Code.

(3) "Medical assistance program" means the medical assistance program established under Chapter 32, Human Resources Code.

(4) "Partnership for long-term care program" means the program established under Subchapter F, Chapter 32, Human Resources

Code, and this subchapter.

Added by Acts 2007, 80th Leg., R.S., Ch. 795 (S.B. 22), Sec. 3, eff. March 1, 2008.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 87 (S.B. 1969), Sec. 27.002(13), eff. September 1, 2009.

Sec. 1651.102. APPLICABILITY. Except to the extent of a conflict, Subchapters A and B apply to a plan issued in accordance with this subchapter.

Added by Acts 2007, 80th Leg., R.S., Ch. 795 (S.B. 22), Sec. 3, eff. March 1, 2008.

Sec. 1651.103. ASSISTANCE OF DEPARTMENT. The department shall assist the Health and Human Services Commission as necessary for the commission to perform its duties and functions with respect to the administration of the partnership for long-term care program.

Added by Acts 2007, 80th Leg., R.S., Ch. 795 (S.B. 22), Sec. 3, eff. March 1, 2008.

Sec. 1651.104. LONG-TERM CARE INSURANCE POLICY FOR PARTNERSHIP FOR LONG-TERM CARE PROGRAM. The commissioner, in consultation with the Health and Human Services Commission, shall adopt minimum standards for a long-term care benefit plan that may qualify as an approved plan under the partnership for long-term care program. The standards must be consistent with provisions governing the expansion of a state long-term care partnership program established under the federal Deficit Reduction Act of 2005 (Pub. L. No. 109-171).

Added by Acts 2007, 80th Leg., R.S., Ch. 795 (S.B. 22), Sec. 3, eff. March 1, 2008.

Sec. 1651.105. REQUIRED TRAINING. (a) Each individual who sells a long-term care benefit plan under the partnership for long-

term care program must complete training and demonstrate evidence of an understanding of these plans and how the plans relate to other public and private coverage of long-term care.

(b) Each long-term care benefit plan issuer that offers a plan under the partnership for long-term care program shall certify to the commissioner, in the form required by the commissioner, that each individual who sells the plan on behalf of the issuer complies with the requirements of this section.

Added by Acts 2007, 80th Leg., R.S., Ch. 795 (S.B. 22), Sec. 3, eff. March 1, 2008.

Sec. 1651.106. EFFECT OF DISCONTINUATION OF PROGRAM ON POLICY. If the partnership for long-term care program is discontinued, an individual who purchased an approved plan before the date the program is discontinued remains eligible to receive dollar-for-dollar asset disregard and asset protection under the medical assistance program.

Added by Acts 2007, 80th Leg., R.S., Ch. 795 (S.B. 22), Sec. 3, eff. March 1, 2008.

Sec. 1651.107. RULES. The commissioner may adopt rules as necessary to implement this subchapter.

Added by Acts 2007, 80th Leg., R.S., Ch. 795 (S.B. 22), Sec. 3, eff. March 1, 2008.

CHAPTER 1652. MEDICARE SUPPLEMENT BENEFIT PLANS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1652.001. DEFINITIONS. In this chapter:

(1) "Applicant" means:

(A) an individual who seeks to contract for insurance or other health benefits under an individual Medicare supplement benefit plan; or

(B) the proposed certificate holder of a group Medicare supplement benefit plan.

(2) "Approved regulatory program" means a state regulatory program that complies with the requirements of Section 1882, Social

Security Act (42 U.S.C. Section 1395ss).

(3) "Medicare" means the Health Insurance for the Aged Act (42 U.S.C. Section 1395 et seq.), as amended.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 4, eff. April 1, 2005.

Sec. 1652.002. MEDICARE SUPPLEMENT BENEFIT PLAN. (a)

"Medicare supplement benefit plan" means a group or individual policy of accident and health insurance, a subscriber contract of a group hospital service corporation operating under Chapter 842, or, to the extent required by federal law, an evidence of coverage issued by a health maintenance organization operating under Chapter 843 that is advertised, marketed, or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical, or surgical expenses of an individual eligible for Medicare.

(b) A policy, contract, subscriber contract, or evidence of coverage is not considered to be a Medicare supplement benefit plan if it is:

(1) a policy, contract, subscriber contract, or evidence of coverage of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or a combination, for employees or former employees, or a combination, or for members or former members, or a combination, of the labor organizations;

(2) a policy or health care benefit plan, including a policy or contract of group insurance, a group contract of a group hospital service corporation operating under Chapter 842, or a group evidence of coverage issued by a health maintenance organization operating under Chapter 843 that is not marketed or held to be a Medicare supplement benefit plan; or

(3) an individual or group evidence of coverage issued in accordance with a contract under Section 1833 or 1876, Social Security Act (42 U.S.C. Section 1395l or 1395mm), by a health maintenance organization operating under Chapter 843.

(c) The commissioner by rule may modify the definition of "Medicare supplement benefit plan" provided by Subsection (a) to the extent necessary for this state to qualify as a state with an approved regulatory program.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 4, eff. April 1, 2005.

Sec. 1652.003. APPLICABILITY OF CHAPTER. This chapter applies to an individual or group Medicare supplement benefit plan delivered or issued for delivery in this state and, regardless of the place where the plan was delivered or issued for delivery, a certificate that was issued under a group Medicare supplement benefit plan and delivered or issued for delivery in this state, if the plan or certificate is issued by:

- (1) a capital stock insurance company, including a life, health and accident, and general casualty insurance company;
- (2) a mutual life insurance company;
- (3) a mutual assessment life insurance company, including a statewide mutual assessment company, local mutual aid association, and burial association;
- (4) a mutual or mutual assessment association of any kind, including an association subject to Section 887.102;
- (5) a mutual insurance company other than a life insurance company;
- (6) a mutual or natural premium life or casualty insurance company;
- (7) a fraternal benefit society;
- (8) a Lloyd's plan;
- (9) a reciprocal or interinsurance exchange;
- (10) a nonprofit hospital, medical, or dental service corporation, including a corporation operating under Chapter 842;
- (11) a stipulated premium company;
- (12) another insurer that by law is required to be authorized by the department; or
- (13) a health maintenance organization operating under Chapter 843, to the extent required by federal law.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 4, eff. April 1, 2005.

Sec. 1652.004. CONSTRUCTION OF CHAPTER. (a) This chapter may not be construed to enlarge the powers of an entity described by Section 1652.003.

(b) This chapter controls to the extent of any conflict with another provision of this code.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 4, eff. April 1, 2005.

Sec. 1652.005. RULES NECESSARY FOR CERTIFICATION. In addition to other rules required or authorized by this chapter, the commissioner shall adopt reasonable rules necessary and proper to carry out this chapter, including rules adopted in accordance with federal law relating to the regulation of Medicare supplement benefit plan coverage that are necessary for this state to obtain or retain certification as a state with an approved regulatory program.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 4, eff. April 1, 2005.

SUBCHAPTER B. BENEFITS

Sec. 1652.051. MINIMUM STANDARDS. (a) The commissioner shall adopt reasonable rules to establish specific standards for provisions in Medicare supplement benefit plans and standards for facilitating comparisons of different Medicare supplement benefit plans. The standards are in addition to and must be in accordance with:

(1) applicable laws of this state, including Chapters 842 and 1201;

(2) applicable federal law, rules, regulations, and standards; and

(3) any model rules and regulations required by federal law, including Section 1882, Social Security Act (42 U.S.C. Section 1395ss).

(b) The standards may include provisions relating to:

(1) terms of renewability;

(2) initial and subsequent conditions of eligibility;

(3) nonduplication of coverage;

(4) probationary periods;

(5) benefit limitations, exceptions, and reductions;

(6) elimination periods;

(7) requirements for replacement;

(8) recurrent conditions;

(9) definitions of terms; and

(10) exclusions required by state or federal law.

(c) The commissioner may adopt reasonable rules that specifically prohibit benefit plan provisions that:

(1) are not otherwise specifically authorized by statute;
and

(2) the commissioner determines are unjust, unfair, or unfairly discriminatory to a person who is covered or proposed for coverage.

(d) Rules adopted under this section must include requirements that are at least equal to those required by federal law, rules, regulations, and standards, including Section 1882, Social Security Act (42 U.S.C. Section 1395ss).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 4, eff. April 1, 2005.

Sec. 1652.052. MINIMUM STANDARDS FOR BENEFITS AND CLAIM PAYMENTS. (a) The commissioner shall adopt reasonable rules to establish minimum standards for benefits and claim payments under Medicare supplement benefit plans.

(b) The standards for benefits and claim payments must include the requirements for certification of Medicare supplement benefit plans prescribed by Section 1882, Social Security Act (42 U.S.C. Section 1395ss).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 4, eff. April 1, 2005.

Sec. 1652.053. DUPLICATE BENEFITS PROHIBITED. A Medicare supplement benefit plan or certificate in force in this state may not contain benefits that duplicate benefits provided by Medicare.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 4, eff. April 1, 2005.

Sec. 1652.054. BASIC PLAN. An entity described by Section 1652.003 that offers for sale in this state a Medicare supplement benefit plan must offer a basic Medicare supplement benefit plan that:

(1) provides only those benefits common to all Medicare supplement benefit plans; and

(2) meets but does not exceed the minimum standards of benefits for Medicare supplement benefit plans adopted by the commissioner and authorized by Section 1882, Social Security Act (42

U.S.C. Section 1395ss).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 4, eff. April 1, 2005.

Sec. 1652.055. ADDITIONAL BENEFITS. (a) In addition to the basic Medicare supplement benefit plan described by Section 1652.054, an entity may offer additional Medicare supplement benefit plans for sale in this state.

(b) The combination of benefits provided by an additional plan must conform to one of the benefit packages adopted by the commissioner and authorized by Section 1882, Social Security Act (42 U.S.C. Section 1395ss).

(c) The commissioner by rule shall provide for the approval of new or innovative benefits that may be provided in a plan other than the basic plan and that otherwise comply with this subchapter. The benefits must:

(1) be offered in a manner consistent with the goal of Medicare supplement benefit plan simplification; and

(2) meet the requirements prescribed by Section 1882, Social Security Act (42 U.S.C. Section 1395ss).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 4, eff. April 1, 2005.

Sec. 1652.056. COVERAGE FOR MAMMOGRAPHY. (a) In this section, "low-dose mammography" means the x-ray examination of the breast using equipment dedicated specifically for mammography, including the x-ray tube, filter, compression device, screens, films, and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast.

(b) Each Medicare supplement benefit plan must include coverage for an annual screening by low-dose mammography for the presence of occult breast cancer.

(c) The coverage for the annual screening may not be less favorable than coverage for other radiological examinations and must be subject to the same dollar limits, deductibles, and coinsurance factors.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 4, eff. April 1, 2005.

Sec. 1652.057. WAIVER OF WAITING PERIOD. (a) An entity that delivers or issues for delivery in this state a Medicare supplement benefit plan or certificate that replaces a Medicare supplement benefit plan or certificate shall give credit for the satisfaction or partial satisfaction of any waiting period, elimination period, or probationary period for a preexisting condition that has been satisfied under the plan being replaced.

(b) A replacement plan that clearly provides a new or additional benefit may include appropriate and clearly stated periods as a condition for payment of the new or additional benefit.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 4, eff. April 1, 2005.

Sec. 1652.058. COVERAGE FOR PREEXISTING CONDITION. (a) A Medicare supplement benefit plan may not contain a provision that excludes coverage for a claim for losses incurred more than six months after the effective date of coverage for a preexisting condition.

(b) A Medicare supplement benefit plan may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 4, eff. April 1, 2005.

SUBCHAPTER C. LOSS RATIO STANDARDS

Sec. 1652.101. LOSS RATIO STANDARDS. (a) A Medicare supplement benefit plan must return to a plan holder benefits that are reasonable in relation to the premium charged.

(b) The commissioner shall adopt reasonable rules to establish minimum loss ratio standards for Medicare supplement benefit plans. The standards must be established:

(1) on the basis of incurred claims experience and earned premiums for the entire period for which rates are computed to provide coverage;

(2) in accordance with accepted actuarial principles and practices; and

(3) to the extent necessary for the state to obtain or

retain certification as a state with an approved regulatory program.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 4, eff. April 1, 2005.

Sec. 1652.102. FILING REQUIREMENTS. (a) Annually, each entity providing Medicare supplement benefit plans in this state shall file with the department the entity's rates, rating schedule, and supporting documentation demonstrating that:

(1) the entity is complying with the applicable loss ratio standards of this state; and

(2) the actual and expected losses in relation to premiums comply with the requirements of this subchapter and the rules adopted by the commissioner.

(b) The documentation required by Subsection (a) must include a report of the ratio of incurred losses to covered premiums for the preceding calendar year, illustrated by calendar year of issue.

(c) The commissioner may adopt rules relating to filing requirements for rates, rating schedules, and loss ratios.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 4, eff. April 1, 2005.

Sec. 1652.103. REVIEW OF PREMIUM INCREASES. (a) The commissioner by rule shall provide a process for reviewing and approving or disapproving a proposed premium increase relating to a Medicare supplement benefit plan.

(b) The rules must comply with federal law, including Section 1882, Social Security Act (42 U.S.C. Section 1395ss).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 4, eff. April 1, 2005.

Sec. 1652.104. BENEFIT CHANGES. (a) Before the date on which a Medicare benefit change required by federal law takes effect, each entity providing in this state a Medicare supplement benefit plan existing on the effective date of the change shall file with the commissioner, in accordance with Chapter 1701:

(1) each appropriate premium adjustment necessary to produce the loss ratios originally anticipated for the applicable plan, accompanied by any supporting documents necessary to justify

the adjustment; and

(2) each appropriate rider, endorsement, or plan form necessary to modify the coverage so as to eliminate benefit duplications with Medicare.

(b) A rider, endorsement, or plan form required by Subsection (a) must provide a clear description of the Medicare supplement benefits provided by the plan.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 4, eff. April 1, 2005.

Sec. 1652.105. REPORTING LOSS RATIO INFORMATION TO SECRETARY OF HEALTH AND HUMAN SERVICES. To the extent necessary for this state to obtain or retain certification as a state with an approved regulatory program, the department shall comply with federal requirements relating to periodic reporting of loss ratio information to the secretary of health and human services, based on a uniform methodology, as authorized by federal law.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 4, eff. April 1, 2005.

SUBCHAPTER D. CONSUMER INFORMATION AND NOTICE

Sec. 1652.151. RULES RELATING TO DISCLOSURE. The rules adopted under Sections 1652.152, 1652.153, and 1652.154 must include provisions and requirements that are at least equal to those required by federal law, including the rules, regulations, and standards adopted under Section 1882, Social Security Act (42 U.S.C. Section 1395ss).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 4, eff. April 1, 2005.

Sec. 1652.152. OUTLINE OF COVERAGE. (a) To provide for full and fair disclosure in the sale of Medicare supplement benefit plans, a Medicare supplement benefit plan or certificate may not be delivered or issued for delivery in this state unless an outline of coverage that complies with this section is delivered to the applicant when the applicant applies for the coverage.

(b) The commissioner by rule shall prescribe the format and content of the outline of coverage required by Subsection (a). The

rules must address the style, arrangement, and overall appearance of the outline of coverage, including the size, color, and prominence of type and the arrangement of text and captions.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 4, eff. April 1, 2005.

Sec. 1652.153. INFORMATIONAL BROCHURE. (a) The commissioner by rule may prescribe a standard form and the contents of an informational brochure intended to improve the ability of an individual eligible for Medicare to understand Medicare and to select the most appropriate Medicare supplement coverage.

(b) Except as provided by Subsection (c), the commissioner by rule may require that the informational brochure be provided to an individual eligible for Medicare concurrently with delivery of the outline of coverage.

(c) If the plan is a direct response Medicare supplement benefit plan, the commissioner by rule may require that the informational brochure be provided on request to an individual eligible for Medicare at any time not later than the time the plan is delivered.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 4, eff. April 1, 2005.

Sec. 1652.154. NOTICE RELATING TO OTHER TYPES OF COVERAGE. (a) The commissioner may adopt reasonable rules for captions or notice requirements for each accident and health insurance policy, subscriber contract, or evidence of coverage sold to an individual eligible for Medicare that are determined to be in the public interest and designed to inform the individual that a particular coverage is not a Medicare supplement benefit plan. This subsection does not apply to:

- (1) a Medicare supplement benefit plan;
- (2) a disability income policy;
- (3) a basic, catastrophic, or major medical expense policy;
- (4) a single premium nonrenewable policy; or
- (5) another policy, contract, or subscriber contract

described by Section 1652.002(b)(1) or (2).

(b) The commissioner may adopt reasonable rules to govern the full and fair disclosure of information relating to replacing an

accident and health insurance policy, a subscriber contract, or a certificate by an individual eligible for Medicare.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 4, eff. April 1, 2005.

Sec. 1652.155. RIGHT TO RETURN FOR REFUND; NOTICE. (a) If an applicant is not satisfied for any reason after examining a Medicare supplement benefit plan document or certificate, the applicant is entitled to receive a refund of the premium if the applicant returns the document or certificate not later than the 30th day after the date it is delivered.

(b) The entity issuing the plan or certificate shall refund the premium directly to the applicant in a timely manner.

(c) A Medicare supplement benefit plan or certificate must have a notice stating the substance prescribed by Subsection (a) prominently printed on the first page of or attached to the plan or certificate.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 4, eff. April 1, 2005.

Sec. 1652.156. ADVERTISING FILING REQUIREMENTS. (a) The commissioner shall adopt reasonable rules to require each entity described by Section 1652.003 to file with the department a copy of any advertisement relating to Medicare supplement benefit plans that the entity intends to use in this state. The rules must require that the entity file the copy not later than the 60th day before the date of intended use.

(b) At the expiration of the 60-day period provided by Subsection (a), an advertisement filed in accordance with that subsection is considered acceptable, unless before the end of that 60-day period the department notifies the entity of the advertisement's nonacceptance.

(c) An entity may not use an advertisement for Medicare supplement benefit plans that does not comply with state law, including department rules and Section 541.084.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 4, eff. April 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 475 (H.B. [2251](#)), Sec. 3, eff.

September 1, 2007.

SUBCHAPTER E. AGENTS

Sec. 1652.201. INFORMATION PROVIDED TO AGENTS. (a) An entity that offers a Medicare supplement benefit plan for sale in this state shall provide to each agent authorized to sell that plan information relating to:

- (1) Medicare;
- (2) the Medicare supplement benefit plans offered by that entity; and
- (3) the agent's ethical obligations to clients.

(b) The commissioner by rule may prescribe the information that must be provided under this section.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 4, eff. April 1, 2005.

Sec. 1652.202. PERMITTED COMPENSATION ARRANGEMENTS. (a) The commissioner by rule shall limit the commission or other compensation that may be paid to an agent for the sale of a Medicare supplement benefit plan or certificate, including a replacement plan or certificate.

(b) The rules must conform to, but may not be more restrictive than, the requirements of federal law necessary for this state to obtain or retain certification as a state with an approved regulatory program.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 4, eff. April 1, 2005.

SUBCHAPTER F. OUTPATIENT PRESCRIPTION DRUGS

Sec. 1652.251. OUTPATIENT PRESCRIPTION DRUG BENEFIT PLANS. (a) An entity described by Section 1652.003 that issues a Medicare supplement benefit plan in this state may offer a group or individual policyholder:

- (1) an outpatient prescription drug benefit plan authorized under 42 U.S.C. Section 1395ss; or
- (2) a new or innovative outpatient prescription drug benefit plan filed with and approved by the commissioner under Section 1652.055.

(b) The commissioner shall approve or disapprove an outpatient drug benefit plan described by Subsection (a) that is filed for approval under Section 1652.055 not later than the 60th day after the date the entity files the plan with the department. A drug benefit plan that has not been approved or disapproved by the commissioner before the 61st day after the date the plan is filed with the department is considered approved on that day.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.075(a), eff. September 1, 2005.

Sec. 1652.252. PRESCRIPTION DRUG DISCOUNT PROGRAMS. (a) In this section, "prescription drug discount program" means any program that entitles a participant to purchase prescription drugs or other medical supplies and services from vendors at a discount under an agreement made with a participating pharmacy.

(b) An entity described by Section 1652.003 may offer participation in a prescription drug discount program in connection with the solicitation of an application for issuance of a Medicare supplement benefit plan.

(c) An offer of participation in a prescription drug discount program described by this section is not a violation of Chapter 541 or any other law prohibiting the offer of rebates in the solicitation of insurance policies.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.075(a), eff. September 1, 2005.

CHAPTER 1653. HIGH DEDUCTIBLE HEALTH PLAN

Sec. 1653.001. DEFINITION. In this chapter, "high deductible health plan" has the meaning assigned by Section 223, Internal Revenue Code of 1986.

Added by Acts 2005, 79th Leg., Ch. 151 (H.B. 1602), Sec. 1, eff. May 24, 2005.

Sec. 1653.002. APPLICABILITY OF OTHER LAW. (a) Subject to Subsection (b), a high deductible health plan is subject to any law

mandating a minimum health insurance benefit or reimbursement.

(b) Notwithstanding any other law, a provision of this code may not be construed to prevent an insurer, health maintenance organization, or other entity issuing a health insurance policy or certificate of coverage from applying deductible or copayment requirements to benefits, including state-mandated health benefits, in order to qualify the health insurance policy or certificate of coverage as a high deductible health plan.

Added by Acts 2005, 79th Leg., Ch. 151 (H.B. 1602), Sec. 1, eff. May 24, 2005.

Sec. 1653.003. RULES. The commissioner shall adopt rules necessary to implement this chapter.

Added by Acts 2005, 79th Leg., Ch. 151 (H.B. 1602), Sec. 1, eff. May 24, 2005.

SUBTITLE J. HEALTH INFORMATION TECHNOLOGY AND AVAILABILITY

CHAPTER 1660. ELECTRONIC DATA EXCHANGE

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1660.001. FINDINGS AND PURPOSE. (a) The legislature finds that patients deserve accurate, instantaneous information about coverage and financial responsibility to make well-informed decisions about their treatment and spending.

(b) The legislature finds that the ability of health benefit plan issuers and administrators to exchange eligibility and benefit information with physicians, health care providers, hospitals, and patients will ensure a more efficient and effective health care delivery system.

(c) The legislature finds that electronic access to eligibility information will reduce the amount of time and resources spent on administrative functions, prevent abuse and fraud, streamline and simplify processing of insurance claims, and increase transparency in premium cost and health care cost.

(d) The legislature finds that patients often request information about their health care coverage from their health care providers and that health care providers therefore need access to real-time information about their patients' eligibility to receive

health care under the health benefit plan, coverage of health care under the health benefit plan, and the benefits associated with the health benefit plan.

(e) The legislature finds that adoption of technology by insurers, health maintenance organizations, and health care providers to facilitate use of electronic data exchange standards currently available will make coverage and health care electronic transactions more predictable, reliable, and consistent.

Added by Acts 2007, 80th Leg., R.S., Ch. 209 (H.B. 522), Sec. 1, eff. May 25, 2007.

Sec. 1660.002. DEFINITIONS. In this chapter:

- (1) "Administrator" has the meaning assigned by Section 4151.001.
- (2) Repealed by Acts 2011, 82nd Leg., R.S., Ch. 1147, Sec. 2.008(7), eff. September 1, 2011.
- (3) "Enrollee" means an individual who is insured by or enrolled in a health benefit plan.
- (4) "Health benefit plan" means an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an evidence of coverage that provides health insurance or health care benefits.
- (5) "Transaction standards" means the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191) transaction standards of the Centers for Medicare and Medicaid Services under 45 C.F.R. Part 162.

Added by Acts 2007, 80th Leg., R.S., Ch. 209 (H.B. 522), Sec. 1, eff. May 25, 2007.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 1147 (H.B. 1951), Sec. 2.008(7), eff. September 1, 2011.

Sec. 1660.003. APPLICABILITY. (a) This chapter applies only to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital

service contract, or an individual or group evidence of coverage or similar coverage document that is offered by:

- (1) an insurance company;
- (2) a group hospital service corporation operating under Chapter 842;
- (3) a fraternal benefit society operating under Chapter 885;
- (4) a stipulated premium insurance company operating under Chapter 884;
- (5) a reciprocal exchange operating under Chapter 942;
- (6) a health maintenance organization operating under Chapter 843;
- (7) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; or
- (8) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844.

Text of subsection effective until April 1, 2025

(b) This chapter does not apply to:

- (1) a Medicaid managed care program operated under Chapter 533, Government Code;
- (2) a Medicaid program operated under Chapter 32, Human Resources Code;
- (3) the state child health plan or any similar plan operated under Chapter 62 or 63, Health and Safety Code; or
- (4) a health benefit plan offered by an insurer or health maintenance organization that provides coverage only for dental services.

Text of subsection effective on April 1, 2025

(b) This chapter does not apply to:

- (1) a Medicaid managed care program operated under Chapter 540 or 540A, Government Code, as applicable;
- (2) a Medicaid program operated under Chapter 32, Human Resources Code;
- (3) the state child health plan or any similar plan operated under Chapter 62 or 63, Health and Safety Code; or
- (4) a health benefit plan offered by an insurer or health maintenance organization that provides coverage only for dental services.

Added by Acts 2007, 80th Leg., R.S., Ch. 209 (H.B. [522](#)), Sec. 1, eff.

May 25, 2007.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 2.137, eff. April 1, 2025.

Sec. 1660.004. GENERAL RULEMAKING. The commissioner may adopt rules as necessary to implement this chapter.

Added by Acts 2007, 80th Leg., R.S., Ch. 209 (H.B. 522), Sec. 1, eff. May 25, 2007.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 1147 (H.B. 1951), Sec. 2.003, eff. September 1, 2011.

SUBCHAPTER C. IDENTIFICATION CARD PILOT PROGRAM

Sec. 1660.101. PILOT PROGRAM. (a) The commissioner shall designate a county or counties for initial participation in an identification card pilot program to begin not later than May 1, 2008.

(b) The commissioner shall require the issuer of a health benefit plan that is offered in the county or counties selected for initial participation in the identification card pilot program to issue identification cards that comply with commissioner rules to each enrollee of the plan.

(c) Repealed by Acts 2011, 82nd Leg., R.S., Ch. 1147, Sec. 2.008(9), eff. September 1, 2011.

Added by Acts 2007, 80th Leg., R.S., Ch. 209 (H.B. 522), Sec. 1, eff. May 25, 2007.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 1147 (H.B. 1951), Sec. 2.008(9), eff. September 1, 2011.

Sec. 1660.102. PILOT PROGRAM RULES. (a) The commissioner shall adopt rules as necessary to implement the identification card pilot program, including the coordination of a testing phase and incorporation of changes identified in the testing phase.

(b) The commissioner may consider recommendations or any other

information provided in response to a department-issued request for information relating to electronic data exchange, including identification card programs, before adopting rules regarding:

- (1) information to be included on the identification cards;
- (2) technology to be used to implement the identification card pilot program; and
- (3) confidentiality and accuracy of the information required to be included on the identification cards.

(c) The commissioner shall consider the requirements of any federal program requiring health benefit plan issuers and administrators to provide point-of-service access to physicians and other health care providers regarding eligibility information before adopting rules to implement this section.

Added by Acts 2007, 80th Leg., R.S., Ch. 209 (H.B. 522), Sec. 1, eff. May 25, 2007.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 1147 (H.B. 1951), Sec. 2.004, eff. September 1, 2011.

Sec. 1660.103. REQUESTS FOR INFORMATION. The commissioner may issue requests for information as needed to implement the identification card pilot program under this subchapter.

Added by Acts 2007, 80th Leg., R.S., Ch. 209 (H.B. 522), Sec. 1, eff. May 25, 2007.

Sec. 1660.104. HEALTH BENEFIT PLAN ISSUER COMPLIANCE. (a) Each issuer of a health benefit plan that offers a health benefit plan in a county or counties designated by the commissioner under Section 1660.101 for initial participation in the identification card pilot program shall comply with this subchapter and rules adopted under this subchapter.

(b) To ensure timely compliance with the requirements of this subchapter, the commissioner may require the issuer of a health benefit plan to submit its procedures for implementation of the requirements to the department in the form prescribed by the commissioner.

Added by Acts 2007, 80th Leg., R.S., Ch. 209 (H.B. 522), Sec. 1, eff. May 25, 2007.

CHAPTER 1661. INFORMATION TECHNOLOGY

Sec. 1661.001. DEFINITIONS. In this chapter:

- (1) "Health benefit plan" means a plan 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 that is offered by:
- (A) an insurance company;
 - (B) a group hospital service corporation operating under Chapter 842;
 - (C) a fraternal benefit society operating under Chapter 885;
 - (D) a stipulated premium company operating under Chapter 884;
 - (E) a Lloyd's plan operating under Chapter 941;
 - (F) an exchange operating under Chapter 942;
 - (G) a health maintenance organization operating under Chapter 843;
 - (H) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846;
 - (I) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844; or
 - (J) an entity not authorized under this code or another insurance law of this state that contracts directly for health care services on a risk-sharing basis, including a capitation basis.
- (2) "Health benefit plan issuer" means an entity authorized to issue a health benefit plan in this state.
- (3) "Health care provider" means:
- (A) an individual who is licensed, certified, or otherwise authorized to provide health care services; or
 - (B) a hospital, emergency clinic, outpatient clinic, or other facility providing health care services.
- (4) "Participating provider" means a health care provider who has contracted with a health benefit plan issuer to provide services to enrollees.

Added by Acts 2009, 81st Leg., R.S., Ch. 261 (H.B. 1342), Sec. 1, eff. May 30, 2009.

Sec. 1661.002. USE OF CERTAIN INFORMATION TECHNOLOGY REQUIRED.

(a) A health benefit plan issuer shall use information technology that provides a participating provider with real-time information at the point of care concerning:

(1) the enrollee's:

- (A) copayment and coinsurance;
- (B) applicable deductibles; and
- (C) covered benefits and services; and

(2) the enrollee's estimated total financial responsibility for the care.

(b) A health benefit plan issuer shall use information technology that provides an enrollee with information concerning the enrollee's:

- (1) copayment and coinsurance;
- (2) applicable deductibles;
- (3) covered benefits and services; and
- (4) estimated financial responsibility for the health care

provided to the enrollee.

(c) Nothing in this section may be interpreted as a guarantee of payment for health care services.

(d) A health benefit plan issuer's Internet website may be used to meet the information technology requirements of this chapter.

Added by Acts 2009, 81st Leg., R.S., Ch. 261 (H.B. 1342), Sec. 1, eff. May 30, 2009.

Text of section effective until April 1, 2025

Sec. 1661.003. EXCEPTIONS. This chapter does not apply to:

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

- (A) for a specified disease or diseases or under a limited benefit policy;
- (B) for accidental death or dismemberment;
- (C) as a supplement to a liability insurance policy; or
- (D) for dental or vision care;

(2) disability income insurance coverage;

- (3) credit insurance coverage;
- (4) a hospital confinement indemnity policy;
- (5) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);
- (6) a workers' compensation insurance policy;
- (7) medical payment insurance coverage provided under a motor vehicle insurance policy;
- (8) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefits so comprehensive that the policy is a health benefit plan and should not be subject to the exemption provided under this section;
- (9) the child health plan program under Chapter 62, Health and Safety Code, or the health benefits plan for children under Chapter 63, Health and Safety Code; or
- (10) a Medicaid managed care program operated under Chapter 533, Government Code, or a Medicaid program operated under Chapter 32, Human Resources Code.

Added by Acts 2009, 81st Leg., R.S., Ch. 261 (H.B. [1342](#)), Sec. 1, eff. May 30, 2009.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. [4611](#)), Sec. 2.138, eff. April 1, 2025.

Text of section effective on April 1, 2025

Sec. 1661.003. EXCEPTIONS. This chapter does not apply to:

- (1) a health benefit plan that provides coverage only:
 - (A) for a specified disease or diseases or under a limited benefit policy;
 - (B) for accidental death or dismemberment;
 - (C) as a supplement to a liability insurance policy; or
 - (D) for dental or vision care;
- (2) disability income insurance coverage;
- (3) credit insurance coverage;
- (4) a hospital confinement indemnity policy;
- (5) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);
- (6) a workers' compensation insurance policy;

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

(8) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefits so comprehensive that the policy is a health benefit plan and should not be subject to the exemption provided under this section;

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

(10) a Medicaid managed care program operated under Chapter 540 or 540A, Government Code, as applicable, or a Medicaid program operated under Chapter 32, Human Resources Code.

Added by Acts 2009, 81st Leg., R.S., Ch. 261 (H.B. 1342), Sec. 1, eff. May 30, 2009.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 2.138, eff. April 1, 2025.

Sec. 1661.004. REQUIRED USE OF TECHNOLOGY BY PROVIDERS. A physician, hospital, or other health care provider shall use information technology as required under this chapter beginning not later than September 1, 2013.

Added by Acts 2009, 81st Leg., R.S., Ch. 261 (H.B. 1342), Sec. 1, eff. May 30, 2009.

Sec. 1661.005. REFUND OF OVERPAYMENT. A physician, hospital, or other health care provider that receives an overpayment from an enrollee must refund the amount of the overpayment to the enrollee not later than the 30th day after the date the physician, hospital, or health care provider determines that an overpayment has been made. This section does not apply to an overpayment subject to Section 843.350 or 1301.132.

Added by Acts 2009, 81st Leg., R.S., Ch. 261 (H.B. 1342), Sec. 1, eff. May 30, 2009.

Sec. 1661.0055. USE OF TECHNOLOGY: WAIVER. (a)

Notwithstanding Section 1661.004, physicians or health care providers with fewer than five full-time-equivalent employees are not required to use information technology as required under this chapter.

(b) A health benefit plan issuer may not require, through contract or otherwise, physicians or health care providers with fewer than five full-time-equivalent employees to use information technology as required under this chapter.

(c) A contract between the issuer of a health benefit plan and a physician or health care provider must provide for a waiver of any requirement for the use of information technology as established or required under this chapter.

(d) The commissioner shall establish the circumstances under which the requirements of this chapter do not apply to a physician or health care provider including:

(1) undue hardship, including fiscal or operational hardship; or

(2) any other special circumstance that would justify an exclusion.

(e) The commissioner shall establish circumstances under which a waiver under Subsection (c) is required, including:

(1) undue hardship, including fiscal or operational hardship; or

(2) any other special circumstance that would justify a waiver.

(f) Any physician or health care provider that is denied a waiver by a health benefit plan issuer may appeal the denial to the commissioner. The commissioner shall determine whether a waiver must be granted.

(g) A health benefit plan issuer may not refuse to contract or renew a contract with a physician or health care provider based in whole or in part on the physician or provider requesting or receiving a waiver or appealing a waiver determination. A health benefit plan issuer may not refuse to contract or renew a contract with a physician or health care provider based in whole or in part on the physician or provider meeting the exemptions contained in Subsections (a) and (b).

(h) A waiver approved under this section expires September 1, 2013.

Added by Acts 2009, 81st Leg., R.S., Ch. 261 (H.B. 1342), Sec. 1, eff. May 30, 2009.

Sec. 1661.006. HEALTH BENEFIT PLAN ISSUER CONDUCT. A contract between a health benefit plan issuer and a physician, hospital, or other health care provider may not prohibit the physician, hospital, or health care provider from collecting, at the time of care, the estimated amount for which the enrollee may be financially responsible.

Added by Acts 2009, 81st Leg., R.S., Ch. 261 (H.B. 1342), Sec. 1, eff. May 30, 2009.

Sec. 1661.007. CERTAIN FEES PROHIBITED. A health benefit plan issuer may not directly charge or collect from an enrollee or a physician, or other health care provider, a fee to cover the costs incurred by the health benefit plan issuer in complying with this chapter.

Added by Acts 2009, 81st Leg., R.S., Ch. 261 (H.B. 1342), Sec. 1, eff. May 30, 2009.

Sec. 1661.009. RULES. (a) The commissioner shall adopt rules as necessary to implement this chapter, including rules that ensure that the information technology used by a health benefit plan issuer does not have legal or technical restrictions for encoding, displaying, exchanging, reading, printing, transmitting, or storing information or data in electronic form.

(b) Rules adopted by the commissioner must be consistent with national standards established by the Workgroup for Electronic Data Interchange or by other similar organizations recognized by the commissioner.

Added by Acts 2009, 81st Leg., R.S., Ch. 261 (H.B. 1342), Sec. 1, eff. May 30, 2009.

CHAPTER 1662. HEALTH CARE COST TRANSPARENCY

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1662.001. DEFINITIONS. In this chapter:

(1) "Billed charge" means the total charges for a health care service or supply billed to a health benefit plan by a health care provider.

(2) "Billing code" means the code used by a health benefit plan issuer or administrator or health care provider to identify a health care service or supply for the purposes of billing, adjudicating, and paying claims for a covered health care service or supply, including the Current Procedural Terminology code, the Healthcare Common Procedure Coding System code, the Diagnosis-Related Group code, the National Drug Code, or other common payer identifier.

(3) "Bundled payment arrangement" means a payment model under which a health care provider is paid a single payment for all covered health care services and supplies provided to an enrollee for a specific treatment or procedure.

(4) "Copayment assistance" means the financial assistance an enrollee receives from a prescription drug or medical supply manufacturer toward the purchase of a covered health care service or supply.

(5) "Cost-sharing information" means information related to any expenditure required by or on behalf of an enrollee with respect to health care benefits that are relevant to a determination of the enrollee's cost-sharing liability for a particular covered health care service or supply.

(6) "Cost-sharing liability" means the amount an enrollee is responsible for paying for a covered health care service or supply under the terms of a health benefit plan. The term generally includes deductibles, coinsurance, and copayments but does not include premiums, balance billing amounts by out-of-network providers, or the cost of health care services or supplies that are not covered under a health benefit plan.

(7) "Covered health care service or supply" means a health care service or supply, including a prescription drug, for which the costs are payable, wholly or partly, under the terms of a health benefit plan.

(8) "Derived amount" means the price that a health benefit plan assigns to a health care service or supply for the purpose of internal accounting, reconciliation with health care providers, or submitting data in accordance with state or federal regulations.

(9) "Enrollee" means an individual, including a dependent, entitled to coverage under a health benefit plan.

(10) "Health care service or supply" means any encounter, procedure, medical test, supply, prescription drug, durable medical equipment, and fee, including a facility fee, provided or assessed in connection with the provision of health care.

(11) "Historical net price" means the retrospective average amount a health benefit plan paid for a prescription drug, inclusive of any reasonably allocated rebates, discounts, chargebacks, and fees and any additional price concessions received by the plan or plan issuer or administrator with respect to the prescription drug, determined in accordance with Section 1662.106.

(12) "Machine-readable file" means a digital representation of data in a file that can be imported or read by a computer system for further processing without human intervention while ensuring no semantic meaning is lost.

(13) "National drug code" means the unique 10- or 11-digit 3-segment number assigned by the United States Food and Drug Administration that is a universal product identifier for drugs in the United States.

(14) "Negotiated rate" means the amount a health benefit plan issuer or administrator has contractually agreed to pay a network provider, including a network pharmacy or other prescription drug dispenser, for covered health care services and supplies, whether directly or indirectly, including through a third-party administrator or pharmacy benefit manager.

(15) "Network provider" means any health care provider of a health care service or supply with which a health benefit plan issuer or administrator or a third party for the issuer or administrator has a contract with the terms on which a relevant health care service or supply is provided to an enrollee.

(16) "Out-of-network allowed amount" means the maximum amount a health benefit plan issuer or administrator will pay for a covered health care service or supply provided by an out-of-network provider.

(17) "Out-of-network provider" means a health care provider of any health care service or supply that does not have a contract under an enrollee's health benefit plan.

(18) "Out-of-pocket limit" means the maximum amount that an enrollee is required to pay during a coverage period for the

enrollee's share of the costs of covered health care services and supplies under the enrollee's health benefit plan, including for self-only and other than self-only coverage, as applicable.

(19) "Prerequisite" means concurrent review, prior authorization, or a step-therapy or fail-first protocol related to a covered health care service or supply that must be satisfied before a health benefit plan issuer or administrator will cover the service or supply. The term does not include a medical necessity determination generally or another form of medical management technique.

(20) "Underlying fee schedule rate" means the rate for a covered health care service or supply from a particular network provider or health care provider that a health benefit plan issuer or administrator uses to determine an enrollee's cost-sharing liability for the service or supply when that rate is different from the negotiated rate or derived amount.

Added by Acts 2021, 87th Leg., R.S., Ch. 333 (H.B. 2090), Sec. 3, eff. September 1, 2021.

Sec. 1662.002. DEFINITION OF ACCUMULATED AMOUNTS. (a) In this chapter, "accumulated amounts" means:

(1) the amount of financial responsibility an enrollee has incurred at the time a request for cost-sharing information is made, with respect to a deductible or out-of-pocket limit; and

(2) to the extent a health benefit plan imposes a cumulative treatment limitation, including a limitation on the number of health care supplies, days, units, visits, or hours covered in a defined period, on a particular covered health care service or supply independent of individual medical necessity determinations, the amount that has accrued toward the limit on the health care service or supply.

(b) For an individual enrolled in coverage other than self-only coverage, the term includes the financial responsibility the individual has incurred toward meeting the individual's own deductible or out-of-pocket limit and the amount of financial responsibility that all individuals enrolled in the individual's coverage have incurred, in aggregate, toward meeting the plan's other than self-only deductible or out-of-pocket limit, as applicable.

(c) The term includes any expense that counts toward a

deductible or out-of-pocket limit, including a copayment or coinsurance, but excludes any expense that does not count toward a deductible or out-of-pocket limit, including a premium payment, out-of-pocket expense for out-of-network health care services or supplies, or an amount for a health care service or supply not covered by the health benefit plan.

Added by Acts 2021, 87th Leg., R.S., Ch. 333 (H.B. 2090), Sec. 3, eff. September 1, 2021.

Sec. 1662.003. APPLICABILITY OF CHAPTER. (a) This chapter applies only to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is offered by:

- (1) an insurance company;
- (2) a group hospital service corporation operating under Chapter 842;
- (3) a health maintenance organization operating under Chapter 843;
- (4) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844;
- (5) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846;
- (6) a stipulated premium company operating under Chapter 884;
- (7) a fraternal benefit society operating under Chapter 885;
- (8) a Lloyd's plan operating under Chapter 941; or
- (9) an exchange operating under Chapter 942.

- (b) Notwithstanding any other law, this chapter applies to:
- (1) a small employer health benefit plan subject to Chapter 1501, including coverage provided through a health group cooperative under Subchapter B of that chapter;
 - (2) a standard health benefit plan issued under Chapter 1507;
 - (3) a basic coverage plan under Chapter 1551;

- (4) a basic plan under Chapter 1575;
- (5) a primary care coverage plan under Chapter 1579;
- (6) a plan providing basic coverage under Chapter 1601;
- (7) a regional or local health care program operated under Section 75.104, Health and Safety Code; and
- (8) a self-funded health benefit plan sponsored by a professional employer organization under Chapter 91, Labor Code.

(c) This chapter does not apply to a health reimbursement arrangement or other account-based health benefit plan or a workers' compensation insurance policy.

Added by Acts 2021, 87th Leg., R.S., Ch. 333 (H.B. 2090), Sec. 3, eff. September 1, 2021.

Sec. 1662.004. RULES. The commissioner may adopt rules necessary to implement this chapter.

Added by Acts 2021, 87th Leg., R.S., Ch. 333 (H.B. 2090), Sec. 3, eff. September 1, 2021.

SUBCHAPTER B. REQUIRED DISCLOSURES TO ENROLLEES

Sec. 1662.051. REQUIRED DISCLOSURE TO ENROLLEE ON REQUEST. (a) On request of a health benefit plan enrollee, the health benefit plan issuer or administrator shall provide to the enrollee a disclosure in accordance with this subchapter.

(b) A health benefit plan issuer or administrator may allow an enrollee to request cost-sharing information for a specific preventive or non-preventive health care service or supply by including terms such as "preventive," "non-preventive," or "diagnostic" when requesting information under Subsection (a).

Added by Acts 2021, 87th Leg., R.S., Ch. 333 (H.B. 2090), Sec. 3, eff. September 1, 2021.

Sec. 1662.052. REQUIRED DISCLOSURE INFORMATION. (a) A disclosure provided under this subchapter must have the following information that is accurate at the time the disclosure request is made, with respect to the requesting enrollee's cost-sharing

liability for a covered health care service and supply:

(1) an estimate of the enrollee's cost-sharing liability for the requested service or supply provided by a health care provider that is calculated based on the information described by Subdivisions (4), (5), and (6);

(2) except as provided by Subsection (b), if the request relates to a service or supply that is provided within a bundled payment arrangement and the arrangement includes a service or supply that has a separate cost-sharing liability, an estimate of the cost-sharing liability for:

(A) the requested covered service or supply; and

(B) each service or supply in the arrangement that has a separate cost-sharing liability;

(3) for a requested service or supply that is a recommended preventive service under Section 2713, Public Health Service Act (42 U.S.C. Section 300gg-13), if the health benefit plan issuer or administrator cannot determine whether the request is for preventive or non-preventive purposes, the cost-sharing liability for non-preventive purposes;

(4) accumulated amounts;

(5) the network provider rate that is composed of the following that are applicable to the health benefit plan's payment model:

(A) the negotiated rate, reflected as a dollar amount, for a network provider for the requested service or supply regardless of whether the issuer or administrator uses the rate to calculate the enrollee's cost-sharing liability; and

(B) the underlying fee schedule rate, reflected as a dollar amount, for the requested service or supply, to the extent that is different from the negotiated rate;

(6) the out-of-network allowed amount or any other rate that provides a more accurate estimate of an amount a health benefit plan issuer or administrator will pay for the requested service or supply, reflected as a dollar amount, if the request for cost-sharing information is for a covered service or supply provided by an out-of-network provider;

(7) if an enrollee requests information for a service or supply subject to a bundled payment arrangement, a list of the services and supplies included in the arrangement;

(8) if applicable, notification that coverage of a specific

service or supply is subject to a prerequisite; and

(9) notice that includes the following information in plain language:

(A) unless balance billing is prohibited for the requested service or supply, a statement that out-of-network providers may bill an enrollee for the difference between a provider's billed charges and the sum of the amount collected from the health benefit plan issuer or administrator and from the enrollee in the form of a copayment or coinsurance amount and that the cost-sharing information provided for the service or supply does not account for that potential additional charge;

(B) a statement that the actual charges to the enrollee for the requested service or supply may be different from the estimate provided, depending on the actual services or supplies the enrollee receives at the point of care;

(C) a statement that the estimate of cost-sharing liability for the requested service or supply is not a guarantee that benefits will be provided for that service or supply;

(D) a statement disclosing whether the health benefit plan counts copayment assistance and other third-party payments in the calculation of the enrollee's deductible and out-of-pocket maximum;

(E) for a service or supply that is a recommended preventive service under Section 2713, Public Health Service Act (42 U.S.C. Section 300gg-13), a statement that a service or supply provided by a network provider may not be subject to cost sharing if it is billed as a preventive service or supply when the health benefit plan issuer or administrator cannot determine whether the request is for a preventive or non-preventive service or supply; and

(F) any additional information, including other disclosures, that the health benefit plan issuer or administrator determines is appropriate provided that the additional information does not conflict with the information required to be provided under this section.

(b) A health benefit plan issuer or administrator is not required to provide an estimate of cost-sharing liability for a bundled payment arrangement in which the cost sharing is imposed separately for each health care service or supply included in the arrangement. If an issuer or administrator provides an estimate for multiple health care services or supplies in a situation in which the

estimate could be relevant to an enrollee, the issuer or administrator must disclose information about the relevant services or supplies individually as required by Subsection (a).

(c) If a health benefit plan issuer or administrator reimburses an out-of-network provider with a percentage of the billed charge for a covered health care service or supply, the out-of-network allowed amount described by Subsection (a) is that reimbursed percentage.

Added by Acts 2021, 87th Leg., R.S., Ch. 333 (H.B. 2090), Sec. 3, eff. September 1, 2021.

Sec. 1662.053. METHOD AND FORMAT FOR DISCLOSURE. A health benefit plan issuer or administrator shall provide the disclosure required under this subchapter through an Internet-based self-service tool described by Section 1662.054, a physical copy in accordance with Section 1662.055, or another means authorized by Section 1662.056.

Added by Acts 2021, 87th Leg., R.S., Ch. 333 (H.B. 2090), Sec. 3, eff. September 1, 2021.

Sec. 1662.054. INTERNET-BASED SELF-SERVICE TOOL. (a) A health benefit plan issuer or administrator may develop and maintain an Internet-based self-service tool to provide a disclosure required under this subchapter.

(b) Information provided on the self-service tool must be made available in plain language, without a subscription or other fee, on an Internet website that provides real-time responses based on cost-sharing information that is accurate at the time of the request.

(c) A health benefit plan issuer or administrator shall ensure that the self-service tool allows a user to:

(1) search for cost-sharing information for a covered health care service or supply by a specific network provider or by all network providers by inputting:

(A) a billing code or descriptive term at the option of the user;

(B) the name of the network provider if the user seeks cost-sharing information with respect to a specific network provider; or

(C) other factors used by the issuer or administrator that are relevant for determining the applicable cost-sharing information, including the location in which the service or supply will be sought or provided, the facility name, or the dosage;

(2) search for an out-of-network allowed amount, percentage of billed charges, or other rate that provides a reasonably accurate estimate of the amount the issuer or administrator will pay for a covered health care service or supply provided by an out-of-network provider by inputting:

(A) a billing code or descriptive term at the option of the user; or

(B) other factors used by the issuer or administrator that are relevant for determining the applicable out-of-network allowed amount or other rate, including the location in which the covered health care service or supply will be sought or provided; and

(3) refine and reorder search results based on geographic proximity of network providers and the amount of the enrollee's estimated cost-sharing liability for the covered health care service or supply if the search returns multiple results.

Added by Acts 2021, 87th Leg., R.S., Ch. 333 (H.B. 2090), Sec. 3, eff. September 1, 2021.

Sec. 1662.055. PHYSICAL COPY OF DISCLOSURE. (a) A health benefit plan issuer or administrator shall make the disclosure required under this subchapter available in a physical form. A disclosure under this section must be made available in plain language, without a fee, at the request of the enrollee.

(b) In providing a disclosure under this section, a health benefit plan issuer or administrator may limit the number of health care providers with respect to which cost-sharing information for a covered health care service or supply is provided to no fewer than 20 providers per request.

(c) A health benefit plan issuer or administrator providing a disclosure under this section shall:

(1) disclose any applicable provider-per-request limit described by Subsection (b) to the enrollee;

(2) provide the cost-sharing information in a physical form in accordance with the enrollee's request as if the request was made

using a self-service tool under Section 1662.054; and

(3) mail the disclosure not later than two business days after the date the enrollee's request is received.

Added by Acts 2021, 87th Leg., R.S., Ch. 333 (H.B. 2090), Sec. 3, eff. September 1, 2021.

Sec. 1662.056. OTHER MEANS OF DISCLOSURE. If an enrollee requests the disclosure required by this subchapter by a means other than a physical copy or the self-service tool described by Section 1662.054, a health benefit plan issuer or administrator may provide the disclosure through the requested means if:

(1) the enrollee agrees that disclosure through that means is sufficient to satisfy the request;

(2) the request is fulfilled at least as rapidly as required for the physical copy; and

(3) the disclosure includes the information required for a physical copy under Section 1662.055.

Added by Acts 2021, 87th Leg., R.S., Ch. 333 (H.B. 2090), Sec. 3, eff. September 1, 2021.

Sec. 1662.057. OTHER CONTRACTUAL AGREEMENTS. (a) A health benefit plan issuer or administrator may satisfy the requirements of this subchapter by entering into a written agreement under which another person, including a pharmacy benefit manager or other third party, provides the disclosure required under this subchapter.

(b) If a health benefit plan issuer or administrator and another person enter into an agreement under Subsection (a), the issuer or administrator is subject to an enforcement action for failure to provide a required disclosure in accordance with this subchapter.

Added by Acts 2021, 87th Leg., R.S., Ch. 333 (H.B. 2090), Sec. 3, eff. September 1, 2021.

Sec. 1662.058. COMPLIANCE WITH SUBCHAPTER. (a) A health benefit plan issuer or administrator that, acting in good faith and

with reasonable diligence, makes an error or omission in a disclosure required under this subchapter does not fail to comply with this subchapter solely because of the error or omission if the issuer or administrator corrects the error or omission as soon as practicable.

(b) A health benefit plan issuer or administrator, acting in good faith and with reasonable diligence, does not fail to comply with this subchapter solely because the issuer's or administrator's Internet website is temporarily inaccessible if the issuer or administrator makes the information available as soon as practicable.

(c) To the extent compliance with this subchapter requires a health benefit plan issuer or administrator to obtain information from another person, the issuer or administrator does not fail to comply with the subchapter because the issuer or administrator relies in good faith on information from the other person unless the issuer or administrator knows or reasonably should have known that the information is incomplete or inaccurate.

Added by Acts 2021, 87th Leg., R.S., Ch. 333 (H.B. 2090), Sec. 3, eff. September 1, 2021.

SUBCHAPTER C. REQUIRED PUBLIC DISCLOSURES

Sec. 1662.101. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a health benefit plan for which federal reporting requirements under 26 C.F.R. Part 54, 29 C.F.R. Part 2590, and 45 C.F.R. Parts 147 and 158 do not apply.

Added by Acts 2021, 87th Leg., R.S., Ch. 333 (H.B. 2090), Sec. 3, eff. September 1, 2021.

Sec. 1662.102. PUBLICATION REQUIRED. A health benefit plan issuer or administrator shall publish on an Internet website the information required under Section 1662.103 in three machine-readable files in accordance with this subchapter.

Added by Acts 2021, 87th Leg., R.S., Ch. 333 (H.B. 2090), Sec. 3, eff. September 1, 2021.

Sec. 1662.103. REQUIRED INFORMATION. (a) A health benefit plan

issuer or administrator shall publish the following information:

(1) a network rate machine-readable file that includes the following information for all covered health care services and supplies, except for prescription drugs that are subject to a fee-for-service reimbursement arrangement:

(A) for each coverage option offered by a health benefit plan issuer or administered by a health benefit plan administrator, the option's name and:

(i) the option's 14-digit health insurance oversight system identifier;

(ii) if the 14-digit identifier is not available, the option's 5-digit health insurance oversight system identifier; or

(iii) if the 14- and 5-digit identifiers are not available, the employer identification number associated with the option;

(B) a billing code, which must be the national drug code for a prescription drug, and a plain-language description for each billing code for each covered service or supply under each coverage option offered by the issuer or administered by the administrator; and

(C) all applicable rates, including negotiated rates, underlying fee schedules, or derived amounts, provided in accordance with Section 1662.104;

(2) an out-of-network allowed amount machine-readable file, including:

(A) for each coverage option offered by a health benefit plan issuer or administered by a health benefit plan administrator, the option's name and:

(i) the option's 14-digit health insurance oversight system identifier;

(ii) if the 14-digit identifier is not available, the option's 5-digit health insurance oversight system identifier; or

(iii) if the 14- and 5-digit identifiers are not available, the employer identification number associated with the option;

(B) a billing code, which must be the national drug code for a prescription drug, and a plain-language description for each billing code for each covered service or supply under each coverage option offered by the issuer or administered by the administrator; and

(C) except as provided by Subsection (b), unique out-of-network billed charges and allowed amounts provided in accordance with Section 1662.105 for covered health care services or supplies provided by out-of-network providers during the 90-day period that begins on the 180th day before the date the machine-readable file is published; and

(3) a prescription drug machine-readable file that includes:

(A) for each coverage option offered by a health benefit plan issuer or administered by a health benefit plan administrator, the option's name and:

(i) the option's 14-digit health insurance oversight system identifier;

(ii) if the 14-digit identifier is not available, the option's 5-digit health insurance oversight system identifier; or

(iii) if the 14- and 5-digit identifiers are not available, the employer identification number associated with the option;

(B) the national drug code and the proprietary and nonproprietary name assigned to the national drug code by the United States Food and Drug Administration for each covered prescription drug provided under each coverage option offered by the issuer or administered by the administrator;

(C) the negotiated rates, which must be:

(i) reflected as a dollar amount with respect to each national drug code that is provided by a network provider, including a network pharmacy or other prescription drug dispenser;

(ii) associated with the national provider identifier, tax identification number, and place of service code for each network provider, including each network pharmacy or other prescription drug dispenser; and

(iii) associated with the last date of the contract term for each provider-specific negotiated rate that applies to each national drug code; and

(D) except as provided by Subsection (b), historical net prices, which must be:

(i) reflected as a dollar amount with respect to each national drug code that is provided by a network provider, including a network pharmacy or other prescription drug dispenser;

(ii) associated with the national provider

identifier, tax identification number, and place of service code for each network provider, including each network pharmacy or other prescription drug dispenser; and

(iii) associated with the 90-day period that begins on the 180th day before the date the machine-readable file is published for each provider-specific historical net price calculated in accordance with Section 1662.106 that applies to each national drug code.

(b) A health benefit plan issuer or administrator shall omit information described by Subsection (a)(2)(C) or (a)(3)(D) in relation to a particular health care service or supply if compliance with that subsection would require the issuer to report payment information in connection with fewer than 20 different claims for payments under a single health benefit plan.

(c) This section does not require the disclosure of information that would violate any applicable health information privacy law.

Added by Acts 2021, 87th Leg., R.S., Ch. 333 (H.B. 2090), Sec. 3, eff. September 1, 2021.

Sec. 1662.104. NETWORK RATE DISCLOSURES. (a) If a health benefit plan issuer or administrator does not use negotiated rates for health care provider reimbursement, the issuer or administrator shall disclose for purposes of Section 1662.103(a)(1)(C) derived amounts to the extent those amounts are already calculated in the normal course of business.

(b) If a health benefit plan issuer or administrator uses underlying fee schedule rates for calculating cost sharing, the issuer or administrator shall disclose for purposes of Section 1662.103(a)(1)(C) the underlying fee schedule rates in addition to the negotiated rate or derived amount.

(c) The applicable rates, including for both individual health care services and supplies and services and supplies in a bundled payment arrangement, that a health benefit plan issuer or administrator must provide under Section 1662.103(a)(1)(C) must be:

(1) except as provided by Subdivision (2), reflected as dollar amounts with respect to each covered health care service or supply that is provided by a network provider;

(2) the base negotiated rate applicable to the service or

supply before an adjustment for enrollee characteristics if the rate is a negotiated rate subject to change based on enrollee characteristics;

(3) associated with the national provider identifier, tax identification number, and place of service code for each network provider;

(4) associated with the last date of the contract term or expiration date for each health care provider-specific applicable rate that applies to each covered service or supply; and

(5) indicated with a notation where a reimbursement arrangement other than a standard fee-for-service model, including capitation or a bundled payment arrangement, applies.

Added by Acts 2021, 87th Leg., R.S., Ch. 333 (H.B. 2090), Sec. 3, eff. September 1, 2021.

Sec. 1662.105. OUT-OF-NETWORK ALLOWED AMOUNTS. (a) An out-of-network allowed amount provided under Section 1662.103(a)(2)(C) must be:

(1) reflected as a dollar amount with respect to each covered health care service or supply that is provided by an out-of-network provider; and

(2) associated with the national provider identifier, tax identification number, and place of service code for each out-of-network provider.

(b) This subchapter does not prohibit a health benefit plan issuer or administrator from satisfying the disclosure requirements described by Section 1662.103(a)(2)(C) by disclosing out-of-network allowed amounts made available by, or otherwise obtained from, an issuer, a health care provider, or other party with which the issuer or administrator has entered into a written agreement to provide the information if the minimum claim threshold described by Section 1662.103(b) is independently met for each health care service or supply and for each plan included in an aggregated allowed amount file.

(c) If a health benefit plan issuer or administrator enters into an agreement under Subsection (b), the health benefit plan issuers, health care providers, or other persons with which the issuer or administrator has contracted may aggregate out-of-network

allowed amounts for more than one plan.

(d) This subchapter does not prohibit a third party from hosting an allowed amount file on its Internet website or a health benefit plan issuer or administrator from contracting with a third party to post the file. If the issuer or administrator does not host the file separately on its Internet website, the issuer or administrator shall provide a link on its Internet website to the location where the file is made publicly available.

Added by Acts 2021, 87th Leg., R.S., Ch. 333 (H.B. 2090), Sec. 3, eff. September 1, 2021.

Sec. 1662.106. HISTORICAL NET PRICE. (a) For purposes of determining the historical net price for a prescription drug, the allocation of price concessions is determined by the dollar value for non-product specific and product-specific rebates, discounts, chargebacks, fees, and other price concessions to the extent that the total amount of any such price concession is known to the health benefit plan issuer or administrator at the time of publication of the historical net price under Section 1662.103(a)(3)(D).

(b) To the extent that the total amount of any non-product specific and product-specific rebates, discounts, chargebacks, fees, or other price concessions is not known to a health benefit plan issuer or administrator at the time of publication of the historical net price under Section 1662.103(a)(3)(D), the issuer or administrator shall allocate those price concessions by using a good faith, reasonable estimate of the average price concessions based on the price concessions received over a period before the current reporting period and of equal duration to the current reporting period.

Added by Acts 2021, 87th Leg., R.S., Ch. 333 (H.B. 2090), Sec. 3, eff. September 1, 2021.

Sec. 1662.107. REQUIRED METHOD AND FORMAT FOR DISCLOSURE. The machine-readable files described by Section 1662.103 must be available in a form and manner prescribed by department rule. The files must be available and accessible to any person free of charge and without conditions, including establishment of a user account,

password, or other credentials, or submission of personally identifiable information to access the file.

Added by Acts 2021, 87th Leg., R.S., Ch. 333 (H.B. 2090), Sec. 3, eff. September 1, 2021.

Sec. 1662.108. FILE UPDATES. A health benefit plan issuer or administrator shall update the machine-readable files described by Section 1662.103 and the information described by this subchapter monthly. The issuer or administrator must clearly indicate in the files the date that the files were most recently updated.

Added by Acts 2021, 87th Leg., R.S., Ch. 333 (H.B. 2090), Sec. 3, eff. September 1, 2021.

Sec. 1662.109. OTHER CONTRACTUAL AGREEMENTS. (a) A health benefit plan issuer or administrator may satisfy the requirements of this subchapter by entering into a written agreement under which another person, including a third-party administrator or health care claims clearinghouse, provides the disclosure required under this subchapter in compliance with this subchapter.

(b) If a health benefit plan issuer or administrator and another person enter into an agreement under Subsection (a), the issuer or administrator is subject to an enforcement action for failure to provide a required disclosure in accordance with this subchapter.

Added by Acts 2021, 87th Leg., R.S., Ch. 333 (H.B. 2090), Sec. 3, eff. September 1, 2021.

Sec. 1662.110. COMPLIANCE WITH SUBCHAPTER. (a) A health benefit plan issuer or administrator that, acting in good faith and with reasonable diligence, makes an error or omission in a disclosure required under this subchapter does not fail to comply with this subchapter solely because of the error or omission if the issuer or administrator corrects the error or omission as soon as practicable.

(b) A health benefit plan issuer or administrator, acting in good faith and with reasonable diligence, does not fail to comply

with this subchapter solely because the issuer's or administrator's Internet website is temporarily inaccessible if the issuer or administrator makes the information available as soon as practicable.

(c) To the extent compliance with this subchapter requires a health benefit plan issuer or administrator to obtain information from another person, the issuer or administrator does not fail to comply with the subchapter because the issuer or administrator relies in good faith on information from the other person unless the issuer or administrator knows or reasonably should have known that the information is incomplete or inaccurate.

Added by Acts 2021, 87th Leg., R.S., Ch. 333 (H.B. 2090), Sec. 3, eff. September 1, 2021.

**SUBTITLE K. CERTAIN BENEFITS AND ARRANGEMENTS THAT ARE NOT INSURANCE
CHAPTER 1681. HEALTH CARE SHARING MINISTRIES**

Sec. 1681.001. TREATMENT AS HEALTH CARE SHARING MINISTRY. A faith-based, nonprofit organization that is tax-exempt under the Internal Revenue Code of 1986 qualifies for treatment as a health care sharing ministry under this chapter if it:

- (1) limits its participants to individuals of a similar faith;
- (2) acts as a facilitator among participants who have medical bills and matches those participants with other participants with the present ability to assist those with medical bills in accordance with criteria established by the health care sharing ministry;
- (3) provides for the medical bills of a participant through contributions from one participant to another;
- (4) provides amounts that participants may contribute with no assumption of risk or promise to pay among the participants and no assumption of risk or promise to pay by the health care sharing ministry to the participants;
- (5) provides a written monthly statement to all participants that lists the total dollar amount of qualified needs submitted to the health care sharing ministry, as well as the amount actually published or assigned to participants for their contribution;
- (6) discloses administrative fees and costs to

participants;

(7) provides that any card issued to a participant for the purpose of presentation to a health care provider clearly indicates that the participant is part of a health care sharing ministry that is not engaging in the business of insurance;

(8) provides a written disclaimer on or accompanying all applications and guideline materials distributed by or on behalf of the ministry that complies with Section 1681.002; and

(9) does not operate a discount health care program as defined by Section 7001.001.

Added by Acts 2013, 83rd Leg., R.S., Ch. 455 (S.B. 874), Sec. 1, eff. June 14, 2013.

Sec. 1681.002. NOTICE. To qualify as a health care sharing ministry under this chapter, the notice described by Section 1681.001(8) must read substantially as follows:

"Notice: This health care sharing ministry facilitates the sharing of medical expenses and is not an insurance company, and neither its guidelines nor its plan of operation is an insurance policy. Whether anyone chooses to assist you with your medical bills will be totally voluntary because no other participant will be compelled by law to contribute toward your medical bills. As such, participation in the ministry or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive any payment for medical expenses or whether this ministry continues to operate, you are always personally responsible for the payment of your own medical bills. Complaints concerning this health care sharing ministry may be reported to the office of the Texas attorney general."

Added by Acts 2013, 83rd Leg., R.S., Ch. 455 (S.B. 874), Sec. 1, eff. June 14, 2013.

Sec. 1681.003. EXEMPTION. Notwithstanding any other provision of this code, a health care sharing ministry that acts in accordance with this chapter is not considered to be engaging in the business of insurance.

Added by Acts 2013, 83rd Leg., R.S., Ch. 455 (S.B. 874), Sec. 1, eff. June 14, 2013.

CHAPTER 1682. HEALTH BENEFITS PROVIDED BY CERTAIN NONPROFIT AGRICULTURAL ORGANIZATIONS

Sec. 1682.001. DEFINITIONS. In this chapter:

- (1) "Nonprofit agricultural organization" means an organization that:
- (A) is exempt from taxation under Section 501(a), Internal Revenue Code of 1986, as an organization described by Section 501(c)(5) of that code;
 - (B) is domiciled in this state;
 - (C) was in existence prior to 1940;
 - (D) is composed of members who are residents of at least 98 percent of the counties in this state;
 - (E) collects annual dues from its members; and
 - (F) was created to promote and develop the most profitable and desirable system of agriculture and the most wholesome and satisfactory conditions of rural life in accordance with its articles of organization and bylaws.
- (2) "Nonprofit agricultural organization health benefits" means health benefits:
- (A) sponsored by a nonprofit agricultural organization or an affiliate of the organization;
 - (B) offered only to:
 - (i) members of the nonprofit agricultural organization; and
 - (ii) family members of members of the nonprofit agricultural organization;
 - (C) that are not provided through an insurance policy or other product the offering or issuance of which is regulated as the business of insurance in this state; and
 - (D) that are deemed by the nonprofit agricultural organization to be important in assisting its members to live long and productive lives.
- (3) "Preexisting condition" means a condition present before the effective date of an individual's enrollment in nonprofit agricultural organization health benefits.

Added by Acts 2021, 87th Leg., R.S., Ch. 1034 (H.B. 3924), Sec. 3, eff. September 1, 2021.

Sec. 1682.002. NONPROFIT AGRICULTURAL ORGANIZATION HEALTH BENEFITS AUTHORIZED. A nonprofit agricultural organization or an affiliate of the organization may offer in this state nonprofit agricultural organization health benefits.

Added by Acts 2021, 87th Leg., R.S., Ch. 1034 (H.B. 3924), Sec. 3, eff. September 1, 2021.

Sec. 1682.003. WAITING PERIOD FOR PREEXISTING CONDITION. Notwithstanding any other provision of this chapter, a nonprofit agricultural organization that offers nonprofit agricultural organization health benefits may not require a waiting period of more than six months for treatment of a preexisting condition otherwise included in nonprofit agricultural organization health benefits.

Added by Acts 2021, 87th Leg., R.S., Ch. 1034 (H.B. 3924), Sec. 3, eff. September 1, 2021.

Sec. 1682.004. REQUIRED DISCLOSURE BY NONPROFIT AGRICULTURAL ORGANIZATION. (a) A nonprofit agricultural organization that offers nonprofit agricultural organization health benefits must provide to an individual applying for nonprofit agricultural organization health benefits written notice that the benefits are not provided through an insurance policy or other product the offering or issuance of which is regulated as the business of insurance in this state.

(b) An individual must sign and return to the nonprofit agricultural organization the notice described by Subsection (a) before the individual may enroll in nonprofit agricultural organization health benefits. The nonprofit agricultural organization must:

(1) maintain a copy of the signed written notice for the duration of the term during which the nonprofit agricultural organization health benefits are provided to the individual; and

(2) at the request of the individual, provide a copy of the written notice to the individual.

Added by Acts 2021, 87th Leg., R.S., Ch. 1034 (H.B. 3924), Sec. 3, eff. September 1, 2021.

Sec. 1682.005. NONPROFIT AGRICULTURAL ORGANIZATION NOT ENGAGED IN BUSINESS OF HEALTH INSURANCE. Notwithstanding any other provision of this code, for the purposes of offering nonprofit agricultural organization health benefits, a nonprofit agricultural organization that acts in accordance with this chapter is not a health insurer and is not engaging in the business of health insurance in this state.

Added by Acts 2021, 87th Leg., R.S., Ch. 1034 (H.B. 3924), Sec. 3, eff. September 1, 2021.

Sec. 1682.006. RISK TRANSFER OR COVERAGE. A nonprofit agricultural organization that offers nonprofit agricultural organization health benefits under this chapter may contract with a company authorized to engage in the business of insurance in this state that is not under common control with the nonprofit agricultural organization to:

(1) transfer to that company all or a portion of the organization's risks arising from nonprofit agricultural organization health benefits offered under this chapter; or

(2) obtain insurance coverage from the company guarantying the nonprofit agricultural organization's obligations arising from nonprofit agricultural organization health benefits offered under this chapter.

Added by Acts 2021, 87th Leg., R.S., Ch. 1034 (H.B. 3924), Sec. 3, eff. September 1, 2021.

SUBTITLE L. QUALIFIED HEALTH PLAN MANDATORY DISCLOSURES
CHAPTER 1693. QUALIFIED HEALTH PLAN IDENTIFICATION CARDS

Sec. 1693.001. DEFINITIONS. Except as provided by Section 1693.003, in this chapter, "enrollee," "exchange," "qualified health plan," and "qualified health plan issuer" have the meanings assigned by 45 C.F.R. Section 155.20 as that section existed on January 1, 2015.

Added by Acts 2015, 84th Leg., R.S., Ch. 732 (H.B. 1514), Sec. 1, eff. September 1, 2015.

Sec. 1693.002. REQUIRED INFORMATION. An identification card or other similar document issued by a qualified health plan issuer to an enrollee of a qualified health plan purchased through an exchange must, in addition to any requirement under other law, including Sections 843.209, 1301.162, and 1369.153, display on the card or document in a location of the issuer's choice the acronym "QHP."

Added by Acts 2015, 84th Leg., R.S., Ch. 732 (H.B. 1514), Sec. 1, eff. September 1, 2015.

Sec. 1693.003. COMMISSIONER DETERMINATIONS REGARDING FEDERAL REGULATIONS. (a) The commissioner shall monitor 45 C.F.R. Section 155.20 for amendments to the definitions listed in Section 1693.001 and determine if it is in the best interest of the state to adopt an amended definition for purposes of this chapter. If the commissioner determines that it is in the best interest of the state to adopt the amended definition, the commissioner by rule shall adopt the amended definition.

(b) In making the determination about an amendment, the commissioner shall consider, in addition to other factors affecting the public interest, the beneficial and adverse effects the amendment may have on:

- (1) individuals who are receiving medical care and health care services in this state; and
- (2) health care providers and physicians.

Added by Acts 2015, 84th Leg., R.S., Ch. 732 (H.B. 1514), Sec. 1, eff. September 1, 2015.

Sec. 1693.004. REPORT TO LEGISLATURE. The commissioner shall prepare a report of a determination made under Section 1693.003, including an explanation of the reasons for the determination, and file the report with the presiding officer of each house of the legislature not later than the 30th day after the date the determination is made.

Added by Acts 2015, 84th Leg., R.S., Ch. 732 (H.B. 1514), Sec. 1, eff. September 1, 2015.

Sec. 1693.005. RULES. The commissioner may adopt rules as necessary to administer and enforce this chapter.

Added by Acts 2015, 84th Leg., R.S., Ch. 732 (H.B. 1514), Sec. 1, eff. September 1, 2015.

**SUBTITLE M. FEDERAL PATIENT PROTECTION AND AFFORDABLE CARE ACT
CHAPTER 1695. LEGISLATIVE CONSIDERATIONS**

Sec. 1695.001. CONSTITUTIONALITY OF PATIENT PROTECTION AND AFFORDABLE CARE ACT. This subtitle does not constitute an acknowledgment by the legislature of the legitimacy of the Patient Protection and Affordable Care Act (Pub. L. No. 111-148) as a constitutional exercise of the power of the United States Congress.

Added by Acts 2017, 85th Leg., 1st C.S., Ch. 5 (H.B. 214), Sec. 1, eff. December 1, 2017.

CHAPTER 1696. COVERAGE FOR ELECTIVE ABORTION; PROHIBITIONS AND REQUIREMENTS

Sec. 1696.001. DEFINITIONS. In this chapter:

(1) "Elective abortion" means an abortion, as defined by Section 245.002, Health and Safety Code, other than an abortion performed due to a medical emergency as defined by Section 171.002, Health and Safety Code.

(2) "Health benefit exchange" means an American Health Benefit Exchange administered by the federal government or created under Section 1311(b) of the Patient Protection and Affordable Care Act (42 U.S.C. Section 18031(b)).

(3) "Qualified health plan" has the meaning assigned by Section 1301(a) of the Patient Protection and Affordable Care Act (42 U.S.C. Section 18021(a)).

Added by Acts 2017, 85th Leg., 1st C.S., Ch. 5 (H.B. 214), Sec. 1, eff. December 1, 2017.

Sec. 1696.002. PROHIBITED COVERAGE THROUGH HEALTH BENEFIT EXCHANGE. (a) A qualified health plan offered through a health benefit exchange may not provide coverage for elective abortion.

(b) This section does not prevent a person from purchasing optional or supplemental coverage for elective abortion under a health benefit plan other than a qualified health plan offered through a health benefit exchange.

Added by Acts 2017, 85th Leg., 1st C.S., Ch. 5 (H.B. 214), Sec. 1, eff. December 1, 2017.

SUBTITLE N. RATES

CHAPTER 1698. RATES FOR CERTAIN COVERAGE

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1698.001. APPLICABILITY OF CHAPTER. This chapter applies only to rates for the following health benefit plans:

- (1) an individual major medical expense insurance policy to which Chapter 1201 applies;
- (2) individual health maintenance organization coverage; or
- (3) a small employer health benefit plan provided under Chapter 1501.

Added by Acts 2021, 87th Leg., R.S., Ch. 877 (S.B. 1296), Sec. 1, eff. September 1, 2021.

Sec. 1698.002. APPLICABILITY OF OTHER LAWS GOVERNING RATES. The requirements of this chapter are in addition to any other provision of this code governing health benefit plan rates. Except as otherwise provided by this chapter, in the case of a conflict between this chapter and another provision of this code, this chapter controls.

Added by Acts 2021, 87th Leg., R.S., Ch. 877 (S.B. 1296), Sec. 1, eff. September 1, 2021.

SUBCHAPTER B. REVIEW OF RATES

Sec. 1698.051. REVIEW OF PREMIUM RATES. (a) In this section:

- (1) "Individual health benefit plan" means:

(A) an individual accident and health insurance policy to which Chapter 1201 applies; or

(B) individual health maintenance organization coverage.

(2) "Small employer health benefit plan" has the meaning assigned by Section 1501.002.

(b) The commissioner by rule shall establish a process under which the commissioner reviews health benefit plan rates and rate changes for compliance with this chapter and other applicable state and federal law, including 42 U.S.C. Sections 300gg, 300gg-94, and 18032(c) and those sections' implementing regulations, including rules establishing geographic rating areas.

Added by Acts 2021, 87th Leg., R.S., Ch. 877 (S.B. [1296](#)), Sec. 1, eff. September 1, 2021.

Sec. 1698.052. ADDITIONAL RULES AND GUIDANCE RELATED TO INDIVIDUAL HEALTH PLAN RATES. (a) In this section, "qualified health plan" has the meaning assigned by Section 1301(a), Patient Protection and Affordable Care Act (42 U.S.C. Section 18021).

(b) The commissioner shall adopt rules and provide guidance regarding additional requirements related to individual health benefit plans, including qualified health plans, to address the following factors:

(1) whether the plan issuer has complied with all requirements for pooling risk and participating in risk adjustment programs in effect under state or federal law;

(2) the covered benefits or health benefit plan design or, for a rate change, any changes to the benefits or design;

(3) the allowable variations for case characteristics, risk classifications, and participation in programs promoting wellness; and

(4) any other factor listed in 45 C.F.R. Section 154.301(a)(4) to the extent applicable.

(c) In making a determination under this section regarding a proposed rate for a qualified health plan, the commissioner shall consider, in addition to the factors under Subsection (b), the following factors:

(1) the purchasing power of consumers who are eligible for

a premium subsidy under the Patient Protection and Affordable Care Act (Pub. L. No. 111-148);

(2) if the plan is in the silver level, as described by 42 U.S.C. Section 18022(d), whether the rate is appropriate for the plan in relation to the rates charged for qualified health plans offering different levels of coverage, taking into account any funding or lack of funding for cost-sharing reductions and the covered benefits for each level of coverage; and

(3) whether the plan issuer utilized the induced demand factors developed by the Centers for Medicare and Medicaid Services for the risk adjustment program established under 42 U.S.C. Section 18063 for the level of coverage offered by the plan or any state-specific induced demand factors established by department regulations.

(d) The commissioner may consider the following factors:

(1) if the commissioner determines appropriate for comparison purposes, medical claims trends reported by plan issuers in this state or in a region of this country or the country as a whole; and

(2) inflation indexes.

Added by Acts 2021, 87th Leg., R.S., Ch. 877 (S.B. [1296](#)), Sec. 1, eff. September 1, 2021.

Sec. 1698.053. PLAN DESIGN FLEXIBILITY WITHIN RATING AREAS. Notwithstanding any other provision of this code, a health benefit plan issuer may:

(1) offer different plan designs by rating area to individuals and small employers; and

(2) provide network access beyond the geographic rating area.

Added by Acts 2021, 87th Leg., R.S., Ch. 877 (S.B. [1296](#)), Sec. 1, eff. September 1, 2021.

Sec. 1698.054. FEDERAL ACTUARIAL LEVELS AND PLAN COST-SHARING. Notwithstanding any other provision of this code, a health benefit plan issuer may offer plan designs with deductibles, coinsurance, and other cost-sharing mechanisms necessary to comply with federal

actuarial values in the individual and small group market in this state.

Added by Acts 2021, 87th Leg., R.S., Ch. 877 (S.B. 1296), Sec. 1, eff. September 1, 2021.

Sec. 1698.055. FEDERAL FUNDING. The commissioner shall seek all available federal funding to cover the cost to the department of reviewing rates under this subchapter.

Added by Acts 2021, 87th Leg., R.S., Ch. 877 (S.B. 1296), Sec. 1, eff. September 1, 2021.

TITLE 9. PROVISIONS APPLICABLE TO LIFE AND HEALTH COVERAGES

CHAPTER 1701. POLICY FORMS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1701.001. DEFINITION. In this chapter, "use" includes issue and deliver.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 5, eff. April 1, 2005.

Sec. 1701.002. APPLICABILITY OF CHAPTER TO FORMS OF CERTAIN DOCUMENTS. This chapter applies to the form of the following document:

- (1) a policy, contract, or certificate of:
 - (A) accident or health insurance, including group accident or health insurance;
 - (B) medical or surgical insurance, including group medical or surgical insurance;
 - (C) life or term insurance, including group life or term insurance;
 - (D) endowment insurance;
 - (E) industrial life insurance; or
 - (F) fraternal benefit insurance;
- (2) an annuity or pure endowment contract, including a group annuity contract;
- (3) an application attached or required to be attached to the policy, contract, or certificate; or

(4) a rider or endorsement to be attached to, printed on, or used in connection with the policy, contract, or certificate.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 5, eff. April 1, 2005.

Sec. 1701.003. APPLICABILITY OF CHAPTER TO CERTAIN INSURERS.

(a) Except as provided by Subsection (b), this chapter applies to any insurer that uses a document described by Section 1701.002 in this state, including:

- (1) a life, accident, health, or casualty insurance company;
- (2) a mutual life insurance company;
- (3) a mutual insurance company other than a mutual life insurance company;
- (4) a mutual or natural premium life insurance company;
- (5) a general casualty company;
- (6) a Lloyd's plan;
- (7) a reciprocal or interinsurance exchange;
- (8) a fraternal benefit society; and
- (9) a group hospital service corporation.

(b) This chapter does not apply to a society, company, or other insurer whose activities are by statute exempt from department control and that is entitled by statute to a certificate from the department showing that exempt status.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 5, eff. April 1, 2005.

Sec. 1701.004. CONSTRUCTION OF CHAPTER. This chapter may not be construed to enlarge the powers of an insurer subject to this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 5, eff. April 1, 2005.

Sec. 1701.005. EXEMPTIONS. (a) This chapter does not apply to:

- (1) a rider or endorsement that is used at the request of the holder of a policy, contract, or certificate subject to this chapter and that relates to:

(A) the manner of distribution of benefits under the policy, contract, or certificate; or

(B) the reservation of rights and benefits under the policy, contract, or certificate; or

(2) the modification of a previously approved insurance policy form for the sole purpose of adding the statement required by Section 154.2021(a)(3), Finance Code.

(b) The commissioner by written order may exempt a document from the requirements of this chapter for the period the commissioner considers proper if the commissioner determines that:

(1) this chapter may not practically be applied to the document;

(2) the document's preparation, use, and meaning have become routine or commonplace; or

(3) the filing and approval of the form of the document are not desirable, appropriate, required, or necessary for the protection of the public.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 5, eff. April 1, 2005.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1190 (H.B. [3762](#)), Sec. 34, eff. September 1, 2009.

Sec. 1701.006. EXEMPTION FOR CERTAIN GROUP ANNUITY TRANSACTIONS. (a) The filing and approval requirements in this chapter do not apply to any group annuity policy, certificate, or contract written or issued by an insurer authorized to engage in the business of insurance in this state that involves use of a separate account if benefits would also have guarantees from an insurer's general account.

(b) For purposes of this section, a group annuity policy, certificate, or contract includes a single premium group annuity policy, certificate, or contract that is negotiated between an insurer and an applicable group or plan sponsor.

Added by Acts 2023, 88th Leg., R.S., Ch. 412 (H.B. [1587](#)), Sec. 3, eff. June 9, 2023.

SUBCHAPTER B. FILING REQUIREMENT

Sec. 1701.051. FILING REQUIRED. (a) Except as provided by Section 1701.005, an insurer may not use a document described by Section 1701.002 in this state unless the form of the document is filed with the department in accordance with this chapter.

(b) Except as provided by Section 1701.052, the insurer must file the form of the document not later than the 60th day before the date the document is used.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 5, eff. April 1, 2005.

Sec. 1701.052. FILE AND USE. (a) An insurer may use a document described by Section 1701.002 immediately after the form of the document is filed if the form, when filed, is accompanied by a certification that meets the requirements of Subsection (b).

(b) The certification accompanying a form must:

(1) be signed by:

(A) an attorney licensed to practice law in this state;

(B) an actuary familiar with the requirements of this code and applicable rules adopted under this code;

(C) the chief executive officer of the insurer; or

(D) an individual designated by the chief executive officer of the insurer; and

(2) affirm that:

(A) the certification is made on behalf of the insurer filing the form;

(B) the insurer is bound by the certification;

(C) the individual making the certification has reviewed the form; and

(D) to the best knowledge, information, and belief of the individual making the certification, the form complies with this code and rules applicable to the form.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 5, eff. April 1, 2005.

Sec. 1701.053. FILING FEE. (a) The department shall collect a fee in an amount determined by the commissioner for the filing of the form of a document under this chapter.

(b) The fee may not exceed:

(1) \$100 for filing the form of a new or amended document

that is not exempt from review under Section 1701.005(b); and

(2) \$50 for filing the form of a new or amended document that is exempt from review under Section 1701.005(b).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 5, eff. April 1, 2005.

Sec. 1701.054. APPROVAL OF FORM. (a) A form filed under this chapter that is not affirmatively approved or disapproved in a written order of the commissioner on or before the 60th day after the date the form is filed is considered approved on the 61st day after the date of filing unless the approval period is extended under this section.

(b) An insurer may request in writing that the approval period for a form be extended for an additional period not to exceed 45 days.

(c) An extension requested under this section is considered granted on the date the department receives the request.

(d) Only one extension may be granted under this section.

(e) If an extension is granted under this section and the commissioner does not affirmatively approve or disapprove the form before the extended period expires, the form is considered approved on the day after the date the extended period expires.

(f) If the commissioner approves a form that is filed without a certification meeting the requirements of Section 1701.052(b) before the expiration of the approval period, including any extension, the remaining portion of the period is waived.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 5, eff. April 1, 2005.

Sec. 1701.055. DISAPPROVAL OF FORM OR WITHDRAWAL OF APPROVAL OR EXEMPTION. (a) Except as provided by Subsection (d), the commissioner may disapprove or, after notice and hearing, withdraw approval of a form if the form:

(1) violates this code, a rule of the commissioner, or any other law; or

(2) contains a provision, title, or heading that is unjust, encourages misrepresentation, or is deceptive.

(b) A form filed under this chapter that contains a coordination of benefits provision may not be approved for use in

this state unless the form provides for the order of benefits determination for insured dependent children. An order of benefits determination provision may not be approved if the provision:

(1) violates this code, a rule of the commissioner, or any other law; or

(2) contains a provision, title, or heading that is unjust, encourages misrepresentation, or is deceptive.

(c) If necessary to accomplish the purpose of Subsection (b), the commissioner may adopt a policy provision and order the inclusion of that provision in a document subject to that subsection.

(d) If a form has been on file with the department for at least 180 days and has previously been affirmatively approved by the commissioner, been considered approved under this chapter, or been exempted from the approval requirements under this chapter, the commissioner may withdraw the approval or exemption only if:

(1) the form violates this code or a rule adopted under this code; or

(2) the commissioner finds proof of gross misrepresentation or fraud to a policyholder.

(e) An order of the commissioner disapproving or withdrawing approval for a form must state the grounds for the disapproval or withdrawal of approval and describe in adequate detail the changes that are necessary to obtain approval.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 5, eff. April 1, 2005.

Sec. 1701.056. USE OF DISAPPROVED FORM PROHIBITED. An insurer who receives written notice that a form filed by the insurer has been disapproved by the commissioner shall immediately stop using the form.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 5, eff. April 1, 2005.

Sec. 1701.057. WITHDRAWAL OF INDIVIDUAL ACCIDENT AND HEALTH INSURANCE POLICY FORM APPROVAL. (a) Except as provided by Subsection (b), the commissioner may, after notice and hearing, withdraw approval of an individual accident and health insurance policy form if, after consideration of all relevant facts, the commissioner determines that:

(1) the benefits provided under the form are unreasonable in relation to the premium charged; or

(2) the reserve required by Section 862.102 is not maintained by the insurer on the policies issued on the form.

(b) If an individual accident and health insurance policy form has been on file with the department for at least 360 days and has been affirmatively approved by the commissioner, been considered approved under this chapter, or been exempted from the approval requirements of this chapter, the commissioner may withdraw the approval or exemption only if:

(1) the form violates this code or a rule adopted under this code; or

(2) the commissioner finds proof of gross misrepresentation or fraud to a policyholder.

(c) To enable the department to determine compliance with Subsection (b), the commissioner:

(1) shall require an insurer to file the rates charged by that insurer for individual accident and health insurance policies; and

(2) may adopt and require an insurer to file in conjunction with the annual statement required under Section 841.255, 982.101, or 982.103 a form for reporting the insurer's experience on individual accident and health insurance policy forms issued by the insurer.

(d) The commissioner shall, in accordance with Section 1201.007, adopt reasonable rules necessary to establish standards under which the approval of an individual accident and health insurance policy form may be withdrawn.

(e) This section does not grant the commissioner the authority to determine, fix, prescribe, or promulgate rates to be charged for an individual accident and health insurance policy.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 5, eff. April 1, 2005.

Sec. 1701.058. RECONSIDERATION OF FORM. (a) Not later than the 45th day after the date of an order of the commissioner disapproving or withdrawing approval of a form under Section 1701.055, an insurer may correct the deficiencies described by the order and file the corrected form with the department for reconsideration by the commissioner.

(b) If the commissioner does not approve or disapprove a form filed for reconsideration under this section on or before the 45th day after the date the form is filed, the form is considered approved on the 46th day after the date the form is filed.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 5, eff. April 1, 2005.

Sec. 1701.059. REPLACEMENT OR AMENDMENT OF DOCUMENT. The commissioner may order an insurer to replace a document described by Section 1701.002 with a corrected document or to amend and correct the document by endorsement or rider if:

- (1) the commissioner disapproves or withdraws approval of the form of the document under Section 1701.055(a); or
- (2) the document is used before the form was approved under this chapter and corrections must be made to the document to bring the document into compliance with this code and rules of the commissioner before the commissioner will approve the form of the document.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 5, eff. April 1, 2005.

Sec. 1701.060. GENERAL RULEMAKING AUTHORITY. (a) The commissioner may adopt reasonable rules necessary to implement the purposes of this chapter, including, after notice and hearing, rules that establish procedures and criteria under which:

- (1) each type of form submitted to the department under this chapter will be reviewed and approved by the commissioner or exempted under Section 1701.005(b); and
- (2) particular types of forms designated by the commissioner may be given a summary review and approval if considered appropriate by the commissioner to expedite review and approval of those forms.

(b) A rule adopted under this chapter may not be repealed or amended until after the first anniversary of the date the rule was adopted unless the commissioner determines that repeal or amendment is in the significant and material interests of the citizens of this state or is necessary as a result of legislative enactment.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 5, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.076(a), eff. September 1, 2005.

Sec. 1701.061. NONINSURANCE BENEFITS. (a) In this section, "noninsurance benefit" means a good or service provided or disclosed as part of a policy or certificate of insurance that is reasonably related to the type of policy or certificate being issued. Examples of noninsurance benefits include:

(1) discount cards for health care programs, vision care programs, dental care programs, prescriptions, physical fitness programs or facilities, or other similar programs;

(2) financial planning, will preparation, or similar services; and

(3) contributions for educational savings on behalf of a policyholder or certificate holder.

(b) An insurer may include a noninsurance benefit that is reasonably related to a policy or certificate as part of the policy or certificate form to be issued to an insured or certificate holder.

(c) A policy form filing that includes a noninsurance benefit shall include:

(1) a description of the noninsurance benefit;

(2) a notice that fully discloses the noninsurance benefit to the policyholder or certificate holder; and

(3) an explanation of any condition on which termination of the noninsurance benefit will occur.

(d) Section 541.061 applies to a noninsurance benefit provided as part of a policy or certificate.

(e) Section 1102.002 does not apply to a noninsurance benefit provided as part of a policy or certificate.

(f) The commissioner may adopt rules to implement this section, including rules to:

(1) determine which noninsurance benefits are reasonably related to the types of insurance subject to this chapter;

(2) ensure that noninsurance benefits included as part of a policy or certificate are not unfairly deceptive or do not otherwise constitute a prohibited inducement; and

(3) address application of other chapters of this code to noninsurance benefits provided as part of a policy or certificate,

including Chapters 82-84, 222, 257, 463, 541-544, 1501, and 1506.

Added by Acts 2007, 80th Leg., R.S., Ch. 695 (H.B. 1847), Sec. 1, eff. June 15, 2007.

Sec. 1701.062. DISCRETIONARY CLAUSES PROHIBITED. (a) An insurer may not use a document described by Section 1701.002 in this state if the document contains a discretionary clause.

(b) A discretionary clause includes a provision that:

(1) purports or acts to bind the claimant to, or grant deference in subsequent proceedings to, adverse eligibility or claim decisions or policy interpretations by the insurer; or

(2) specifies:

(A) that a policyholder or other claimant may not contest or appeal a denial of a claim;

(B) that the insurer's interpretation of the terms of a document or decision to deny coverage or the amount of benefits is binding upon a policyholder or other claimant;

(C) that in an appeal, the insurer's decision about or interpretation of the terms of a document or coverage is binding; or

(D) a standard of review in any appeal process that gives deference to the original claim decision or provides standards of interpretation or review that are inconsistent with the laws of this state, including the common law.

Added by Acts 2011, 82nd Leg., R.S., Ch. 560 (H.B. 3017), Sec. 2, eff. June 17, 2011.

SUBCHAPTER C. SANCTIONS; APPLICABILITY OF OTHER LAWS

Sec. 1701.101. RESTITUTION. (a) The commissioner may order an insurer to make complete restitution to each insured of this state who is financially damaged by the insurer's use of a form filed and used but not approved under this chapter if, after notice and opportunity for hearing, the commissioner determines:

(1) the form does not comply with this code and the rules of the commissioner;

(2) use of the form resulted in financial damage to an insured of this state; and

(3) the insurer intentionally used the form with the

knowledge that it did not comply with this code and the rules of the commissioner.

(b) The commissioner may determine the form and amount of restitution ordered under this section and the period in which the restitution must be made.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 5, eff. April 1, 2005.

Sec. 1701.102. LIMIT ON SANCTIONS. Except as provided by Section 1701.101, the commissioner may not impose penalties or other sanctions on an insurer for the issuance of a document the form of which is filed under Section 1701.052.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 5, eff. April 1, 2005.

Sec. 1701.103. APPLICABILITY OF OTHER LAWS. Except as provided by Section 1701.102, this chapter may not be construed to limit the applicability of any other statute.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 5, eff. April 1, 2005.

SUBCHAPTER D. CERTAIN POLICY APPLICATION FORMS

Sec. 1701.151. POLICY APPLICATION FORM FOR INDIVIDUAL ACCIDENT AND HEALTH POLICY. A policy application form that is required to be or that is attached to an individual accident and health policy shall comply with the rules of the commissioner adopted under Chapter 1201.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 5, eff. April 1, 2005.

TITLE 10. PROPERTY AND CASUALTY INSURANCE

SUBTITLE A. GENERAL PROVISIONS

CHAPTER 1802. PROPERTY AND CASUALTY INSURANCE INITIATIVES TASK FORCE

Sec. 1802.001. PROPERTY AND CASUALTY INSURANCE INITIATIVES TASK FORCE. (a) The commissioner may establish a task force to study the utility and feasibility of instituting various property and casualty insurance initiatives in this state.

(b) The initiatives studied may include:

(1) possible coordination with:

(A) the Texas Economic Development Bank to make certain property and casualty insurance an enterprise zone program under Chapter 2303, Government Code; and

(B) Neighborhood Housing Service (NHS) programs to establish voluntary NHS-Insurance Industry Partnerships;

(2) possible insurance agent programs to increase minority agency access to standard insurance companies, including minority intern programs with insurance companies;

(3) possible tax incentives for insurance written in underserved areas; and

(4) a consumer education program designed to increase the ability of consumers to differentiate among different products and providers in the property and casualty insurance market.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

CHAPTER 1803. REPORTS OF INSURANCE COVERAGE FOR STATE AGENCIES

Sec. 1803.001. DEFINITIONS. In this chapter:

(1) "Insurer" means an insurance company or other entity that is authorized by the department to engage in the business of insurance in this state, including:

(A) a reciprocal or interinsurance exchange;

(B) a mutual insurance company;

(C) a county mutual insurance company; and

(D) a Lloyd's plan.

(2) "State agency" has the meaning assigned by Section 412.001, Labor Code.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1803.002. REPORTING REQUIREMENTS. (a) Each insurer that enters into an insurance policy or other contract or agreement with a state agency for the purchase by the state agency of property, casualty, or liability insurance coverage, including a policy, contract, or agreement subject to competitive bidding requirements, shall report to the State Office of Risk Management the intended sale

of the insurance coverage.

(b) The insurer shall report the intended sale of the insurance coverage not later than the 30th day before the date the sale is scheduled to occur in the manner prescribed by the State Office of Risk Management.

(c) The State Office of Risk Management may require an insurer to submit copies of insurance forms, policies, and other relevant information.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1803.003. FAILURE TO REPORT. An insurer that fails to comply with the reporting requirements of this chapter is subject to sanctions under Chapter 82.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1803.004. RULES. The State Office of Risk Management shall adopt rules as necessary to implement this chapter. The office shall consult with the commissioner in adopting rules.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

CHAPTER 1804. RATES AND FORMS FOR NATIONAL DEFENSE PROJECTS

Sec. 1804.001. APPLICABILITY OF CHAPTER. This chapter applies only to insurance in relation to a national defense project in this state.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1804.002. SPECIAL RATES AND RATING PLANS FOR CASUALTY INSURANCE. (a) The commissioner may promulgate special rates and special rating plans for workers' compensation insurance, automobile

insurance, and other lines of casualty insurance, to apply only to the construction or operation of a national defense project.

(b) The commissioner may promulgate the special rates and special rating plans separately for each class of insurance or in combination for all classes of insurance.

(c) The commissioner may adopt rules as may be necessary, proper, or advisable to place in effect special rates and special rating plans promulgated under this section.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1804.003. SPECIAL RATES AND FORMS FOR MATERIAL DAMAGE INSURANCE. (a) The commissioner may promulgate special rates and forms for fire insurance, windstorm insurance, and other kinds of material damage insurance required or used on a national defense project.

(b) The commissioner may adopt rules incidental to the business described by Subsection (a) and necessary to place in effect special rates and forms promulgated under this section.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

CHAPTER 1805. JOINT UNDERWRITING AND ADVISORY ORGANIZATIONS
SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1805.001. APPLICABILITY OF CHAPTER. This chapter applies to the kinds of insurance and insurers subject to:

- (1) Section 403.002;
- (2) Section 941.003 with respect to the application of a law described by Section 941.003(b)(1) or (c);
- (3) Section 942.003 with respect to the application of a law described by Section 942.003(b)(1) or (c);
- (4) Subchapter A, B, or C, Chapter 5;
- (5) Subchapter H, Chapter 544;
- (6) Subchapter A, Chapter 2301;
- (7) Chapter 252, 253, 254, 255, 426, 1806, 1807, 2001, 2002, 2003, 2004, 2005, 2006, 2008, 2051, 2052, 2053, 2055, 2171, 2251, or 2252;

- (8) Subtitle B or C, Title 10; or
- (9) Chapter 2154, Occupations Code.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2H.001, eff. April 1, 2009.

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.0591(e), eff. September 1, 2007.

SUBCHAPTER B. ADVISORY ORGANIZATIONS

Sec. 1805.051. LICENSE APPLICATION. (a) A corporation, unincorporated association, partnership, or individual may file with the commissioner an application for an advisory organization license for the kinds of insurance specified in the application.

(b) The applicant must:

(1) file with the commissioner:

(A) a copy of the applicant's:

(i) constitution and bylaws;

(ii) article of agreement or association or certificate of incorporation; and

(iii) rules governing the applicant's activities as an advisory organization; and

(B) a statement of qualifications to act as an advisory organization; and

(2) pay a \$100 license fee.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1805.052. ISSUANCE OF LICENSE; TERM. (a) The commissioner shall issue a license to an applicant the commissioner determines is qualified, without regard to:

(1) the state of domicile or residence of the applicant; or

(2) the location of the applicant's place of business.

(b) The commissioner shall grant or deny a license to an applicant not later than the 60th day after the date the commissioner receives the application.

(c) A license issued under this subchapter remains in effect until the commissioner suspends or revokes the license.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1805.053. INFORMATION REPORTED BY ADVISORY ORGANIZATION.

(a) An advisory organization may file with the commissioner prospective loss costs, supplementary rating information, and policy forms. A filing made by an advisory organization under this section is subject to the provisions of this code or other insurance laws of this state governing rate filings.

(b) An advisory organization at least quarterly shall file with the commissioner a list of:

(1) each subscriber company engaging in business in this state; and

(2) the products or information the subscriber company purchases.

(c) On request by the commissioner, an advisory organization shall provide to the department a summary of the actuarial assumptions, trend factors, economic factors, and other criteria used in trending data for companies engaging in business in this state.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1805.054. INSURER'S AUTHORITY TO SUBSCRIBE TO ADVISORY ORGANIZATION. An insurer engaging in business in this state may subscribe to an advisory organization.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1805.055. SUBMISSION, RECEIPT, AND USE OF INFORMATION BY INSURER. (a) Except as provided by Subsection (b), an insurer may submit to or receive from an advisory organization the following only if the advisory organization holds a license issued under this subchapter:

(1) statistical plans;
 (2) historical data;
 (3) prospective loss costs;
 (4) supplementary rating information;
 (5) policy forms and endorsements;
 (6) research;
 (7) rates of individual insurers that are effective at the time the information is submitted or received or that were previously in effect; and

(8) performance of inspections.

(b) An insurer may not:

(1) accept from an advisory organization recommendations for rates; or

(2) submit to or receive from an advisory organization recommendations for profit or expenses other than loss adjustment expenses.

(c) An insurer that subscribes to an advisory organization may use prospective loss costs, supplementary rating information, and policy forms filed by the advisory organization under Section 1805.053(a) and may incorporate the information into the insurer's filings.

(d) Notwithstanding any other law, an insurer that reports data under this subchapter is not relieved of the responsibility of reporting that data directly to the department at the department's request.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1805.056. AUDIT. (a) The department shall require an annual audit of an advisory organization that provides statistics or other information to the department in a proceeding to set rates.

(b) The audit must:

(1) be conducted at the expense of the advisory organization under rules adopted by the commissioner; and

(2) examine the advisory organization's method of collecting, analyzing, and reporting data to ensure the accuracy of data.

(c) The audit may examine source documents within individual

companies.

(d) Except for individual company information, an audit is public information.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1805.057. RATE FILING REVIEW. The commissioner may:

- (1) review the rate filing of an insurer that relies on the prospective loss costs provided by an advisory organization; and
- (2) require the insurer to provide the insurer's actual data and loss experience in addition to the information provided by the advisory organization.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1805.058. PROHIBITED ACTS. (a) An advisory organization may not compile or distribute recommendations for:

- (1) rates; or
- (2) profit or expenses other than loss adjustment expenses.

(b) An insurer or advisory organization may not:

- (1) attempt to monopolize, combine, or conspire with another person to monopolize an insurance market;
- (2) engage in a boycott, on a concerted basis, of an insurance market; or
- (3) make an agreement with another insurer, advisory organization, or person if the agreement has the purpose or effect of restraining trade unreasonably or substantially lessening competition in the business of insurance.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1805.059. DISCIPLINARY ACTION. (a) If, after a hearing, the commissioner determines that the furnishing of specified services by an advisory organization involves an act or practice that is unfair, unreasonable, or otherwise inconsistent with this chapter or

other applicable laws of this state, the commissioner may issue a written order:

(1) specifying the manner in which the act or practice is unfair, unreasonable, or inconsistent with the applicable law; and

(2) requiring the advisory organization to discontinue the act or practice.

(b) In addition to any other remedies available at law, the commissioner may impose a sanction authorized under Chapter 82.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1805.060. SUNSET REVIEW. During the period in which the Sunset Advisory Commission performs its review of the department under Chapter 325, Government Code, the commission shall review the authority granted under this subchapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1805.061. CONFLICT WITH OTHER LAW. To the extent this subchapter conflicts with Section 2053.052(c), 2053.055, 2053.151, 2053.152, or 2053.153, or Subchapter A or C, Chapter 2053, with respect to the setting of rates for workers' compensation insurance, the referenced provision of Chapter 2053 controls.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER C. EXAMINATIONS

Sec. 1805.101. EXAMINATION AUTHORIZED. (a) As often as the department determines expedient, the department may examine a group, association, or other organization referred to in this chapter, including an advisory organization described by Subchapter B.

(b) An officer, manager, agent, or employee of the group, association, or organization may be examined at any time under oath and shall make available any book, record, account, document, or agreement governing the method of operation of the group,

association, or organization.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1805.102. EXAMINATION COSTS. The group, association, or other organization shall pay the reasonable costs of an examination under this subchapter on presentation of a detailed account of the costs.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1805.103. OUT-OF-STATE EXAMINATION. In lieu of an examination under this subchapter, the department may accept the report of an examination made by the insurance supervisory official of another state in accordance with the laws of that state.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER D. CERTAIN PRACTICES IN JOINT UNDERWRITING OR JOINT REINSURANCE

Sec. 1805.151. AUTHORITY OF COMMISSIONER. If, after a hearing, the commissioner determines that an activity or practice of a group, association, or other organization of insurers engaging in joint underwriting or joint reinsurance is unfair, unreasonable, or otherwise inconsistent with this chapter or other applicable law, the commissioner may issue a written order:

- (1) specifying the manner in which the activity or practice is unfair, unreasonable, or inconsistent with the applicable law; and
- (2) requiring the group, association, or organization to discontinue the activity or practice.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

CHAPTER 1806. PROHIBITED PRACTICES AND REBATES RELATED TO POLICIES
SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1806.001. DEFINITION. In this chapter, "nonprofit business association" means a business association that is a nonprofit corporation exempt from federal income taxation under Section 501(a), Internal Revenue Code of 1986, and its subsequent amendments by being described as an exempt organization by Section 501(c)(6) of that code.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1806.002. CONSTRUCTION OF CERTAIN PROVISIONS; SERVICES RELATED TO LOSS CONTROL. (a) Nothing in Section 1806.053, 1806.054, 1806.059, 1806.104, 1806.1041, 1806.153, 1806.1541, or 1806.156 may be construed as:

(1) permitting an unfair method of competition or a false, misleading, or deceptive act or practice under Section 17.46, Business & Commerce Code; or

(2) prohibiting an insurer or an insurer's agent from offering or giving to an insured or applicant, for free or at a discounted price in a manner that is not unfairly discriminatory to insureds or applicants of the same class and of essentially the same hazard, services or other offerings not specified in the insurance policy that relate to loss control of the risks covered under the policy, subject to Subsection (b).

(b) The cost to the insurer or the insurer's agent offering the product or service to any given customer must be reasonable in comparison to that customer's premiums or insurance coverage for the policy class.

(c) Other than for purposes related to loss control of risks covered under the policy, the insurer or insurer's agent offering the product or service may not provide to another person any data or other information obtained about the customer from or in connection with the product or service.

(d) The commissioner may adopt rules as necessary to implement this section.

Added by Acts 2023, 88th Leg., R.S., Ch. 396 (H.B. 1074), Sec. 1, eff. September 1, 2023.

SUBCHAPTER B. PROVISIONS APPLICABLE TO AUTOMOBILE INSURANCE

Sec. 1806.051. APPLICABILITY OF SUBCHAPTER. This subchapter applies to an insurer writing automobile insurance in this state, including an insurance company, corporation, reciprocal or interinsurance exchange, mutual insurance company, association, Lloyd's plan, or other insurer.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1806.052. CONSTRUCTION OF SUBCHAPTER. This subchapter may not be construed to prohibit the modification of rates by a rating plan that is filed in accordance with the requirements of Chapter 2251 or Article 5.13-2, as applicable, that has not been disapproved by the commissioner, and that is designed to encourage the prevention of accidents, and to account for all relevant factors inside and outside this state, including the peculiar hazards and experience of past and prospective individual risks.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1806.053. DISCRIMINATIONS OR DISTINCTIONS. Except as provided by this subchapter, with respect to business written in this state:

(1) an insurer may not discriminate or make a distinction, or permit discrimination or a distinction to be made, among insureds having like hazards with respect to premiums charged for, or dividends or other benefits payable under, an insurance policy;

(2) an insurer or an insurer's agent may not make an insurance contract or an agreement relating to that insurance, other than as expressed in the policy; and

(3) an insurer or an insurer's agent or other representative may not directly or indirectly pay, allow, or give, or offer to pay, allow, or give, as an inducement to the insured, a rebate payable on the policy or a special favor or advantage in the dividends or other benefits to accrue, or anything of value, not

specified in the policy.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 28 (S.B. 840), Sec. 2, eff. September 1, 2013.

Sec. 1806.054. OTHER PROHIBITED INDUCEMENTS. Except as provided by Section 1806.055, 1806.056, or 1806.057, an insurer or an insurer's officer, director, agent, or other representative may not, for the purpose of writing the insurance of an insured, grant to the insured or contract with the insured for a special favor or advantage in dividends or other profits, or commissions or dividends of commissions or profits to accrue on the policy, or compensation or other valuable consideration not specified in the policy, or an inducement not specified in the policy.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1806.055. PROFIT SHARING AUTHORIZED; CERTAIN PROHIBITIONS.

(a) Section 1806.054 does not prohibit an insurer from sharing earned profits with the insurer's policyholders under a profit sharing agreement contained in the policy if:

(1) the insurer shares profits uniformly among those insured under the policy; and

(2) the insurer distributes earnings equitably among those insureds under the terms of the policy.

(b) An insurer may not:

(1) discriminate in the distribution of profits among insureds of the same class;

(2) distribute the profit to an insured before the expiration of the policy; or

(3) establish a class of insureds for the distribution of profits, except on the commissioner's approval.

(c) A violation of this section is unjust discrimination and rebating.

(d) The commissioner may revoke the certificate of authority of

an insurer that violates this section or the license of an agent who violates this section.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1806.056. PROFIT SHARING BASED ON COMBAT DUTY AUTHORIZED.

(a) This subchapter does not prohibit an insurer from distributing to policyholders who are on active duty in the United States Armed Forces any estimated profits resulting from service by those policyholders in a foreign country in a combat theater of operations after January 1, 1990.

(b) An insurer that elects to make distributions under this section must:

(1) file a written application describing the insurer's distribution with the commissioner for approval of a policyholder dividend amount that exceeds 10 percent of surplus; or

(2) notify the commissioner in writing of each distribution of a policyholder dividend amount that is not greater than 10 percent of surplus.

(c) If the commissioner does not act on the application on or before the fifth business day after the date the commissioner receives the application, the distribution is considered approved.

(d) An insurer may distribute estimated profits among policyholders under this section based on:

(1) the time served by a policyholder in a combat theater of operations;

(2) the location of the policyholder's military service;

(3) the duration of the applicable insurance policy; or

(4) any other reasonable basis.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 463 (S.B. 1006), Sec. 2, eff. June 14, 2013.

Sec. 1806.057. PROFIT SHARING WITH MEMBERS OF CERTAIN ASSOCIATIONS AUTHORIZED. (a) Section 1806.054 does not prohibit an

insurer from sharing profits with policyholders who are part of a group program established by a nonprofit business association and who participate in the group program because of membership in the association.

(b) An insurer that elects to make distributions under this section must:

(1) file a written application describing the insurer's distribution with the commissioner for approval of a policyholder dividend amount that exceeds 10 percent of surplus; or

(2) notify the commissioner in writing of each distribution of a policyholder dividend amount that is not greater than 10 percent of surplus.

(c) If the commissioner does not act on the application on or before the fifth business day after the date the commissioner receives the application, the distribution is considered approved.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 463 (S.B. 1006), Sec. 3, eff. June 14, 2013.

Sec. 1806.058. PARTICIPATING POLICIES. (a) This subchapter, Subtitle C, and Subchapter A, Chapter 5, may not be construed to prohibit:

(1) a stock company, mutual insurance company, reciprocal or interinsurance exchange, or Lloyd's plan from operating under this subchapter, Subchapter A, Chapter 5, and Subtitle C; or

(2) a stock company, mutual insurance company, reciprocal or interinsurance exchange, or Lloyd's plan from issuing participating policies.

(b) An insurer must obtain commissioner approval before distributing a policyholder dividend if the dividend amount exceeds 10 percent of surplus. The commissioner may not approve a distribution of profits or dividends until the insurer has adequate reserves. The reserves must be computed on the same basis for all classes of insurers operating under this subchapter, Subtitle C, and Subchapter A, Chapter 5.

(c) The insurer must notify the commissioner in writing of each

distribution if the insurer's policyholder dividend amount is not greater than 10 percent of surplus.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 463 (S.B. 1006), Sec. 4, eff. June 14, 2013.

Sec. 1806.059. CERTAIN PROMOTIONAL PRACTICES AUTHORIZED.

Section 1806.053 does not prohibit an insurer or an insurer's agent or other representative from, in connection with an offer or sale of an insurance policy subject to this subchapter, giving, providing, or allowing or offering to give, provide, or allow an item that is a promotional advertising item, educational item, or traditional courtesy commonly extended to consumers and that is valued at \$25 or less.

Added by Acts 2013, 83rd Leg., R.S., Ch. 28 (S.B. 840), Sec. 3, eff. September 1, 2013.

**SUBCHAPTER C. PROVISIONS APPLICABLE TO CASUALTY INSURANCE
AND FIDELITY, GUARANTY, AND SURETY BONDS**

Sec. 1806.101. DEFINITIONS. In this subchapter:

- (1) "Insurance" includes a suretyship.
- (2) "Insurer" means an insurance company or other legal entity described by Sections 1806.102(a) and (b).
- (3) "Policy" includes a bond.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.032(a), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.032(a), eff. September 1, 2007.

Sec. 1806.102. APPLICABILITY OF SUBCHAPTER. (a) This

subchapter applies to an insurer, including a corporation, reciprocal or interinsurance exchange, mutual insurance company, association, Lloyd's plan, or other organization, writing casualty insurance or writing fidelity, surety, or guaranty bonds, on risks or operations in this state.

(b) This subchapter applies to:

(1) a farm mutual insurance company with respect to each line of insurance that a farm mutual insurance company is authorized to write under Section 911.151; and

(2) a county mutual insurance company with respect to each line of insurance that a county mutual insurance company is authorized to write under Section 912.151.

(c) Except as otherwise provided by this subchapter, this subchapter does not apply to the writing of:

(1) automobile insurance;

(2) life, health, or accident insurance;

(3) professional liability insurance;

(4) reinsurance;

(5) aircraft insurance;

(6) fraternal benefit insurance;

(7) fire insurance;

(8) workers' compensation insurance;

(9) marine insurance, including noncommercial inland marine insurance and ocean marine insurance;

(10) title insurance;

(11) explosion insurance, except insurance against loss from personal injury or property damage resulting accidentally from:

(A) a steam boiler;

(B) a heater or pressure vessel;

(C) an electrical device;

(D) an engine; or

(E) all machinery and appliances used in connection with or in the operation of a boiler, heater, vessel, electrical device, or engine described by Paragraphs (A)-(D); or

(12) insurance coverage for any of the following conditions or risks:

(A) weather or climatic conditions, including lightning, tornado, windstorm, hail, cyclone, rain, or frost and freeze;

(B) earthquake or volcanic eruption;

- (C) smoke or smudge;
- (D) excess or deficiency of moisture;
- (E) flood;
- (F) the rising water of an ocean or an ocean's tributary;
- (G) bombardment, invasion, insurrection, riot, civil war or commotion, military or usurped power, or any order of a civil authority made to prevent the spread of a conflagration, epidemic or catastrophe;
- (H) vandalism or malicious mischief;
- (I) strike or lockout;
- (J) water or other fluid or substance resulting from:
 - (i) the breakage or leakage of a sprinkler, pump, or other apparatus erected for extinguishing fire, or a water pipe or other conduit or container; or
 - (ii) casual water entering a building through a leak or opening in the building or by seepage through building walls; or
- (K) accidental damage to a sprinkler, pump, fire apparatus, pipe, or other conduit or container described by Paragraph (J)(i).

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. [2017](#)), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 3B.033, eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. [3167](#)), Sec. 9.033, eff. September 1, 2007.

Sec. 1806.103. CONSTRUCTION OF SUBCHAPTER. (a) This subchapter does not limit in any manner the kinds or classes of insurance that an insurer may write under an appropriate statute or the insurer's charter or certificate of authority.

(b) This subchapter may not be construed to prohibit the modification of rates by a rating plan that complies with Chapter 2251 or Article 5.13-2, as applicable.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. [2017](#)), Sec. 2, eff. April 1, 2007.

Sec. 1806.104. PROHIBITED ACTS. (a) Except as otherwise provided by this subchapter, an insurer, an insurer's employee, or a broker or agent may not knowingly:

(1) issue an insurance policy that is not in accordance with an applicable filing; or

(2) charge, demand, or receive a premium on an insurance policy that is not in accordance with an applicable filing.

(b) Except as provided in an applicable filing, an insurer, an insurer's employee, or a broker or agent may not directly or indirectly pay, allow, or give, or offer to pay, allow, or give, as an inducement to insurance, or after insurance has been written, a rebate, discount, abatement, credit or reduction of the premium stated in an insurance policy, or a special favor or advantage in the dividends or other benefits to accrue on the policy, or any valuable consideration or inducement, not specified in the policy.

(c) An insured named in an insurance policy or an employee of an insured may not knowingly receive or accept, directly or indirectly, a rebate, discount, abatement, credit, or reduction of the premium stated in an insurance policy, or a special favor or advantage or valuable consideration or inducement.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.032(b), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.032(b), eff. September 1, 2007.

Sec. 1806.1041. CERTAIN PROMOTIONAL PRACTICES AUTHORIZED.

Section 1806.104 does not prohibit an insurer, an insurer's employee, or a broker or agent from, in connection with an offer or sale of an insurance policy subject to this subchapter, giving, providing, or allowing or offering to give, provide, or allow an item that is a promotional advertising item, educational item, or traditional courtesy commonly extended to consumers and that is valued at \$25 or less.

Added by Acts 2013, 83rd Leg., R.S., Ch. 28 (S.B. 840), Sec. 4, eff. September 1, 2013.

Sec. 1806.105. PROFIT SHARING AUTHORIZED; CERTAIN PROHIBITIONS.

(a) This subchapter does not prohibit an insurer from sharing earned profits with the insurer's policyholders in accordance with a profit sharing agreement contained in the policy, provided that any profit sharing under the policy with those insureds must be uniform among the insureds and may consist only of the equitable distribution of earnings among the insureds in accordance with the terms of the policy.

(b) An insurer may not:

(1) discriminate in the distribution of profits among insureds of the same class;

(2) distribute the profit to an insured before the expiration of the policy; or

(3) establish a class of insureds for the distribution of profits, except on the commissioner's approval.

(c) A distribution of profits or dividends to an insured may not take effect or be distributed until:

(1) the insurer has adequate reserves, as computed on the same basis for all classes of insurers to which this subchapter applies; and

(2) if the policyholder dividend amount exceeds 10 percent of surplus, the commissioner approves the distribution.

(d) The insurer must notify the commissioner in writing of each distribution if the insurer's policyholder dividend amount is not greater than 10 percent of surplus.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 463 (S.B. 1006), Sec. 5, eff. June 14, 2013.

Sec. 1806.106. PROFIT SHARING WITH CERTAIN ASSOCIATIONS

AUTHORIZED. (a) This subchapter does not prohibit an insurer from sharing profits with policyholders who are part of a group program

established by a nonprofit business association and who participate in the group program because of membership in the association.

(b) An insurer that elects to make distributions under this section must:

(1) file a written application describing the insurer's distribution with the commissioner for approval of a policyholder dividend amount that exceeds 10 percent of surplus; or

(2) notify the commissioner in writing of each distribution of a policyholder dividend amount that is not greater than 10 percent of surplus.

(c) If the commissioner does not act on the application on or before the fifth business day after the date the commissioner receives the application, the distribution is considered approved.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 463 (S.B. 1006), Sec. 6, eff. June 14, 2013.

Sec. 1806.107. ENFORCEMENT. (a) A violation of this subchapter is unjust discrimination and rebating.

(b) The commissioner may revoke the certificate of authority of an insurer that violates this subchapter or the license of an agent who violates this subchapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER D. PROVISIONS APPLICABLE TO FIRE INSURANCE AND ALLIED LINES

Sec. 1806.151. APPLICABILITY OF SUBCHAPTER. (a) Each insurance policy or contract insuring property in this state against loss by fire, including a policy or contract or portion of a policy or contract that insures the shore end of a marine risk against loss by fire, must be issued in accordance with:

- (1) this subchapter;
- (2) Section 403.002;
- (3) Subchapter C, Chapter 5;

- (4) Subchapter H, Chapter 544; and
- (5) Chapters 252, 2001, 2002, 2003, 2004, 2005, 2006, and

2171.

(b) An insurer issuing an insurance policy or contract described by Subsection (a), including a fire insurance company, marine insurance company, fire and marine insurance company, and fire and tornado insurance company, is governed by the laws described by Subsection (a).

(c) This section applies to an insurer or to an insurance policy or contract regardless of:

(1) the kind and character of property insured;

(2) whether the property is:

(A) fixed or movable;

(B) stationary or in transit; or

(C) consigned or billed for shipment inside or outside the boundaries of this state or to a foreign country;

(3) whether the insurer is organized:

(A) under the laws of this state, another state, territory, or possession of the United States, or a foreign country; or

(B) by authority of the federal government; or

(4) the kind of insurer or the name of the insurer issuing the policy or contract.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1806.152. CONSTRUCTION OF SUBCHAPTER. (a) This subchapter, Subtitle D, and Subchapter C, Chapter 5, may not be construed to deal with the collection of premiums, but each insurer may make rules and regulations the insurer considers just between the insurer and the insurer's agents and policyholders.

(b) A bona fide extension of credit may not be construed as discrimination or as a violation of this subchapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1806.153. UNJUST DISCRIMINATION; REBATES. (a) An insurer

or an insurer's officer, director, agent, or other representative may not grant or contract for a special favor or advantage in:

- (1) dividends or other profits to accrue on an insurance policy;
- (2) commissions in the dividends or other profits to accrue on an insurance policy;
- (3) commissions or division of commission; or
- (4) a position, valuable consideration, or inducement not specified in an insurance policy.

(b) An insurer may not directly or indirectly give, sell, or purchase or offer to give, sell, or purchase as an inducement to insurance or in connection with insurance:

- (1) stocks, bonds, or other securities of an insurer or other corporation, partnership, or individual;
- (2) dividends or profits that have accrued or will accrue on stocks, bonds, or other securities of an insurer or other corporation, partnership, or individual; or
- (3) anything of value not specified in the policy.

(c) An insurer or an insurer's officer, director, agent, or other representative that violates this section has engaged in unjust discrimination.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1806.154. PROFIT SHARING AUTHORIZED. (a) Section 1806.153 does not prohibit an insurer from sharing profits with the insurer's policyholders if:

- (1) a profit sharing agreement is placed on or in the face of the policy;
- (2) the profit sharing is uniform and does not discriminate among individuals or among classes; and
- (3) the profit is not distributed to an insured before the expiration of the insurance policy.

(b) An insurer or an insurer's officer, director, agent, or other representative that violates this section has engaged in unjust discrimination.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1806.1541. CERTAIN PROMOTIONAL PRACTICES AUTHORIZED. Section 1806.153 does not prohibit an insurer from, in connection with an offer or sale of an insurance policy or contract subject to this subchapter, giving, providing, or allowing or offering to give, provide, or allow an item that is a promotional advertising item, educational item, or traditional courtesy commonly extended to consumers and that is valued at \$25 or less.

Added by Acts 2013, 83rd Leg., R.S., Ch. 28 (S.B. 840), Sec. 5, eff. September 1, 2013.

Sec. 1806.155. INSURER LIABILITY ON POLICY ISSUED WITHOUT AUTHORITY. (a) If an insurer or an insurer's agent issues an insurance policy without authority and the policyholder sustains a loss or damage covered under the policy, the insurer is liable to the policyholder under the policy in the same manner and to the same extent as if the insurer had been authorized to issue the policy, although the policy was issued in violation of this code.

(b) This section may not be construed to give an insurer the authority to issue an insurance policy or contract other than as provided by this code.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1806.156. ACCEPTANCE OF REBATE OR OTHER INDUCEMENT; CRIMINAL PENALTY. (a) A person commits an offense if the person knowingly receives or accepts from an insurer, an insurer's agent, broker, or other representative, or any other person a rebate of premium payable on an insurance policy, or a special favor or advantage in dividends or other financial profits accrued or to accrue on the policy, or any valuable consideration, position or inducement not specified in the policy.

(b) An offense under this section is punishable by:

- (1) a fine of not more than \$100;
- (2) confinement in jail for not more than 90 days; or
- (3) both a fine and confinement under this subsection.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

CHAPTER 1807. APPLICABILITY TO MARINE INSURANCE

Sec. 1807.001. DEFINITIONS. In this chapter:

(1) "Insurable property and interests" includes:

- (A) goods, freights, and cargoes;
- (B) merchandise;
- (C) effects;
- (D) disbursements;
- (E) profits;
- (F) money, bullion, and precious stones;
- (G) securities;
- (H) choses in action;
- (I) evidences of debt;
- (J) valuable papers; and
- (K) bottomry and respondentia interests.

(2) "Marine insurance" means:

(A) insurance and reinsurance that covers:

(i) loss or damage to:

(a) a hull, vessel, or craft of any kind, an aid to navigation, a dry dock, or a marine railway, whether complete, under construction, or awaiting construction; or

(b) insurable property and interests in respect to, appertaining to, or in connection with a risk or peril of navigation, transit, or transportation:

(1) on or under a sea, lake, or river or other water, in the air, or on land in connection with or incident to export, import, or waterborne risks;

(2) while being assembled, packed, crated, baled, compressed, or similarly prepared for shipment;

(3) while awaiting shipment; or

(4) during any delay, storage, or transshipment or reshipment incident to the initial shipment;

(ii) a marine builder or repairer risk;

(iii) a marine protection or indemnity risk; or

(iv) a war risk regarding any insurable property or interest described by this section; and

(B) insurance defined as marine insurance by another

statute, lawful custom, or rule adopted by the commissioner.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1807.002. INAPPLICABILITY OF CERTAIN LAWS TO MARINE INSURANCE; EXCEPTION. (a) The following provisions do not apply to marine insurance:

- (1) Sections 36.002, 37.051, 403.002, and 501.159;
 - (2) Subchapter H, Chapter 544;
 - (3) Chapters 5, 252, 253, 493, 494, 1804, 1805, 1806, and 2171; and
 - (4) Subtitles B, C, D, E, F, H, and I.
- (b) Subsection (a) does not apply to:
- (1) a farm mutual insurance company operating under Chapter 911;
 - (2) a mutual insurance company engaged in business under Chapter 12, Title 78, Revised Statutes, before that chapter's repeal by Section 18, Chapter 40, Acts of the 41st Legislature, 1st Called Session, 1929, as amended by Section 1, Chapter 60, General Laws, Acts of the 41st Legislature, 2nd Called Session, 1929, that retains the rights and privileges under the repealed law to the extent provided by those sections; or
 - (3) a county mutual insurance company operating under Chapter 912.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 594 (S.B. 1070), Sec. 3.13, eff. September 1, 2017.

CHAPTER 1810. PROMOTIONAL EVENT PRIZE PROGRAMS

Sec. 1810.001. DEFINITION. In this chapter, "promotional event prize program" means a written contract entered into in this state for commercial marketing or promotional purposes:

- (1) under which a monetary risk is transferred from one or more parties to the contract to another party to the contract;
- (2) that does not require as a condition precedent to the

imposition of contractual liability on the part of the person accepting the risk:

(A) actual economic loss by the person who transfers the risk; or

(B) submission of proof of economic loss by the person transferring the risk; and

(3) that specifically states that the contract is not for insurance and performance under the contract is not covered by any state guaranty association.

Added by Acts 2007, 80th Leg., R.S., Ch. 246 (H.B. 2708), Sec. 1, eff. May 25, 2007.

Sec. 1810.002. PROGRAM NOT INSURANCE; NOT COVERED BY GUARANTY ASSOCIATION. A promotional event prize program does not constitute the business of insurance in this state. A person's claim for performance under a contract for a promotional event prize program is not a covered claim under Chapter 462 and a promotional event prize program is not covered by the Texas Property and Casualty Insurance Guaranty Association or any other state guaranty association.

Added by Acts 2007, 80th Leg., R.S., Ch. 246 (H.B. 2708), Sec. 1, eff. May 25, 2007.

Sec. 1810.003. CERTAIN MARKETING PROHIBITED. A promotional event prize program may not be marketed or described as insurance.

Added by Acts 2007, 80th Leg., R.S., Ch. 246 (H.B. 2708), Sec. 1, eff. May 25, 2007.

CHAPTER 1811. CERTIFICATES OF PROPERTY AND CASUALTY INSURANCE
SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1811.001. DEFINITIONS. In this chapter:

(1) "Agent" means a person required to hold a license as a property and casualty agent or surplus lines agent.

(2) "Certificate holder" means a person, other than a policyholder:

(A) who is designated on a certificate of insurance as

a certificate holder; or

(B) to whom a certificate of insurance has been issued by an insurer or agent at the request of the policyholder.

(3) "Certificate of insurance" means a document, instrument, or record, including an electronic record, no matter how titled or described, that is executed by an insurer or agent and issued to a third person not a party to the subject insurance contract, as a statement or summary of property or casualty insurance coverage. The term does not include an insurance binder or policy form.

(4) "Electronic record" has the meaning assigned by Section 322.002, Business & Commerce Code.

(5) "Insurance" means an insurance contract for property or casualty insurance.

(6) "Insurer" means a company or insurance carrier that is engaged in the business of making property or casualty insurance contracts. The term includes:

- (A) a stock fire or casualty insurance company;
- (B) a mutual fire or casualty insurance company;
- (C) a Mexican casualty insurance company;
- (D) a Lloyd's plan;
- (E) a reciprocal or interinsurance exchange;
- (F) a county mutual insurance company;
- (G) a farm mutual insurance company;
- (H) a risk retention group;
- (I) the Medical Liability Insurance Joint Underwriting Association under Chapter 2203;
- (J) the Texas Windstorm Insurance Association under Chapter 2210;
- (K) the FAIR Plan Association under Chapter 2211;
- (L) an eligible surplus lines insurer; and
- (M) any other insurer authorized to write property or casualty insurance in this state.

(7) "Lender" has the meaning assigned by Section 549.001.

(8) "Person" means:

- (A) an individual; or
- (B) a partnership, corporation, limited liability company, association, trust, or other legal entity, including an insurer or a political subdivision or agency of this state.

(9) "Policyholder" means a person who has contracted with a

property or casualty insurer for insurance coverage.

(10) "Record" has the meaning assigned by Section 322.002, Business & Commerce Code.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1212 (S.B. 425), Sec. 1, eff. September 1, 2011.

Sec. 1811.002. APPLICABILITY. (a) This chapter applies to a certificate holder, policyholder, insurer, or agent with regard to a certificate of insurance issued on property or casualty operations or a risk located in this state, regardless of where the certificate holder, policyholder, insurer, or agent is located.

(b) This chapter may not be construed to apply to:

(1) a statement, summary, or evidence of property insurance required by a lender in a lending transaction involving:

(A) a mortgage;

(B) a lien;

(C) a deed of trust; or

(D) any other security interest in real or personal property as security for a loan;

(2) a certificate issued under:

(A) a group or individual policy for:

(i) life insurance;

(ii) credit insurance;

(iii) accident and health insurance;

(iv) long-term care benefit insurance; or

(v) Medicare supplement insurance; or

(B) an annuity contract; or

(3) standard proof of motor vehicle liability insurance under Section 601.081, Transportation Code.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1212 (S.B. 425), Sec. 1, eff. September 1, 2011.

Sec. 1811.003. RULES. The commissioner may adopt rules as necessary or proper to accomplish the purposes of this chapter.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1212 (S.B. 425), Sec. 1, eff. September 1, 2011.

Sec. 1811.004. FILING FEE. (a) The department may collect a fee in an amount determined by the commissioner for the filing of a new or amended certificate of insurance form under this chapter.

(b) The fee may not exceed \$100.

(c) A fee collected under this section shall be deposited to the credit of the Texas Department of Insurance operating account.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1212 (S.B. 425), Sec. 1, eff. September 1, 2011.

SUBCHAPTER B. PROHIBITED ACTS AND PRACTICES

Sec. 1811.051. ALTERING, AMENDING, OR EXTENDING THE TERMS OF AN INSURANCE POLICY; CONTRACTUAL RIGHTS OF CERTIFICATE HOLDER. (a) A property or casualty insurer or agent may not issue a certificate of insurance or any other type of document purporting to be a certificate of insurance if the certificate or document alters, amends, or extends the coverage or terms and conditions provided by the insurance policy referenced on the certificate or document.

(b) A certificate of insurance or any other type of document may not convey a contractual right to a certificate holder.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1212 (S.B. 425), Sec. 1, eff. September 1, 2011.

Sec. 1811.052. USE OF APPROVED CERTIFICATE OF INSURANCE FORMS.

(a) An insurer or an agent may not issue a certificate of insurance unless the form of the certificate:

(1) has been filed with and approved by the department under Section 1811.101; or

(2) is a standard form deemed approved by the department under Section 1811.103.

(b) A person may not execute, issue, or require the issuance of a certificate of insurance for risks located in this state, unless the certificate of insurance form has been filed with and approved by the department.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1212 (S.B. 425), Sec. 1,

eff. September 1, 2011.

Sec. 1811.053. ALTERATION OR MODIFICATION OF APPROVED CERTIFICATE OF INSURANCE FORMS. A person may not alter or modify a certificate of insurance form approved under Section 1811.101 unless the alteration or modification is approved by the department.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1212 (S.B. 425), Sec. 1, eff. September 1, 2011.

Sec. 1811.054. ISSUANCE OF FALSE OR MISLEADING CERTIFICATE OF INSURANCE. A person may not require the issuance of a certificate of insurance from an insurer, agent, or policyholder that contains any false or misleading information concerning the policy of insurance to which the certificate refers.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1212 (S.B. 425), Sec. 1, eff. September 1, 2011.

Sec. 1811.055. REQUEST FOR DOCUMENTS IN LIEU OF CERTIFICATE OF INSURANCE. A person may not require an agent or insurer, either in addition to or in lieu of a certificate of insurance, to issue any other document or correspondence, instrument, or record, including an electronic record, that is inconsistent with this chapter.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1212 (S.B. 425), Sec. 1, eff. September 1, 2011.

Sec. 1811.056. USE OF DISAPPROVED CERTIFICATE OF INSURANCE FORMS. A person who receives written notice under Section 1811.102 that a certificate of insurance form filed under this chapter has been disapproved by the commissioner shall immediately stop using the form.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1212 (S.B. 425), Sec. 1, eff. September 1, 2011.

SUBCHAPTER C. CERTIFICATE OF INSURANCE FORMS

Sec. 1811.101. FILING AND APPROVAL OF FORMS. (a) Except as provided by Subsection (b), an insurer or agent may not deliver or issue for delivery in this state a certificate of insurance unless the certificate's form:

(1) has been filed with and approved by the commissioner; and

(2) contains the phrase "for information purposes only" or similar language.

(b) If a certificate of insurance form does not contain the language required by Subsection (a)(2), the commissioner may approve the form if the form states:

(1) that the certificate of insurance does not confer any rights or obligations other than the rights and obligations conveyed by the policy referenced on the form; and

(2) that the terms of the policy control over the terms of the certificate of insurance.

(c) A filed form is approved at the expiration of 60 days after the date the form is filed unless the commissioner by order approves or disapproves the form during the 60-day period beginning the date the form is filed. The commissioner's approval of a filed form constitutes a waiver of any unexpired portion of the 60-day period.

(d) The commissioner may extend by not more than 10 days the 60-day period described by Subsection (c) during which the commissioner may approve or disapprove a form filed by an insurer or agent. The commissioner shall notify the insurer or agent of the extension before the expiration of the 60-day period.

(e) A filed form for which an extension has been granted under Subsection (d) is considered approved at the expiration of the extension period described by that subsection absent an earlier approval or disapproval of the form.

(f) A person may not use a form unless the form has been filed with and approved by the commissioner.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1212 (S.B. [425](#)), Sec. 1, eff. September 1, 2011.

Sec. 1811.102. DISAPPROVAL OF FORMS; WITHDRAWAL OF APPROVAL.

(a) The commissioner shall disapprove a form filed under Section

1811.101 or withdraw approval of a form if the form:

(1) contains a provision or has a title or heading that is misleading, is deceptive, or violates public policy;

(2) violates any state law, including a rule adopted under this code;

(3) requires an agent to provide certification of insurance coverage that is not available in the line or type of insurance coverage referenced on the form; or

(4) directly or indirectly requires the commissioner to make a coverage determination under a policy of insurance or insurance transaction.

(b) The commissioner may not disapprove a form filed under Section 1811.101 or withdraw approval of a form based solely on the fact that the form contains language described by Section 1811.101(b).

(c) An order issued by the commissioner disapproving a form, or a notice of the commissioner's intention to withdraw approval of a form, must state the grounds for the disapproval or withdrawal of approval in sufficient detail to reasonably inform the person filing the form of those grounds and the changes to the form necessary to obtain approval.

(d) An order disapproving a form or withdrawing approval of a form takes effect on the date prescribed by the commissioner in the order. An order withdrawing approval of a form may not become effective until the 30th day after the date of the order.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1212 (S.B. 425), Sec. 1, eff. September 1, 2011.

Sec. 1811.103. STANDARD CERTIFICATE OF INSURANCE FORMS. A standard certificate of insurance form promulgated by the Association for Cooperative Operations Research and Development, the American Association of Insurance Services, or the Insurance Services Office (ISO) is deemed approved on the date the form is filed with the department. Notwithstanding this section, the commissioner may withdraw approval of a standard form under Section 1811.102.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1212 (S.B. 425), Sec. 1, eff. September 1, 2011.

Sec. 1811.104. PUBLIC INSPECTION OF INFORMATION. A certificate of insurance form and any supporting information filed with the department under this subchapter is open to public inspection as of the date of the filing.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1212 (S.B. 425), Sec. 1, eff. September 1, 2011.

SUBCHAPTER D. EFFECT OF APPROVAL OF CERTIFICATE OF INSURANCE FORM

Sec. 1811.151. CONFIRMATION OF POLICY ISSUANCE. A certificate of insurance form that has been approved by the commissioner and properly executed and issued by a property and casualty insurer or an agent constitutes a confirmation that the referenced insurance policy has been issued or that coverage has been bound. This section applies regardless of whether the face of the certificate includes the phrase "for information purposes only" or similar language.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1212 (S.B. 425), Sec. 1, eff. September 1, 2011.

Sec. 1811.152. CERTIFICATE OF INSURANCE NOT POLICY OF INSURANCE. A certificate of insurance is not a policy of insurance and does not amend, extend, or alter the coverage afforded by the referenced insurance policy.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1212 (S.B. 425), Sec. 1, eff. September 1, 2011.

Sec. 1811.153. RIGHTS CONFERRED BY CERTIFICATE OF INSURANCE. A certificate of insurance shall not confer to a certificate holder new or additional rights beyond what the referenced policy or any executed endorsement of insurance provides.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1212 (S.B. 425), Sec. 1, eff. September 1, 2011.

Sec. 1811.154. REFERENCE TO OTHER CONTRACTS. A certificate of

insurance may not contain a reference to a legal or insurance requirement contained in a contract other than the underlying contract of insurance, including a contract for construction or services.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1212 (S.B. 425), Sec. 1, eff. September 1, 2011.

Sec. 1811.155. NOTICE. (a) A person may have a legal right to notice of cancellation, nonrenewal, or material change or any similar notice concerning a policy of insurance only if:

(1) the person is named within the policy or an endorsement to the policy; and

(2) the policy or endorsement or a law, including a rule, of this state requires notice to be provided.

(b) A certificate of insurance may not alter the terms and conditions of the notice required by a policy of insurance or the law of this state.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1212 (S.B. 425), Sec. 1, eff. September 1, 2011.

Sec. 1811.156. CERTIFICATE OF INSURANCE ISSUED IN VIOLATION OF CHAPTER. A certificate of insurance that is executed, issued, or required and that is in violation of this chapter is void and has no effect.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1212 (S.B. 425), Sec. 1, eff. September 1, 2011.

SUBCHAPTER E. ENFORCEMENT AND REMEDIES

Sec. 1811.201. POWERS OF COMMISSIONER. (a) If the commissioner has reason to believe that an insurer or agent has violated or is threatening to violate this chapter or a rule adopted under this chapter, the commissioner may:

- (1) issue a cease and desist order;
- (2) seek an injunction under Section 1811.203;
- (3) request that the attorney general recover a civil

penalty under Section 1811.203;

(4) impose sanctions on the insurer or agent as provided by Chapter 82; or

(5) take any combination of those actions.

(b) This section does not prevent or limit any action by or remedy available to the commissioner under applicable law.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1212 (S.B. 425), Sec. 1, eff. September 1, 2011.

Sec. 1811.202. HEARING; NOTICE. (a) The commissioner may hold a hearing on whether to issue a cease and desist order under Section 1811.201 if the commissioner has reason to believe that:

(1) an insurer or agent has violated or is threatening to violate this chapter or a rule adopted under this chapter; or

(2) an insurer or agent has engaged in or is threatening to engage in an unfair act related to a certificate of insurance.

(b) The commissioner shall serve on the insurer or agent a statement of charges and a notice of hearing in the form provided by Section 2001.052, Government Code.

(c) A hearing under this section is a contested case under Chapter 2001, Government Code.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1212 (S.B. 425), Sec. 1, eff. September 1, 2011.

Sec. 1811.203. CIVIL PENALTY; INJUNCTION. (a) A person, including an insurer or agent, who wilfully violates this chapter is subject to a civil penalty of not more than \$1,000 for each violation.

(b) The commissioner may request that the attorney general institute a civil suit in a district court in Travis County for injunctive relief to restrain a person, including an insurer or agent, from continuing a violation or threat of violation of Subchapter B. On application for injunctive relief and a finding that a person, including an insurer or agent, is violating or threatening to violate Subchapter B, the district court shall grant the injunctive relief and issue an injunction without bond.

(c) On request by the commissioner, the attorney general may

institute and conduct a civil suit in the name of the state for injunctive relief, to recover a civil penalty, or for both injunctive relief and a civil penalty, as authorized under this subchapter.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1212 (S.B. 425), Sec. 1, eff. September 1, 2011.

Sec. 1811.204. INVESTIGATION OF COMPLAINTS. (a) The commissioner may:

(1) investigate a complaint or allegation of specific violations by a person, including an insurer or agent, who has allegedly engaged in an act or practice prohibited by Subchapter B; and

(2) enforce the provisions of this chapter.

(b) If the commissioner has reason to believe that a person, including an insurer or agent, is performing an act in violation of Subchapter B, the person shall immediately provide to the commissioner, on written request of the commissioner, information relating to that act.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1212 (S.B. 425), Sec. 1, eff. September 1, 2011.

CHAPTER 1812. AVAILABILITY OF SPECIMEN POLICIES

Sec. 1812.001. DEFINITION. In this chapter, "specimen policy" means a standardized form, including an insurance policy form or endorsement, used by an insurer to write personal automobile, commercial automobile, inland marine, or residential property insurance in this state that does not contain personally identifiable information about an insured.

Added by Acts 2013, 83rd Leg., R.S., Ch. 101 (S.B. 852), Sec. 1, eff. September 1, 2013.

Sec. 1812.002. AVAILABILITY OF CERTAIN FORMS. (a) Notwithstanding any other provision of this code relating to the delivery of policy forms, an insurer may elect to make a personal automobile, commercial automobile, inland marine, or residential

property insurance policy available to an insured by posting a specimen policy on the insurer's Internet website instead of other authorized means. An insurer making the election must comply with Section 1812.003.

(b) On request of and at no cost to an insured, an insurer shall provide to the insured a copy of a specimen policy applicable to the insured that is posted on the insurer's Internet website.

(c) The office of public insurance counsel may post an insurer's specimen policy on the office's Internet website. The posting, other than a posting described by Subsection (a), of an insurer's specimen policy on an Internet website does not create a duty to comply with the requirements of this chapter.

Added by Acts 2013, 83rd Leg., R.S., Ch. 101 (S.B. 852), Sec. 1, eff. September 1, 2013.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 842 (S.B. 494), Sec. 1, eff. September 1, 2015.

Sec. 1812.003. NOTICE OF AVAILABILITY OF CERTAIN FORMS. (a) An insurer that posts a specimen policy on the insurer's Internet website under this chapter must, on issuance or renewal of a policy incorporating the specimen policy:

(1) on the declarations page of the insured's policy:

(A) disclose that the specimen policy is available on the insurer's Internet website; and

(B) clearly identify each posted specimen policy incorporated into the insured's policy;

(2) explain that and how an insured, on request and at no charge, may obtain a copy of the specimen policy from the insurer; and

(3) provide to the department and the office of public insurance counsel an electronic copy of the specimen policy that may be posted on the Internet website of the department or the office of public insurance counsel.

(b) An insurer that during an insured's policy period posts a specimen policy or amends a posted specimen policy incorporated into an insured's policy must, on the date the specimen policy is posted or amended, in writing and in the insurer's customary manner of

communicating with the insured:

- (1) notify the insured that the specimen policy is available on the insurer's Internet website;
- (2) clearly identify each added or amended specimen policy incorporated into the insured's policy; and
- (3) explain that and how the insured, on request and at no charge, may obtain a copy of the specimen policy from the insurer.

Added by Acts 2013, 83rd Leg., R.S., Ch. 101 (S.B. 852), Sec. 1, eff. September 1, 2013.

Sec. 1812.004. ACCESSIBILITY OF CERTAIN AVAILABLE FORMS. A specimen policy posted on the insurer's Internet website under this chapter must be, until no policy incorporating the specimen policy is in force:

- (1) easily accessible on the website; and
- (2) provided in a format readily capable of being saved or printed using a widely available and free computer application or program.

Added by Acts 2013, 83rd Leg., R.S., Ch. 101 (S.B. 852), Sec. 1, eff. September 1, 2013.

Sec. 1812.005. RETENTION OF CERTAIN AVAILABLE FORMS. An insurer that posts a specimen policy on the insurer's Internet website under this chapter must for at least five years after the latest date a policy incorporating the specimen policy is in force:

- (1) preserve an electronic copy of the specimen policy; and
- (2) make a printed or electronic copy of the specimen policy available on request at no cost.

Added by Acts 2013, 83rd Leg., R.S., Ch. 101 (S.B. 852), Sec. 1, eff. September 1, 2013.

**SUBTITLE B. LIABILITY INSURANCE FOR PHYSICIANS AND
HEALTH CARE PROVIDERS
CHAPTER 1901. PROFESSIONAL LIABILITY INSURANCE FOR PHYSICIANS AND
HEALTH CARE PROVIDERS**

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1901.001. DEFINITIONS. In this chapter:

(1) "Health care provider" means:

(A) a person, partnership, professional association, corporation, facility, or institution, or an officer, employee, or agent of the person or entity acting in the course and scope of authority, employment, or agency, as applicable, if the person or entity is licensed or chartered by this state to provide health care as:

- (i) a registered nurse;
- (ii) a hospital;
- (iii) a dentist;
- (iv) a podiatrist;
- (v) a chiropractor;
- (vi) an optometrist or therapeutic optometrist;
- (vii) a pharmacist;
- (viii) a veterinarian;
- (ix) a not-for-profit kidney dialysis center;
- (x) a blood bank that is a nonprofit corporation chartered to operate a blood bank and is accredited by the American Association of Blood Banks;
- (xi) a for-profit or not-for-profit nursing home;

or

(xii) a for-profit or not-for-profit assisted living facility; or

(B) a health care practitioner or facility that the commissioner, in accordance with Section 2203.103(b), determines is eligible for coverage under this chapter.

(2) "Hospital" means a public or private institution licensed under Chapter 241 or 577, Health and Safety Code.

(3) "Physician" means a person licensed to practice medicine in this state.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. [2017](#)), Sec. 2, eff. April 1, 2007.

Sec. 1901.002. APPLICABILITY OF CHAPTER. This chapter applies to:

(1) an insurer authorized to write or engaged in writing

professional liability insurance for a physician or health care provider; and

(2) a rating organization acting on behalf of an insurer described by Subdivision (1).

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1901.003. APPLICABILITY OF OTHER LAW. Chapters 2251 and 2301 and Article 5.13-2 apply to rates and forms for professional liability insurance for physicians and health care providers under this chapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1901.004. ANNUAL REPORTS. (a) An insurer that issues professional liability insurance policies covering physicians and health care providers shall file annually with the commissioner a report of:

- (1) all claims and the amounts of those claims;
- (2) amounts of claims reserves;
- (3) investment income of the insurer derived from medical professional liability premiums;
- (4) information relating to amounts of judgments and settlements paid on claims; and
- (5) other information required by the commissioner.

(b) The commissioner may promulgate a form on which the information under Subsection (a) must be reported. The form must require that the information be reported in an accurate manner and be reasonably calculated to:

- (1) facilitate interpretation; and
- (2) protect the confidentiality of the physician or health care provider.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1901.005. RULES. The commissioner shall establish by rule:

- (1) criteria that insurers must follow in establishing reconsideration procedures under Section 1901.101; and
- (2) standards and procedures to be followed in the review of rates and premiums by the commissioner.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER B. RATE STANDARDS

Sec. 1901.051. CONSIDERATIONS IN SETTING RATES. (a) In setting rates, an insurer shall consider:

- (1) past and prospective loss and expense experience for all professional liability insurance for physicians and health care providers written in this state, subject to Subsection (b);
- (2) a reasonable margin for underwriting profit and contingencies;
- (3) investment income; and
- (4) dividends or savings allowed or returned by the insurer to the insurer's policyholders or members.

(b) If the department finds that the group or risk to be insured is not of sufficient size to be credible, an insurer must also consider in setting rates past and prospective loss and expense experience for all professional liability insurance for physicians and health care providers written outside this state.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1901.052. GROUPING OF RISKS. In setting rates, an insurer may group risks by classification, rating schedule, or any other reasonable method.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1901.053. MODIFICATION OF CLASSIFICATION RATES. (a) An

insurer may modify classification rates to produce rates for individual risks in accordance with rating plans that establish standards for measuring variations in hazards or expense provisions.

(b) The standards may measure any difference among risks that can be demonstrated to have a probable effect on losses or expenses.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1901.054. LIMITATIONS ON RATES. (a) Rates set under this chapter may not be excessive or inadequate, as described by this section, or unreasonable or unfairly discriminatory.

(b) A rate is not excessive unless the rate is unreasonably high for the insurance coverage provided.

(c) A rate is not inadequate unless the rate is unreasonably low for the insurance coverage provided and:

(1) is insufficient to sustain projected losses and expenses; or

(2) the use of the rate has or, if continued, will have the effect of destroying competition or creating a monopoly.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.034(a), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.034(a), eff. September 1, 2007.

Sec. 1901.0541. USE IN UNDERWRITING OF CERTAIN INFORMATION RELATED TO LAWSUITS; REFUND. (a) Notwithstanding any other provision of this code, an insurer may not consider for the purpose of setting premiums or reducing a claims-free discount for a particular insured physician's professional liability insurance a lawsuit filed against the physician if:

(1) before trial, the lawsuit was dismissed by the claimant or nonsuited; and

(2) no payment was made to the claimant under a settlement agreement.

(b) An insurer that, in setting premiums or reducing a claims-free discount for a physician's professional liability insurance, considers a lawsuit filed against the physician shall refund to the physician any increase in premiums paid by the physician that is attributable to that lawsuit or reinstate the claims-free discount if the lawsuit is dismissed by the claimant or nonsuited without payment to the claimant under a settlement agreement. The insurer shall issue the refund or reinstate the discount on or before the 30th day after the date the insurer receives written evidence that the lawsuit was dismissed or nonsuited without payment to the claimant under a settlement agreement.

(c) This section does not prohibit an insurer from considering and using aggregate historical loss and expense experience applicable generally to a classification of physicians' professional liability insurance to set rates for that classification to the extent authorized by Chapter 2251 and Article 5.13-2. Notwithstanding Section 2251.052(c), an insurer may not assign a physician to a particular classification based on a factor described by Subsection (a).

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.035(a), eff. September 1, 2007.

Added by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.035(a), eff. September 1, 2007.

Sec. 1901.055. CLAIM SURCHARGE. A claim surcharge assessed by an insurer against a physician or health care provider under a professional liability insurance policy may be based only on claims actually paid by an insurer as a result of:

- (1) a settlement; or
- (2) an adverse judgment or decision of a court.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1901.056. ABSOLUTE RATES PROHIBITED. (a) In this section, "absolute rates" means rates, rating plans, or rating classifications that are filed under Chapter 2251 or Article 5.13-2 by an insurer or authorized rating organization and that are required

to be used, to the exclusion of all others, by each insurer authorized to write policies.

(b) A provision of this chapter, Chapter 2251, or Article 5.13-2 relating to the regulation of rates, rating plans, and rating classifications for professional liability insurance for physicians and health care providers does not:

(1) give the commissioner the power to promulgate uniform or absolute rates; or

(2) prevent different insurers or organizations authorized to file rates from filing different rates for risks in a given classification or modified rates for individual risks made in accordance with rating plans.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1901.057. CONSIDERATIONS IN APPROVING RATES. In approving rates under this chapter, the department shall consider the impact of risk management courses taken by physicians and health care providers in this state.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.034(b), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.034(b), eff. September 1, 2007.

SUBCHAPTER C. REVIEW OF RATES

Sec. 1901.101. RECONSIDERATION OF RATES AND PREMIUMS. (a) Each insurer to which this chapter applies shall adopt a procedure for reconsideration of a rate or premium charged a physician or health care provider for professional liability insurance coverage.

(b) The procedure must include:

(1) an opportunity for a hearing before officers or employees who have responsibility for determining rates and premiums to be charged for professional liability insurance; and

(2) a requirement that the insurer reconsider the rate or

premium and provide the physician or health care provider a written explanation of the rate or premium being charged.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1901.102. APPEAL. A physician or health care provider that is not satisfied with a decision under procedures established under Section 1901.101 may appeal to the commissioner for:

- (1) a review of the rate or premium; and
- (2) a determination of whether the rate or premium being charged complies with criteria under Sections 1901.051-1901.054 and 1901.057.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER D. BEST PRACTICES FOR NURSING HOMES

Sec. 1901.151. BEST PRACTICES. (a) The commissioner shall adopt best practices for risk management and loss control that may be used by for-profit and not-for-profit nursing homes.

(b) In developing or amending the best practices, the commissioner shall consult with the Health and Human Services Commission and a task force appointed by the commissioner.

(c) The task force must be composed of representatives of:

- (1) insurers that write professional liability insurance for nursing homes;
- (2) the Texas Medical Liability Insurance Underwriting Association;
- (3) nursing homes; and
- (4) consumers.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1901.152. CONSIDERATION OF BEST PRACTICES IN SETTING RATES. In setting rates for professional liability insurance applicable to a for-profit or not-for-profit nursing home, an insurer

or the Texas Medical Liability Insurance Underwriting Association may consider whether the nursing home adopts and implements the best practices adopted under this subchapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1901.153. STANDARD OF CARE FOR CIVIL ACTIONS NOT ESTABLISHED. The best practices for risk management and loss control adopted under this subchapter do not establish standards of care for nursing homes applicable in a civil action against a nursing home.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER E. POLICY FORMS

Sec. 1901.201. STANDARDIZED POLICY FORMS; APPROVAL OF OTHER FORMS. (a) The commissioner shall prescribe standardized policy forms for occurrence, claims-made, and claims-paid professional liability insurance policies for physicians and health care providers.

(b) An insurer may not use a form other than a standardized policy form in writing professional liability insurance for physicians and health care providers unless the form has been approved by the commissioner.

(c) An insurer writing professional liability insurance for physicians and health care providers may use an endorsement if the endorsement has been filed with and approved by the commissioner.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER F. COVERAGE

Sec. 1901.251. PREMIUM BASIS. An insurer may not write a professional liability insurance policy under this chapter on less than an annual premium basis.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April

1, 2007.

Sec. 1901.252. COVERAGE FOR EXEMPLARY DAMAGES. (a) Except as provided by Subsection (b), a medical professional liability insurance policy issued to or renewed for a physician or health care provider in this state may not include coverage for exemplary damages that may be assessed against the physician or health care provider.

(b) The commissioner may approve an endorsement form that provides for coverage for exemplary damages for use on a medical professional liability insurance policy issued to:

- (1) a hospital; or
- (2) a for-profit or not-for-profit nursing home or assisted living facility.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1901.253. NOTICE OF PREMIUM INCREASE, CANCELLATION, OR NONRENEWAL. (a) An insurer that issues a professional liability insurance policy for a physician or health care provider must provide to the insured written notice of at least 90 days if the insurer intends to:

- (1) increase the premiums on the policy; or
- (2) cancel or not renew the policy for a reason other than for nonpayment of premiums or because the insured is no longer licensed.

(b) If the insurer intends to increase the premiums, the insurer shall state in the notice the amount of the increase.

(c) If the insurer intends to cancel or not renew the policy, the insurer shall state in the notice the reason for cancellation or nonrenewal.

(d) An insurer may provide notice of cancellation under this section only within the first 90 days from the effective date of the policy.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1901.254. PROHIBITION OF USE OF CERTAIN INFORMATION FOR PHYSICIAN OR HEALTH CARE PROVIDER. (a) For the purpose of writing professional liability insurance for physicians and health care providers, an insurer may not consider whether, or the extent to which, a physician or health care provider provides services in this state to individuals who are recipients of Medicaid or covered by the state child health plan program established by Chapter 62, Health and Safety Code, including any consideration resulting in:

- (1) denial of coverage;
- (2) refusal to renew coverage;
- (3) cancellation of coverage;
- (4) limitation of the amount, extent, or kind of coverage available; or
- (5) a determination of the rate or premium to be paid.

(b) The commissioner may adopt rules as necessary to implement this section.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.035(b), eff. September 1, 2007.

Added by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.035(b), eff. September 1, 2007.

Sec. 1901.255. COVERAGE FOR VOLUNTEER HEALTH CARE PROVIDERS.

(a) In this section:

(1) "Charitable organization" has the meaning assigned by Section 84.003, Civil Practice and Remedies Code.

(2) "Volunteer health care provider" has the meaning assigned by Section 84.003, Civil Practice and Remedies Code.

(b) An insurer may make available professional liability insurance covering a volunteer health care provider for an act or omission resulting in death, damage, or injury to a patient while the person is acting in the course and scope of the person's duties as a volunteer health care provider as described by Chapter 84, Civil Practice and Remedies Code.

(c) This section does not affect the liability of a volunteer health care provider who is serving as a direct service volunteer of a charitable organization. Section 84.004(c), Civil Practice and Remedies Code, applies to the volunteer health care provider without regard to whether the volunteer health care provider obtains

liability insurance under this section.

(d) An insurer may make professional liability insurance available under this section to a volunteer health care provider without regard to whether the volunteer health care provider is a "health care provider" as defined by Section 1901.001.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.036(a), eff. September 1, 2007.

Added by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.036(a), eff. September 1, 2007.

CHAPTER 1902. CERTAIN LIABILITY COVERAGE FOR PHYSICIANS AND HEALTH CARE PROVIDERS

Sec. 1902.001. DEFINITIONS. In this chapter:

(1) "Health care provider" has the meaning assigned by Section 1901.001.

(2) "Manufacturer" has the meaning assigned by Section 82.001, Civil Practice and Remedies Code.

(3) "Physician" has the meaning assigned by Section 1901.001.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1902.002. COVERAGE FOR PHYSICIANS OR HEALTH CARE PROVIDERS UNDER VENDOR ENDORSEMENTS OR CERTAIN POLICIES. A physician or health care provider is considered a vendor for purposes of coverage under a vendor's endorsement or a manufacturer's general liability or products liability policy.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1902.003. EXCLUSIONS AND LIMITATIONS ON COVERAGE UNDER VENDOR ENDORSEMENTS PROHIBITED. An insurer may not exclude or otherwise limit coverage for physicians or health care providers under a vendor's endorsement issued to a manufacturer.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

CHAPTER 1903. LOSS CONTROL INFORMATION AND SERVICES
SUBCHAPTER A. LOSS CONTROL SERVICES FOR PROFESSIONAL LIABILITY
INSURANCE FOR HOSPITALS

Sec. 1903.001. DEFINITION. In this subchapter, "hospital" means a public or private institution licensed under Chapter 241 or 577, Health and Safety Code.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1903.002. INAPPLICABILITY OF SUBCHAPTER. This subchapter and Subchapter C do not apply to insurance policies that provide excess coverage issued by the Texas Medical Liability Insurance Underwriting Association under Chapter 2203, or to those policies if the policies are serviced by an insurer acting as a servicing carrier under an agreement entered into between the association and the insurer and approved by the commissioner.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1903.003. LOSS CONTROL SERVICES REQUIRED. (a) Before writing professional liability insurance for a hospital in this state, an insurer must maintain or provide loss control facilities that:

- (1) provide loss control services reasonably commensurate with the risks, exposures, and experience of the insured's business;
- (2) are adequate to provide loss control services required by the nature of the policyholder's operations; and
- (3) include surveys, recommendations, training programs, consultations, and analyses of accident causes.

(b) To provide the facilities required by this section, the insurer may:

- (1) employ qualified personnel;
- (2) retain qualified independent contractors;

(3) contract with the policyholder to provide qualified loss control personnel and services; or

(4) use a combination of methods described by this subsection.

(c) Independent contractors and other personnel described by Subsection (b) must have the qualifications of a field safety representative. A field safety representative must be an individual who:

(1) holds a:

(A) bachelor's degree in science or engineering;

(B) bachelor of arts degree in nursing;

(C) bachelor of science degree in nursing, pharmacy, or physical therapy; or

(D) master's degree in hospital administration;

(2) is a licensed engineer;

(3) is a certified safety professional;

(4) is a certified industrial hygienist;

(5) has at least 10 years' experience in occupational safety and health; or

(6) has completed a course of training in loss control services approved by the department.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1903.004. SANCTIONS. (a) If there is evidence that reasonable loss control services are not being maintained or provided by an insurer as required by this subchapter or are not being used by the insurer in a reasonable manner to prevent injury to patients of the insurer's policyholders, the commissioner shall order a hearing to determine whether the insurer is not in compliance with this subchapter.

(b) If it is determined that the insurer is not in compliance, the commissioner may impose any sanction authorized by Chapter 82.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1903.005. RULES. The commissioner may adopt reasonable

rules for the enforcement of this subchapter after holding a public hearing on the proposed rules.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER B. LOSS CONTROL INFORMATION FOR GENERAL AND CERTAIN PROFESSIONAL LIABILITY INSURANCE

Sec. 1903.051. LOSS CONTROL INFORMATION REQUIRED. (a) Before writing professional liability insurance, including medical professional liability insurance, for insureds other than hospitals or general liability insurance in this state, an insurer must provide to the insurer's policyholders loss control information reasonably commensurate with the risks, exposures, and experience of the insured's business.

(b) To provide the information described by Subsection (a) or services, the insurer may:

- (1) employ qualified personnel;
- (2) retain qualified independent contractors;
- (3) contract with the policyholder to provide qualified loss control personnel and services; or
- (4) use a combination of methods described by this subsection.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1903.052. SANCTIONS. (a) If there is evidence that reasonable loss control information is not being provided by an insurer as required by this subchapter or is not being used by the insurer in a reasonable manner to reduce losses, the commissioner shall order a hearing to determine whether the insurer is not in compliance with this subchapter.

(b) If it is determined that the insurer is not in compliance, the commissioner may impose any sanction authorized by Chapter 82.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1903.053. RULES. After opportunity for a hearing, the commissioner may adopt reasonable rules for the enforcement of this subchapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER C. CIVIL PROCEEDINGS

Sec. 1903.101. IMMUNITY FROM LIABILITY. (a) An insurer or an agent or employee of the insurer is not liable, and a cause of action does not arise against the insurer, agent, or employee, for an accident based on an allegation that the accident was caused or could have been prevented by a program, information, inspection, or other activity or service undertaken by the insurer to prevent accidents or to control losses, as applicable, in connection with the operations of the insured.

(b) The immunity from liability provided by this section does not affect the liability of an insurer as otherwise provided in an insurance policy.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1903.102. LOSS CONTROL INFORMATION NOT DISCOVERABLE OR ADMISSIBLE. Loss control information provided by an insurer to an insured is not discoverable or admissible as evidence in a civil proceeding.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBTITLE C. AUTOMOBILE INSURANCE

CHAPTER 1951. GENERAL PROVISIONS: AUTOMOBILE INSURANCE

Sec. 1951.001. RATES FOR AUTOMOBILE INSURANCE. Rates for personal and commercial automobile insurance in this state are determined as provided by Chapter 2251 and Article 5.13-2.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April

1, 2007.

Sec. 1951.002. RULES. The commissioner may adopt and enforce reasonable rules necessary to carry out the provisions of this subtitle.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1951.003. FORMER MILITARY VEHICLES. (a) In this section, "former military vehicle" has the meaning assigned by Section 504.502, Transportation Code.

(b) A rating plan that includes a classification applicable to antique, privately owned passenger vehicles that are maintained primarily for use in exhibitions, club activities, parades, or other functions of public interest and that may be used occasionally for other purposes must include in that classification former military vehicles maintained for those uses.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1951.004. CRIMINAL PENALTY. (a) An insurer, or an officer or representative of an insurer, commits an offense if the insurer, officer, or representative violates:

- (1) Section 1951.001, 1951.002, 1952.051, 1952.052, 1952.053, 1952.054, or 1952.055;
- (2) Subchapter B, Chapter 1806;
- (3) Subchapter C, Chapter 1953;
- (4) Chapter 254; or
- (5) Article 5.01, 5.03, 5.06, 5.10, or 5.11.

(b) An offense under this section is a misdemeanor punishable by a fine of not less than \$100 or more than \$500.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2H.002,

eff. April 1, 2009.

**CHAPTER 1952. POLICY PROVISIONS AND FORMS FOR
AUTOMOBILE INSURANCE**

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1952.001. APPLICABILITY OF CHAPTER. Except as otherwise provided by this chapter, this chapter applies to an insurer writing automobile insurance in this state, including an insurance company, corporation, reciprocal or interinsurance exchange, mutual insurance company, association, Lloyd's plan, or other insurer.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 282 (H.B. 949), Sec. 1, eff. September 1, 2013.

SUBCHAPTER B. POLICY FORMS AND PROVISIONS IN GENERAL

Sec. 1952.051. POLICY FORMS FOR AUTOMOBILE INSURANCE.

Notwithstanding Subsections (1)-(4) and (7), Article 5.06, policy forms and endorsements for automobile insurance in this state are regulated under Chapter 2301 and Article 5.13-2.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1952.0515. REQUIRED COVERAGE. An agent or insurer, including a county mutual insurance company, may not deliver or issue for delivery in this state a personal automobile insurance policy unless the policy provides at least the minimum coverage specified by Subchapter D, Chapter 601, Transportation Code.

Added by Acts 2013, 83rd Leg., R.S., Ch. 803 (S.B. 1567), Sec. 1, eff. September 1, 2013.

Sec. 1952.052. USE OF PREVIOUSLY APPROVED OR ADOPTED POLICY FORMS AUTHORIZED. An insurer may continue to use a policy form or

endorsement approved or adopted by the commissioner under Article 5.06 before June 11, 2003, on notification in writing to the commissioner that the insurer will continue to use the policy form or endorsement.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1952.053. WITHDRAWAL OF APPROVAL. The commissioner may, after notice and hearing, withdraw the commissioner's approval of a policy or endorsement form that was approved by the commissioner under Article 5.06.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1952.054. REQUIRED DISCLOSURES REGARDING SHORT-TERM POLICIES. (a) An insurance policy or other document evidencing proof of purchase of a personal automobile insurance policy written for a term of less than 30 days may not be used to obtain an original or renewal driver's license, an automobile registration or license plates, or a motor vehicle inspection certificate. An insurance policy or other document described by this subsection must contain the following statement:

TEXAS LAW PROHIBITS USE OF THIS DOCUMENT TO OBTAIN A MOTOR VEHICLE INSPECTION CERTIFICATE, AN ORIGINAL OR RENEWAL DRIVER'S LICENSE, OR AN AUTOMOBILE REGISTRATION OR LICENSE PLATES.

(b) Before accepting any premium or fee for a personal automobile insurance policy or binder for a term of less than 30 days, an agent or insurer must make the following written disclosure to the applicant or insured:

TEXAS LAW PROHIBITS USE OF THIS POLICY OR BINDER TO OBTAIN A MOTOR VEHICLE INSPECTION CERTIFICATE, AN ORIGINAL OR RENEWAL DRIVER'S LICENSE, OR AN AUTOMOBILE REGISTRATION OR LICENSE PLATES.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1952.055. CERTIFICATE OF INSURANCE AS SUBSTITUTE FOR INSURANCE POLICY. (a) An insurer that complies with applicable requirements may issue and deliver a certificate of insurance as a substitute for issuing and delivering an insurance policy adopted or approved by the commissioner. The certificate must:

- (1) be in the form prescribed by the commissioner; and
- (2) refer to and identify the policy form for which the certificate is substituted.

(b) A certificate under this section represents the insurance policy and, when issued, is evidence that the certificate holder is insured under the identified policy form. The certificate is subject to the same limitations, conditions, coverages, selection of options, and other provisions provided in the policy, and the certificate must show and adequately reference that policy information. The certificate or subsequent attachments to the certificate must refer to all endorsements to the policy.

(c) A certificate under this section must be executed in the same manner as though an insurance policy were issued. If an insurer substitutes a certificate for a policy, the insurer shall simultaneously provide the insured receiving the certificate with an outline of coverages in the form and content approved by the commissioner. At the insured's request, the insurer shall provide the insured with a copy of the policy.

(d) The commissioner may adopt rules necessary to implement this section, including a rule limiting the application of this section to private passenger automobile insurance policies.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1952.056. REQUIRED PROVISION: COVERAGE FOR CERTAIN SPOUSES. A personal automobile insurance policy or any similar policy form adopted or approved by the commissioner under Article 5.06 or filed under Subchapter B, Chapter 2301, that covers liability arising out of ownership, maintenance, or use of a motor vehicle of a spouse who is otherwise insured by the policy must contain a provision to continue coverage for the spouse during a period of

separation in contemplation of divorce.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1952.057. PROHIBITED PROVISION: PAYMENT ON CONVICTION FOR DRUG OFFENSE. (a) An insurer may not deliver or issue for delivery in this state an automobile insurance policy that provides payment on final conviction of the named insured for loss for a covered motor vehicle seized by federal or state law enforcement officers as evidence in a case against the named insured under Chapter 481, Health and Safety Code, or under the federal Controlled Substances Act (21 U.S.C. Section 801 et seq.).

(b) For purposes of this section, a named insured for:

(1) an individual automobile insurance policy is the person named on the declaration page of the policy and the person's spouse; and

(2) an automobile insurance policy other than an individual policy is the company or corporation named on the declaration page of the policy and any officer, director, or shareholder of that company or corporation.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1952.058. LOSS CONTROL INFORMATION AND SERVICES REQUIRED.

(a) An insurer must provide loss control information as a prerequisite to writing commercial automobile liability insurance in this state.

(b) The insurer shall provide to the insurer's policyholders loss control information reasonably commensurate with the risks, exposures, and experience of the insured's business. To provide loss control information or services, the insurer may:

(1) employ qualified personnel;

(2) retain qualified independent contractors;

(3) contract with the policyholder to provide qualified loss control personnel and services; or

(4) use a combination of methods described by this subsection.

(c) If there is evidence that an insurer is not providing reasonable loss control information or is not using that information in a reasonable manner to reduce losses, the commissioner shall order a hearing to determine whether the insurer is in compliance with this section. If the commissioner determines that the insurer is not in compliance, the commissioner may impose any sanction authorized by Chapter 82.

(d) An insurer or an agent or employee of the insurer is not liable, and a cause of action does not arise against the insurer, agent, or employee, for any accident based on the allegation that the accident was caused or could have been prevented by a program, information, inspection, or other activity or service undertaken by the insurer for the prevention of accidents in connection with operations of the insured. The immunity provided by this subsection does not affect the liability of an insurer for compensation or as otherwise provided in an insurance policy.

(e) Loss control information an insurer provides to an insured under this section is not subject to discovery and is not admissible as evidence in any civil proceeding.

(f) The commissioner, after holding a public hearing on the proposed rules, may adopt reasonable rules for the enforcement of this section.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1952.059. REQUIRED PROVISION: COVERAGE FOR CERTAIN VEHICLES ACQUIRED DURING POLICY TERM. (a) This section applies to an insurer authorized to write automobile insurance in this state, including an insurance company, reciprocal or interinsurance exchange, mutual insurance company, capital stock company, county mutual insurance company, Lloyd's plan, or other entity.

(b) A personal automobile insurance policy must contain a provision defining a covered vehicle in accordance with this section for a motor vehicle acquired by the insured during the policy term.

(c) Coverage under this section is required only for a vehicle that is:

- (1) a private passenger automobile; or
- (2) a pickup, utility vehicle, or van with a gross vehicle

weight of 25,000 pounds or less that is not used for the delivery or transportation of goods, materials, or supplies, other than samples, unless:

(A) the delivery of the goods, materials, or supplies is not the primary use for which the vehicle is employed; or

(B) the vehicle is used for farming or ranching.

(d) Coverage under this section is required only for a vehicle that is acquired during the policy term and of which the insurer is notified on or before:

(1) the 20th day after the date on which the insured becomes the owner of the vehicle; or

(2) a later date specified by the policy.

(e) Coverage under this section for a vehicle that replaces a covered vehicle shown in the declarations for the policy must be the same as the coverage for the vehicle being replaced. An insured must notify the insurer of a replacement vehicle during the time prescribed by Subsection (d) only if the insured wishes to:

(1) add coverage for damage to the vehicle; or

(2) continue existing coverage for damage to the vehicle after the period prescribed by Subsection (d) expires.

(f) Coverage under this section for a vehicle that is acquired during the policy term in addition to the covered vehicles shown in the declarations for the policy and of which the insurer is notified as prescribed by Subsection (d) must be the broadest coverage provided under the policy for any covered vehicle shown in the declarations.

Added by Acts 2013, 83rd Leg., R.S., Ch. 282 (H.B. 949), Sec. 2, eff. September 1, 2013.

Sec. 1952.060. REQUIRED PROVISION: LIABILITY COVERAGE FOR TEMPORARY VEHICLES DURING POLICY TERM; PRIMARY COVERAGE REQUIRED.

(a) In this section:

(1) "Repair facility" means a person who rebuilds, repairs, or services a motor vehicle for consideration or under a warranty, service, or maintenance contract.

(2) "Resident relative" means an individual who:

(A) resides in the same household as the insured; and

(B) is related to the insured within the third degree

of consanguinity or affinity as described by Chapter 573, Government Code.

(3) "Temporary vehicle" includes a vehicle that is loaned or provided to an insured by an automobile repair facility for the insured's use while the insured's vehicle is at the facility for service, repair, maintenance, or damage or to obtain an estimate and is:

(A) in the lawful possession of the insured or resident relative of the insured;

(B) not owned by the insured, any resident relative of the insured, or any other person residing in the insured's household; and

(C) operated by or in the possession of the insured or resident relative of the insured until the vehicle is returned to the repair facility.

(b) A personal automobile insurance policy, including a policy issued by a county mutual insurance company, must define temporary vehicle as defined by this section and include in the policy's primary liability coverage primary liability coverage for a temporary vehicle as a covered vehicle during the policy term.

(c) Coverage under this section is required only for a vehicle that is:

(1) a private passenger automobile; or

(2) a pickup, utility vehicle, or van with a gross vehicle weight of 14,000 pounds or less that is not used for the delivery or transportation of goods, materials, or supplies, other than samples, unless:

(A) the delivery of the goods, materials, or supplies is not the primary use for which the vehicle is employed; or

(B) the vehicle is used for farming or ranching.

(d) The coverage required by this section provides primary coverage for the insured's legal liability for bodily injury and property damage and for damage to the temporary vehicle, not excess coverage. The coverage must insure:

(1) the person named in the personal automobile insurance policy; and

(2) any resident relative of the insured and licensed operator residing in the household except for a person specifically named in a named driver exclusion under Section 1952.353(b).

(e) The policy limits of a personal automobile insurance policy

must be available for the coverage required by this section.

Added by Acts 2019, 86th Leg., R.S., Ch. 1367 (H.B. 3420), Sec. 1, eff. September 1, 2019.

Amended by:

Acts 2021, 87th Leg., R.S., Ch. 24 (H.B. 1787), Sec. 1, eff. September 1, 2021.

SUBCHAPTER C. UNINSURED OR UNDERINSURED MOTORIST COVERAGE

Sec. 1952.101. UNINSURED OR UNDERINSURED MOTORIST COVERAGE REQUIRED. (a) In this section, "uninsured or underinsured motorist coverage" means the provisions of an automobile liability insurance policy that provide for coverage in at least the limits prescribed by Chapter 601, Transportation Code, that protects insureds who are legally entitled to recover from owners or operators of uninsured or underinsured motor vehicles damages for bodily injury, sickness, disease, or death, or property damage resulting from the ownership, maintenance, or use of any motor vehicle.

(b) An insurer may not deliver or issue for delivery in this state an automobile liability insurance policy, including a policy provided through the Texas Automobile Insurance Plan Association under Chapter 2151, that covers liability arising out of the ownership, maintenance, or use of any motor vehicle unless the insurer provides uninsured or underinsured motorist coverage in the policy or supplemental to the policy.

(c) The coverage required by this subchapter does not apply if any insured named in the insurance policy rejects the coverage in writing. Unless the named insured requests in writing the coverage required by this subchapter, the insurer is not required to provide that coverage in or supplemental to a reinstated insurance policy or renewal insurance policy if the named insured rejected the coverage in connection with that insurance policy or an insurance policy previously issued to the insured by the same insurer or by an affiliated insurer.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.037(a), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.037(a), eff. September 1, 2007.

Sec. 1952.102. UNINSURED MOTOR VEHICLE. (a) For purposes of the coverage required by this subchapter, "uninsured motor vehicle," subject to the terms of the coverage, is considered to include an insured motor vehicle as to which the insurer providing liability insurance is unable because of insolvency to make payment with respect to the legal liability of the insured within the limits specified in the insurance.

(b) The commissioner may, in the policy forms filed under Subchapter B, Chapter 2301, allow "uninsured motor vehicle" to be defined or, in policy forms adopted under Article 5.06, define "uninsured motor vehicle," to exclude certain motor vehicles whose operators are in fact uninsured.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1952.103. UNDERINSURED MOTOR VEHICLE. For purposes of the coverage required by this subchapter, "underinsured motor vehicle" means an insured motor vehicle on which there is collectible liability insurance coverage with limits of liability for the owner or operator that were originally lower than, or have been reduced by payment of claims arising from the same accident to, an amount less than the limit of liability stated in the underinsured coverage of the insured's policy.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1952.104. REQUIRED PROVISIONS RELATING TO UNINSURED OR UNDERINSURED MOTORIST COVERAGE. The portion of a policy form adopted under Article 5.06 or filed as provided by Subchapter B, Chapter 2301, to provide coverage under this subchapter must:

(1) provide that, regardless of the number of persons insured, policies or bonds applicable, vehicles involved, or claims made, the total aggregate limit of liability to any one person who

sustains bodily injury or property damage as the result of a single occurrence may not exceed the limit of liability for those coverages as stated in the insurance policy and that the total aggregate limit of liability to all claimants, if more than one, may not exceed the total limit of liability per occurrence as stated in the policy;

(2) provide for the exclusion of the recovery of damages for bodily injury or property damage, or both, resulting from the intentional acts of the insured; and

(3) require that, for the insured to recover under the uninsured motorist coverage if the owner or operator of any motor vehicle that causes bodily injury or property damage to the insured is unknown, actual physical contact must have occurred between the motor vehicle owned or operated by the unknown person and the person or property of the insured.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1952.105. LIABILITY LIMITS. (a) The limits of liability for bodily injury, sickness, disease, or death must be offered to an insured in the amounts desired by the insured, but not in amounts greater than the limits of liability specified in the bodily injury liability provisions of the insured's policy.

(b) Subject to a deductible amount of \$250, coverage for property damage must be offered to an insured in the amounts desired by the insured, but not in amounts greater than the limits of liability specified in the property damage liability provisions of the insured's policy.

(c) Notwithstanding Subsections (a) and (b), amounts of liability limits for bodily injury, sickness, disease, or death and amounts for coverage for property damage may not be offered in amounts less than those prescribed by Chapter 601, Transportation Code.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1952.106. RECOVERY UNDER UNDERINSURED MOTORIST COVERAGE. Underinsured motorist coverage must provide for payment to the

insured of all amounts that the insured is legally entitled to recover as damages from owners or operators of underinsured motor vehicles because of bodily injury or property damage, not to exceed the limit specified in the insurance policy, and reduced by the amount recovered or recoverable from the insurer of the underinsured motor vehicle.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1952.107. RECOVERY UNDER COLLISION OR COMBINED COVERAGE.

(a) An insured who has collision coverage and uninsured or underinsured property damage liability coverage may recover under the coverage the insured chooses.

(b) If neither the collision coverage or the uninsured or underinsured property damage liability coverage is sufficient alone to cover all damage resulting from a single occurrence, the insured may recover under both coverages. If recovering under both coverages, the insured shall designate one coverage as the primary coverage and pay the deductible applicable to that coverage. The primary coverage must be exhausted before any recovery is made under the secondary coverage.

(c) If both the primary and secondary coverages are used to pay damages from a single occurrence, the insured may not be required to pay the deductible applicable to the secondary coverage when the amount of the deductible otherwise applicable to the secondary coverage is the same as or less than the amount of the deductible applicable to the primary coverage. If both coverages are used to pay damages from a single occurrence and the amount of the deductible otherwise applicable to the secondary coverage is greater than the amount of the deductible applicable to the primary coverage, the insured shall pay the difference between the amount of the two deductibles with respect to the secondary coverage.

(d) The insured may not recover under both the primary and secondary coverages more than the actual damages suffered.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1952.108. INSURER'S RIGHT OF RECOVERY. (a) An insurer that makes a payment to any person under any coverage required by this subchapter is subject to the terms of that coverage and, to the extent of the payment, is entitled to the proceeds of any settlement or judgment resulting from the exercise of any right of recovery of the person to whom the payment is made against any person or organization legally responsible for the bodily injury, sickness, disease, or death for which the payment is made, including the proceeds recoverable from the assets of an insolvent insurer.

(b) If, under an insurance policy issued under this subchapter, an insurer makes a payment as a result of the insolvency of another insurer:

(1) the insolvent insurer's insured shall be given credit to the extent of the paying insurer's payment in any judgment obtained against the insured with respect to the insured's legal liability for damages described by Subsection (a); and

(2) subject to Subchapter F, Chapter 462, the paying insurer has the right to proceed directly against the insolvent insurer or that insurer's receiver, and in pursuing that right the paying insurer has any rights that the insolvent insurer's insured might otherwise have had if the insured had made the payment.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1952.109. BURDEN OF PROOF IN DISPUTE. The insurer has the burden of proof in a dispute as to whether a motor vehicle is uninsured.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1952.110. VENUE. Notwithstanding Section 15.032, Civil Practice and Remedies Code, an action against an insurer in relation to the coverage provided under this subchapter, including an action to enforce that coverage, may be brought only in the county in which:

(1) the policyholder or beneficiary instituting the action resided at the time of the accident involving the uninsured or underinsured motor vehicle; or

(2) the accident occurred.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER D. PERSONAL INJURY PROTECTION COVERAGE

Sec. 1952.151. PERSONAL INJURY PROTECTION. "Personal injury protection" consists of provisions of an automobile liability insurance policy that provide for payment to the named insured in the policy, members of the insured's household, and any authorized operator or passenger of the named insured's motor vehicle, including a guest occupant, of all reasonable expenses that:

(1) arise from an accident;

(2) are incurred not later than the third anniversary of the date of the accident; and

(3) are for:

(A) necessary medical, surgical, x-ray, or dental services, including prosthetic devices, and necessary ambulance, hospital, professional nursing, or funeral services;

(B) in the case of an income producer, replacement of income lost as the result of the accident; or

(C) in the case of a person injured in the accident who was not an income or wage producer at the time of the accident, reimbursement of necessary and reasonable expenses incurred for essential services ordinarily performed by the injured person for care and maintenance of the family or family household.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1952.152. PERSONAL INJURY PROTECTION COVERAGE REQUIRED.

(a) An insurer may not deliver or issue for delivery in this state an automobile liability insurance policy, including a policy provided through the Texas Automobile Insurance Plan Association under Chapter 2151, that covers liability arising out of the ownership, maintenance, or use of any motor vehicle unless the insurer provides personal injury protection coverage in the policy or supplemental to the policy.

(b) The coverage required by this subchapter does not apply if

any insured named in the insurance policy rejects the coverage in writing. Unless the named insured requests in writing the coverage required by this subchapter, the insurer is not required to provide that coverage in or supplemental to a reinstated insurance policy or renewal insurance policy if the named insured rejected the coverage in connection with that insurance policy or an insurance policy previously issued to the insured by the same insurer or by an affiliated insurer.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.038(a), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.038(a), eff. September 1, 2007.

Sec. 1952.153. MAXIMUM REQUIRED AMOUNT OF PERSONAL INJURY PROTECTION. This subchapter does not require an insurer to provide personal injury protection coverage in an amount that exceeds \$2,500 for all benefits, in the aggregate, for each person.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1952.154. LOSS OF INCOME BENEFITS. An insurer providing loss of income benefits under coverage required by this subchapter may require that the insured, as a condition of receiving those benefits, provide the insurer with reasonable medical proof of the insured's injury causing loss of income.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1952.155. BENEFITS PAYABLE WITHOUT REGARD TO FAULT OR COLLATERAL SOURCE; EFFECT ON SUBROGATION. (a) The benefits under coverage required by this subchapter are payable without regard to:

- (1) the fault or nonfault of the named insured or recipient

in causing or contributing to the collision; and

(2) any collateral source of medical, hospital, or wage continuation benefits.

(b) Except as provided by Subsection (c), an insurer paying benefits under coverage required by this subchapter does not have a right of subrogation or claim against any other person or insurer to recover any benefits by reason of the alleged fault of the other person in causing or contributing to the collision.

(c) An insurer paying benefits pursuant to this subchapter, including a county mutual insurance company, shall have a right of subrogation and a claim against a person causing or contributing to the collision if, on the date of loss, financial responsibility as required by Chapter 601, Transportation Code, has not been established for a motor vehicle involved in the collision and operated by that person.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. [2017](#)), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 3B.039(a), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. [3167](#)), Sec. 9.039(a), eff. September 1, 2007.

Acts 2023, 88th Leg., R.S., Ch. 709 (H.B. [2190](#)), Sec. 135, eff. September 1, 2023.

Sec. 1952.156. PAYMENT OF BENEFITS. (a) Subject to the requirements of this section and Section 1952.157, an insurer shall pay benefits under the coverage required by this subchapter periodically as claims for those benefits arise, but not later than the 30th day after the date the insurer receives satisfactory proof of a claim.

(b) The coverage required by this subchapter may:

(1) prescribe a period of not less than six months after the date of an accident within which the original proof of loss with respect to a claim for benefits must be presented to the insurer; and

(2) provide that an insurer may require reasonable medical proof of an alleged recurrence of an injury for which an original claim for benefits was made if a lapse occurs in the period of total

disability or in the medical treatment of an injured person who:

(A) has received benefits under that coverage; and

(B) subsequently claims additional benefits based on the alleged recurrence.

(c) The aggregate benefits payable under the coverage required by this subchapter to any person may not exceed the maximum limits prescribed in the insurance policy.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1952.157. ACTION FOR FAILURE TO PAY BENEFITS. (a) If the insurer fails to pay benefits under the coverage required by this subchapter when due, the person entitled to those benefits may bring an action in contract to recover the benefits.

(b) If the insurer is required to pay benefits described by Subsection (a), the person entitled to the benefits is entitled to recover reasonable attorney's fees, a penalty of 12 percent, and interest at the legal rate from the date those amounts became overdue.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1952.158. EXCLUSION OF BENEFITS. An insurer shall exclude benefits to an insured or the insured's personal representative under the coverage required by this subchapter if the insured's conduct contributed to the injury the insured sustained and that conduct:

(1) involved intentionally causing injury to the insured;

or

(2) occurred while committing a felony or while seeking to elude lawful apprehension or arrest by a law enforcement official.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1952.159. OFFSET AGAINST LIABILITY CLAIM. (a) If a liability claim is made by a guest or passenger described by Section

1952.151 against the owner or operator of the motor vehicle in which the guest or passenger was riding or against the owner's or operator's liability insurer, the owner or operator of the motor vehicle or the owner's or operator's liability insurer is entitled to an offset, credit, or deduction against any award made to the guest or passenger in an amount equal to the amounts paid by the owner, the operator, or the owner's or operator's automobile liability insurer to the guest or passenger under personal injury protection.

(b) This subchapter does not authorize a direct action against a liability insurer if that right does not presently exist at law.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1952.160. INAPPLICABILITY TO ACCIDENT OR HEALTH INSURANCE. This subchapter applies only to an automobile insurance policy subject to this subtitle or Subchapter A, Chapter 5, and does not apply to any other accident or health insurance policy, regardless of whether the accident or health insurance policy provides indemnity against automobile-connected injuries.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1952.161. CERTAIN COVERAGE UNAFFECTED. This subchapter does not:

(1) affect the offering of medical payments coverage, disability benefits, or accidental death benefits, as presently prescribed by the commissioner; or

(2) prevent an insurer from providing benefits broader than the minimum benefits described by this subchapter, subject to the rules prescribed by the commissioner.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

**SUBCHAPTER E. SHORT-TERM LIABILITY INSURANCE FOR
CERTAIN MOTORISTS**

Sec. 1952.201. APPLICABILITY OF SUBCHAPTER. This subchapter applies to an insurer authorized to write automobile insurance in this state, including an insurance company, reciprocal or interinsurance exchange, mutual insurance company, capital stock company, county mutual insurance company, Lloyd's plan, or other entity.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1952.202. DEFINITIONS. In this subchapter:

(1) "Motor vehicle" means any private passenger vehicle or utility type vehicle that has a gross weight of not more than 25,000 pounds.

(2) "Short-term liability insurance policy" means an insurance policy that:

(A) provides coverage for at least 24 hours but not for more than one week;

(B) meets the requirements of Chapter 601, Transportation Code;

(C) covers liability for bodily injury, death, and property damage arising from the use or operation of a motor vehicle; and

(D) is not insurance assigned to an authorized insurer by the Texas Automobile Insurance Plan Association under Section 2151.102(a).

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1952.203. SHORT-TERM LIABILITY INSURANCE PROGRAM. (a) The commissioner by rule may establish a program to provide for the sale of short-term liability insurance policies to nonresident motorists who are visiting this state.

(b) The commissioner may negotiate an agreement with any insurer under which the insurer will sell insurance policies described by this section.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April

1, 2007.

Sec. 1952.204. AGENT LICENSE REQUIRED. A person representing an insurer in selling short-term liability insurance policies under this subchapter must be licensed under Title 13.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1952.205. SALE OF SHORT-TERM LIABILITY INSURANCE POLICIES. An insurer selling short-term liability insurance policies under this subchapter shall use policy forms adopted by the commissioner under Article 5.06 or filed and in effect as provided by Subchapter B, Chapter 2301, as applicable, unless the insurer is exempt from using those forms.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER F. GARAGE INSURANCE

Sec. 1952.251. DEFINITIONS. In this subchapter:

(1) "Garage customer" means a person or organization other than:

(A) the named insured under a garage insurance policy;
(B) an employee, director, officer, shareholder, partner, or agent of the named insured; or

(C) a resident of the same household as:
(i) the named insured; or
(ii) an employee, director, officer, shareholder, partner, or agent of the named insured.

(2) "Garage insurance" means automobile insurance as defined by Article 5.01 issued to a named insured who is engaged in the business of selling, servicing, or repairing motor vehicles as defined by commissioner rule or order.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1952.252. GARAGE INSURANCE. (a) A garage insurance policy may provide that a garage customer is not an insured under the policy and that the coverage under the policy does not apply to a garage customer except to the extent that any other insurance coverage that is collectible and available to the garage customer is not equal to the minimum financial responsibility limits specified by Chapter 601, Transportation Code.

(b) Notwithstanding any provision to the contrary in another insurance policy as to whether the insurance coverage described by Subsection (a) that is provided under that policy is primary, excess, or contingent insurance, or otherwise, the other insurance coverage is the primary insurance as to the garage customer.

(c) A garage insurance policy containing a provision described by Subsection (a) may not cover a garage customer except to the extent permitted by this section, notwithstanding the terms of the other insurance policy providing coverage described by Subsection (a).

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER G. REPAIR OF MOTOR VEHICLES

Sec. 1952.301. LIMITATION ON PARTS, PRODUCTS, OR REPAIR PERSONS OR FACILITIES PROHIBITED. (a) Except as provided by rules adopted by the commissioner, under an automobile insurance policy that is delivered, issued for delivery, or renewed in this state, an insurer may not directly or indirectly limit the insurer's coverage under a policy covering damage to a motor vehicle by:

(1) specifying the brand, type, kind, age, vendor, supplier, or condition of parts or products that may be used to repair the vehicle; or

(2) limiting the beneficiary of the policy from selecting a repair person or facility to repair damage to the vehicle.

(b) In settling a liability claim by a third party against an insured for property damage claimed by the third party, an insurer may not require the third-party claimant to have repairs made by a particular repair person or facility or to use a particular brand, type, kind, age, vendor, supplier, or condition of parts or products.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April

1, 2007.

Sec. 1952.302. PROHIBITED ACTS IN CONNECTION WITH REPAIR OF MOTOR VEHICLE. In connection with the repair of damage to a motor vehicle covered under an automobile insurance policy, an insurer, an employee or agent of an insurer, an insurance adjuster, or an entity that employs an insurance adjuster may not:

(1) solicit or accept a referral fee or gratuity in exchange for referring a beneficiary or third-party claimant to a repair person or facility to repair the damage;

(2) state or suggest, either orally or in writing, to a beneficiary that the beneficiary must use a specific repair person or facility or a repair person or facility identified on a preferred list compiled by an insurer for the damage repair or parts replacement to be covered by the policy; or

(3) restrict the right of a beneficiary or third-party claimant to choose a repair person or facility by requiring the beneficiary or third-party claimant to travel an unreasonable distance to repair the damage.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1952.303. CONTRACTS BETWEEN INSURER AND REPAIR PERSON OR FACILITY. (a) A contract between an insurer and a repair person or facility, including an agreement under which the repair person or facility agrees to extend discounts for parts or labor to the insurer in exchange for referrals by the insurer, may not result in a reduction of coverage under an insured's automobile insurance policy.

(b) The commissioner may adopt rules under Chapter 542 with respect to any fraudulent activity of any party to an agreement described by Subsection (a).

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1952.304. PROVISION OF INFORMATION REGARDING REPAIRS. An insurer may not prohibit a repair person or facility from providing a

beneficiary or third-party claimant with information that states:

- (1) the description, manufacturer, or source of the parts used; and
- (2) the amounts charged to the insurer for the parts and related labor.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1952.305. NOTICE OF RIGHTS REGARDING REPAIR OF MOTOR VEHICLE. (a) At the time a motor vehicle is presented to an insurer, an insurance adjuster, or other person in connection with a claim for damage repair, the insurer, insurance adjuster, or other person shall provide to the beneficiary or third-party claimant notice of the provisions of this subchapter.

(b) The commissioner shall adopt a rule establishing the method or methods insurers must use to comply with the notice provisions of this section.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1952.306. COMPLAINTS. A beneficiary, third-party claimant, or repair person or facility may submit a written, documented complaint to the department with respect to an alleged violation of this subchapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 1952.307. RULES. Rules adopted by the commissioner to implement this subchapter must include requirements that:

- (1) any limitation described by Section 1952.301(a) be clearly and prominently displayed on the face of the insurance policy or certificate in lieu of an insurance policy; and
- (2) the insured give written consent to a limitation described by Section 1952.301(a) after the insured is notified orally and in writing of the limitation at the time the insurance policy is

purchased.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER H. NAMED DRIVER POLICIES

Sec. 1952.351. DEFINITIONS. In this subchapter:

(1) "Household" means a unit composed of individuals living together in the same dwelling, without regard to whether they are related to each other. The term includes a unit composed of individuals living together in:

(A) a home or mobile home;

(B) a duplex unit, apartment unit, or condominium unit;

or

(C) any dwelling unit in a multiunit residential structure.

(2) "Named driver exclusion" means a provision or endorsement of an automobile insurance policy that excludes specified drivers from coverage under the policy.

(3) "Named driver policy" means an automobile insurance policy that provides any type of coverage for individuals named on the policy but that does not provide coverage for every individual who has permission to use a covered vehicle and who resides in a named insured's household.

(4) "Operator's policy" means an automobile insurance policy that, in accordance with Section 601.077, Transportation Code, provides coverage for the named insured when operating an automobile the insured does not own.

Added by Acts 2019, 86th Leg., R.S., Ch. 455 (H.B. 259), Sec. 1, eff. September 1, 2019.

Sec. 1952.352. APPLICABILITY. This subchapter applies to an insurer writing automobile insurance in this state, including an insurance company, corporation, reciprocal or interinsurance exchange, mutual insurance company, capital stock company, association, county mutual insurance company, Lloyd's plan, and any other insurer.

Added by Acts 2019, 86th Leg., R.S., Ch. 455 (H.B. 259), Sec. 1, eff. September 1, 2019.

Sec. 1952.353. NAMED DRIVER POLICIES PROHIBITED; CERTAIN NAMED DRIVER EXCLUSIONS AUTHORIZED. (a) An insurer may not deliver, issue for delivery, or renew a named driver policy unless the named driver policy is an operator's policy.

(b) An insurer may use a named driver exclusion only if the exclusion specifically names each excluded driver and does not exclude a class of drivers and the named insured accepts the exclusion in writing.

Added by Acts 2019, 86th Leg., R.S., Ch. 455 (H.B. 259), Sec. 1, eff. September 1, 2019.

CHAPTER 1953. RATE REGULATION AND RATEMAKING FOR AUTOMOBILE INSURANCE
SUBCHAPTER A. RATE REGULATION

Sec. 1953.001. EXCLUSION OF CERTAIN TYPES OR CLASSES OF INSURANCE FROM CERTAIN REGULATIONS. (a) This section applies only to insurance against liability for damages arising out of the ownership, operation, maintenance, or use of a motor vehicle described by Article 5.01 or against loss of or damage to a motor vehicle described by Article 5.01 that, in the judgment of the commissioner, is a type or class of insurance that is also the subject of or is more properly regulated under other insurance rating laws that cover that type or class of insurance.

(b) A type or class of insurance to which this section applies is excluded from regulation under this chapter and:

- (1) Articles 5.01, 5.01B, 5.03, 5.04, 5.04-1, 5.06, 5.10, and 5.11;
- (2) Chapters 251 and 254;
- (3) Subchapters A and B, Chapter 1806; and
- (4) Chapters 1951 and 1952.

(c) If the commissioner finds that a type or class of insurance to which this section applies is also the subject of or is more properly regulated under other insurance rating laws that cover that type or class of insurance, the commissioner shall issue an order declaring which other insurance rating laws apply to:

- (1) the type or class of insurance; and
- (2) any motor vehicle equipment described by Article 5.01.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1H.001, eff. April 1, 2009.

SUBCHAPTER B. RATEMAKING

Sec. 1953.051. CERTAIN RATING PLANS PROHIBITED. (a) A rating plan regarding the writing of automobile insurance, other than insurance written under Chapter 2151, may not:

- (1) assign a rate consequence to a charge or conviction for a violation of Subtitle C, Title 7, Transportation Code; or
- (2) otherwise cause premiums for automobile insurance to be increased because of a charge or conviction described by Subdivision (1).

(b) A rating plan regarding the writing of personal automobile insurance may not:

- (1) assign a rate consequence solely to:
 - (A) a consumer inquiry, as defined by Section 544.551, made by an applicant or insured; or
 - (B) a claim filed by an insured under a personal automobile insurance policy that is not paid or payable under the policy; or
- (2) otherwise cause premiums for personal automobile insurance to be increased solely because of an inquiry or claim described by Subdivision (1).

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1H.001, eff. April 1, 2009.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1137 (S.B. 189), Sec. 4, eff. September 1, 2015.

Sec. 1953.052. PREMIUM SURCHARGE REQUIRED. (a) An insurer described by Section 1952.001 shall assess a premium surcharge in an amount as stated in the insurer's rating plan against an insured for no more than three years immediately following the date the insured is convicted of:

- (1) an offense relating to the operating of a motor vehicle

while intoxicated in violation of Section 49.04 or 49.07, Penal Code;
or

(2) an offense under Section 49.08, Penal Code.

(b) An insurer may apply the premium surcharge described by Subsection (a) only to a private passenger automobile policy, as defined by the department.

(c) If an insured assessed a premium surcharge under Subsection (a) is convicted of an offense under one of the statutes listed in Subsection (a)(1) or (2) during the period the insured is assessed the premium surcharge, the period for which the premium surcharge is assessed is increased by three additional consecutive years for each conviction.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1H.001, eff. April 1, 2009.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 216 (S.B. 1490), Sec. 1, eff. September 1, 2017.

SUBCHAPTER C. LOSS AND EXPENSE EXPERIENCE

Sec. 1953.101. RECORDING AND REPORTING OF LOSS AND EXPENSE EXPERIENCE AND OTHER DATA. (a) The commissioner shall adopt reasonable rules and statistical plans for the recording and reporting of loss experience and other required data by insurers. The rules and plans must ensure that each insurer's total loss and expense experience is made available at least as frequently as annually in the form and with the detail necessary to aid in determining whether rates and rating systems in use under the following provisions comply with the standards adopted under those provisions:

- (1) this chapter;
- (2) Articles 5.01, 5.03, and 5.04, if applicable;
- (3) Subchapters A and B, Chapter 1806; and
- (4) Chapters 1951 and 1952.

(b) In adopting the rules, the commissioner shall adopt rules that are as uniform as is practicable to the rules and forms of statistical plans used in other states.

(c) Each insurer shall use the statistical plans adopted under this section to record and report loss experience and other required

data in accordance with the rules adopted by the commissioner.

(d) The commissioner may modify statistical plans adopted under this section.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1H.001, eff. April 1, 2009.

Sec. 1953.102. RULES ALLOWING INTERCHANGE OF LOSS EXPERIENCE INFORMATION. The commissioner may adopt reasonable rules to allow the interchange of loss experience information as necessary for the application of rating plans.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1H.001, eff. April 1, 2009.

Sec. 1953.103. EXCHANGE OF INFORMATION AND EXPERIENCE DATA WITH OTHER STATES. To further the uniform administration of rating laws, the department or an insurer may:

(1) exchange information and experience data with insurance supervisory officials, insurers, and rating organizations in other states; and

(2) consult and cooperate with the individuals or entities described by Subdivision (1) with respect to ratemaking and the application of rating systems.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1H.001, eff. April 1, 2009.

Sec. 1953.104. SWORN STATEMENTS. (a) The department may require a sworn statement from an insurer affected by this subchapter that shows:

(1) the insurer's experience on any classification or classifications of risks; and

(2) other information that is necessary or helpful in performing duties or exercising authority imposed by law.

(b) The department shall prescribe the necessary forms for statements and reports required under Subsection (a) with due regard for the rules, methods, and forms in use in other states for similar

purposes so that uniformity of statistics is not disturbed.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1H.001, eff. April 1, 2009.

CHAPTER 1954. INSURANCE FOR TRANSPORTATION NETWORK COMPANY DRIVERS
SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1954.001. DEFINITIONS. In this chapter:

(1) "Digital network" means any online-enabled application, software, website, or system offered or used by a transportation network company that enables a prearranged ride with a transportation network company driver.

(2) "Personal vehicle" means a vehicle that is used by a transportation network company driver and is:

(A) owned, leased, or otherwise authorized for use by the driver; and

(B) not a taxicab, limousine, or similar for-hire vehicle.

(3) "Prearranged ride" means transportation provided by a transportation network company driver to a transportation network company rider, beginning at the time a driver accepts a ride requested by a rider through a digital network controlled by a transportation network company and ending at the time the last requesting rider departs from the driver's personal vehicle. The term does not include:

(A) a shared expense carpool or vanpool arrangement or service; or

(B) transportation provided using a taxicab, limousine, or similar for-hire vehicle.

(4) "Transportation network company" means a corporation, partnership, sole proprietorship, or other entity operating in this state that uses a digital network to connect a transportation network company rider to a transportation network company driver for a prearranged ride.

(5) "Transportation network company driver" means an individual who:

(A) receives connections to potential transportation network company riders and related services from a transportation network company in exchange for payment of a fee to the company; and

(B) uses a personal vehicle to offer or provide a prearranged ride to a transportation network company rider on connection with the rider through a digital network controlled by the company in exchange for compensation or payment of a fee.

(6) "Transportation network company rider" means an individual who uses a transportation network company's digital network to connect with a transportation network company driver who provides a prearranged ride to the individual in the driver's personal vehicle between points chosen by the individual.

Added by Acts 2015, 84th Leg., R.S., Ch. 742 (H.B. 1733), Sec. 1, eff. January 1, 2016.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 855 (H.B. 2501), Sec. 1, eff. September 1, 2017.

Sec. 1954.002. APPLICABILITY OF CHAPTER. (a) This chapter applies to automobile insurance policies in this state, including policies issued by a Lloyd's plan, a reciprocal or interinsurance exchange, and a county mutual insurance company.

(b) This chapter does not apply to an entity arranging nonemergency medical transportation services under a contract with the state or a managed care organization for individuals qualifying for Medicaid or Medicare unless the entity:

(1) provides the transportation services through a digital network that connects transportation network company drivers to transportation network company riders for prearranged rides;

(2) contracts individually with each transportation network company driver who is connected to transportation network company riders for the prearranged rides through the entity's digital network; and

(3) otherwise meets all requirements under the Medicaid or Medicare program for delivery of nonemergency medical transportation services.

Added by Acts 2015, 84th Leg., R.S., Ch. 742 (H.B. 1733), Sec. 1, eff. January 1, 2016.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 855 (H.B. 2501), Sec. 2, eff. September 1, 2017.

SUBCHAPTER B. INSURANCE REQUIREMENTS

Sec. 1954.051. GENERAL INSURANCE REQUIREMENT. (a) A transportation network company driver or transportation network company on the driver's behalf shall maintain primary automobile insurance as required by this subchapter.

(b) Insurance maintained under this subchapter must allow a transportation network company driver to use a personal vehicle to transport transportation network company riders for compensation and cover the driver while:

(1) the driver is logged on to the transportation network company's digital network as provided by Section 1954.052; or

(2) the driver is engaged in a prearranged ride as provided by Section 1954.053.

(c) Insurance maintained under this subchapter must comply with the law applicable to personal automobile insurance in this state, including this subtitle and Chapter 601, Transportation Code.

(d) The coverage requirements of this subchapter may be satisfied by:

(1) automobile insurance maintained by the transportation network company driver;

(2) automobile insurance maintained by the transportation network company; or

(3) a combination of Subdivisions (1) and (2).

(e) Insurance required under this subchapter may be placed with an automobile insurer authorized to engage in business in this state or with an eligible surplus lines insurer.

Added by Acts 2015, 84th Leg., R.S., Ch. 742 (H.B. 1733), Sec. 1, eff. January 1, 2016.

Sec. 1954.052. INSURANCE REQUIREMENTS: BETWEEN PREARRANGED RIDES. At the time a transportation network company driver is logged on to the transportation network company's digital network and is available to receive transportation network requests but is not engaged in a prearranged ride, the automobile insurance policy must provide:

(1) the following minimum amounts of liability insurance

coverage:

(A) \$50,000 for bodily injury to or death for each person in an incident;

(B) \$100,000 for bodily injury to or death of a person per incident; and

(C) \$25,000 for damage to or destruction of property of others in an incident;

(2) uninsured or underinsured motorist coverage where required by Section 1952.101; and

(3) personal injury protection coverage where required by Section 1952.152.

Added by Acts 2015, 84th Leg., R.S., Ch. 742 (H.B. 1733), Sec. 1, eff. January 1, 2016.

Sec. 1954.053. INSURANCE REQUIREMENTS: DURING PREARRANGED RIDES. At the time a transportation network company driver is engaged in a prearranged ride, the automobile insurance policy must provide, at a minimum:

(1) coverage with a total aggregate limit of liability of \$1 million for death, bodily injury, and property damage for each incident;

(2) uninsured or underinsured motorist coverage where required by Section 1952.101; and

(3) personal injury protection coverage where required by Section 1952.152.

Added by Acts 2015, 84th Leg., R.S., Ch. 742 (H.B. 1733), Sec. 1, eff. January 1, 2016.

Sec. 1954.054. LAPSE OF OR INSUFFICIENT COVERAGE. If an insurance policy maintained by a transportation network company driver under this subchapter has lapsed or does not provide the coverage required by this subchapter, the transportation network company shall provide the coverage required by this subchapter beginning with the first dollar of a claim against the driver.

Added by Acts 2015, 84th Leg., R.S., Ch. 742 (H.B. 1733), Sec. 1, eff. January 1, 2016.

Sec. 1954.055. RELATION TO PERSONAL AUTOMOBILE INSURANCE. Coverage under an automobile insurance policy maintained by the transportation network company is not contingent on a transportation network company driver's personal automobile insurer initially denying a claim.

Added by Acts 2015, 84th Leg., R.S., Ch. 742 (H.B. 1733), Sec. 1, eff. January 1, 2016.

Sec. 1954.056. FINANCIAL RESPONSIBILITY. (a) Insurance satisfying the requirements of this subchapter satisfies the financial responsibility requirement for an automobile under Chapter 601, Transportation Code.

(b) A transportation network company driver shall carry proof of insurance that satisfies Sections 1954.052 and 1954.053 with the driver when the driver uses a vehicle in connection with a transportation network company's digital network. In the event of a collision, a driver shall provide the proof of insurance to a directly interested person, automobile insurer, and investigating peace officer on request under Section 601.053, Transportation Code. On request, a driver shall also disclose to a directly interested person, automobile insurer, and investigating peace officer whether, at the time of the collision, the driver was:

- (1) logged on to the company's digital network; or
- (2) engaged in a prearranged ride.

Added by Acts 2015, 84th Leg., R.S., Ch. 742 (H.B. 1733), Sec. 1, eff. January 1, 2016.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 709 (H.B. 2190), Sec. 136, eff. September 1, 2023.

SUBCHAPTER C. RELATIONSHIP BETWEEN TRANSPORTATION NETWORK COMPANY AND TRANSPORTATION NETWORK COMPANY DRIVER

Sec. 1954.101. REQUIRED DISCLOSURES. Before a transportation network company driver may accept a request for a prearranged ride on a transportation network company's digital network, the company shall

disclose in writing the following:

(1) the insurance policy, including the types of coverage and the limits for the policy, that the company provides while a driver uses a personal vehicle in connection with the company's digital network; and

(2) that the driver's personal automobile insurance policy may not provide coverage, depending on the policy's terms, while the driver is logged on to the company's digital network and is available to receive transportation requests or is engaged in a prearranged ride.

Added by Acts 2015, 84th Leg., R.S., Ch. 742 (H.B. 1733), Sec. 1, eff. January 1, 2016.

Sec. 1954.102. CONTROL OF TRANSPORTATION NETWORK COMPANY DRIVERS. A transportation network company does not control, direct, or manage a personal vehicle or a transportation network company driver who connects to the company's digital network except as agreed by written contract.

Added by Acts 2015, 84th Leg., R.S., Ch. 742 (H.B. 1733), Sec. 1, eff. January 1, 2016.

SUBCHAPTER D. PERSONAL AUTOMOBILE INSURANCE

Sec. 1954.151. AUTHORIZED EXCLUSIONS FROM COVERAGE. (a) An insurer may exclude from coverage under a personal automobile insurance policy issued to an owner or operator of a personal vehicle any loss or injury that occurs while a transportation network company driver using the personal vehicle:

(1) is logged on to a transportation network company's digital network; or

(2) is engaged in a prearranged ride.

(b) Subsection (a) applies to any coverage included in a personal automobile insurance policy, including:

(1) liability coverage for bodily injury and property damage;

(2) personal injury protection coverage under Subchapter D, Chapter 1952;

(3) uninsured and underinsured motorist coverage;

- (4) medical payment coverage;
- (5) comprehensive physical damage coverage; and
- (6) collision physical damage coverage.

(c) An exclusion authorized under this section applies notwithstanding a financial responsibility requirement under Chapter 601, Transportation Code.

(d) This subchapter may not be construed to invalidate or limit an exclusion contained in a policy form, including a policy form in use or approved for use in this state before January 1, 2016, that excludes coverage for automobiles used to carry persons or property for compensation or available for hire by the public.

Added by Acts 2015, 84th Leg., R.S., Ch. 742 (H.B. 1733), Sec. 1, eff. January 1, 2016.

Sec. 1954.152. COVERAGE UNDER PERSONAL AUTOMOBILE INSURANCE NOT REQUIRED. (a) This subchapter does not require a personal automobile insurance policy to cover a transportation network company driver while:

- (1) the driver is logged on to a transportation network company's digital network;
- (2) the driver is engaged in a prearranged ride; or
- (3) the driver otherwise uses a vehicle to transport passengers for compensation.

(b) This section does not prevent an insurer from providing coverage that may be excluded under this section if the insurer elects to provide the coverage in the policy or by endorsement.

Added by Acts 2015, 84th Leg., R.S., Ch. 742 (H.B. 1733), Sec. 1, eff. January 1, 2016.

Sec. 1954.153. DEFENSE OR INDEMNIFICATION OF CLAIM. (a) An automobile insurer that issues a personal automobile insurance policy that includes an exclusion from coverage authorized by Section 1954.151 does not have a duty to defend or indemnify a claim arising from an event subject to the exclusion.

(b) An automobile insurer that defends or indemnifies a claim against a transportation network company driver for which coverage is excluded under the terms of the policy as authorized by this

subchapter has a right of contribution against another insurer that provides automobile insurance to the driver in satisfaction of the coverage requirements under Section 1954.052 or 1954.053, as applicable.

Added by Acts 2015, 84th Leg., R.S., Ch. 742 (H.B. 1733), Sec. 1, eff. January 1, 2016.

Sec. 1954.154. ASSISTANCE IN CLAIM INVESTIGATION. In an insurance claim investigation, a transportation network company and any insurer providing coverage under Subchapter B shall assist each insurer involved in the claim by providing information to directly interested persons and an insurer of the transportation network company driver. Information provided under this section must include:

(1) the precise times that a driver logged on and off of the transportation network company's digital network in the 12-hour period immediately preceding and the 12-hour period immediately following the accident; and

(2) a clear description of the coverage, exclusions, and limits provided under an automobile insurance policy maintained under Subchapter B.

Added by Acts 2015, 84th Leg., R.S., Ch. 742 (H.B. 1733), Sec. 1, eff. January 1, 2016.

Sec. 1954.155. PAYMENT OF CERTAIN CLAIMS. If there is a lien on a personal vehicle and the transportation network company's insurer covers a claim arising out of an incident that occurred during a prearranged ride, the insurer shall issue payment for the claim:

(1) directly to the person who is repairing the vehicle; or

(2) jointly to the owner of the personal vehicle and the primary lienholder.

Added by Acts 2015, 84th Leg., R.S., Ch. 742 (H.B. 1733), Sec. 1, eff. January 1, 2016.

**SUBTITLE D. FIRE INSURANCE AND ALLIED LINES,
INCLUDING RESIDENTIAL PROPERTY INSURANCE
CHAPTER 2001. GENERAL PROVISIONS: FIRE INSURANCE AND ALLIED LINES,
INCLUDING RESIDENTIAL PROPERTY INSURANCE**

Sec. 2001.001. APPLICABILITY OF SUBTITLE. (a) Each insurance policy or contract insuring property in this state against loss by fire, including a policy or contract or portion of a policy or contract that insures the shore end of a marine risk against loss by fire, must be issued in accordance with:

- (1) this chapter;
- (2) Section 403.002;
- (3) Subchapter C, Chapter 5;
- (4) Subchapter H, Chapter 544;
- (5) Subchapter D, Chapter 1806; and
- (6) Chapters 252, 2002, 2003, 2004, 2005, 2006, and 2171.

(b) An insurer issuing an insurance policy or contract described by Subsection (a), including a fire insurance company, marine insurance company, fire and marine insurance company, and fire and tornado insurance company, is governed by the laws described by Subsection (a).

(c) This section applies to an insurer or to an insurance policy or contract regardless of:

- (1) the kind and character of property insured;
- (2) whether the property is:
 - (A) fixed or movable;
 - (B) stationary or in transit; or
 - (C) consigned or billed for shipment inside or outside the boundaries of this state or to a foreign country;
- (3) whether the insurer is organized:
 - (A) under the laws of this state, another state, territory, or possession of the United States, or a foreign country; or
 - (B) by authority of the federal government; or
- (4) the kind of insurer or the name of the insurer issuing the policy or contract.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2001.002. RATES. (a) Rates for all lines of insurance subject to a law described by Section 2001.001(a) are determined as provided by Chapter 2251 and Article 5.13-2.

(b) The requirement imposed by Subsection (a) does not affect the requirement for the commissioner to conduct inspections of commercial property and prescribe a manual of rules and rating schedules for commercial property under a law described by Section 2001.001(a).

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2001.003. AUTHORITY TO REQUIRE SWORN STATEMENTS. For an insurer described by Section 2001.001, the department may require from the insurer or a director, officer, representative, or agent of the insurer a sworn statement covering any period that states:

(1) the rates and premiums collected for fire insurance on each class of risks and on all property in this state;

(2) the causes of fire, if known to the insurer or individual or if the insurer or individual possesses relevant information or data or can obtain the information or data at reasonable expense; and

(3) all necessary facts and information to allow the department to determine enforcement and to enforce a law described by Section 2001.001(a).

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2001.004. AUTHORITY TO INSPECT AND TAKE TESTIMONY REGARDING RECORDS. (a) The commissioner or a person authorized by the commissioner may:

(1) visit:

(A) a general, local, or other office of an insurer engaged in the business of insurance in this state;

(B) the insurer's home office located outside this state, if applicable; and

(C) the office of any of the insurer's officers, directors, agents, or other representatives; and

(2) require the insurer or an officer, director, agent, or other representative of the insurer to produce for inspection by the commissioner or the commissioner's authorized representative all of the books, records, and papers of the insurer, officer, director, agent, or representative.

(b) The commissioner or the commissioner's authorized representative may:

(1) examine and make or have made copies of the books, records, and papers described by Subsection (a); and

(2) take testimony under oath regarding the books, records, and papers and compel the attendance of witnesses for that purpose.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2001.005. AUTHORITY TO REQUIRE PROVISION OF DATA. The department may require:

(1) any or all of the fire insurance companies engaged in the business of insurance in this state to jointly or separately provide to the department any data the company or companies possess, including maps, tariffs, inspection reports, and any data affecting fire insurance risks in this state or any part of this state; and

(2) any two or more of those companies or any joint agents or representatives of the companies to provide to the department for use in implementing a law described by Section 2001.001(a) any data the companies, agents, or representatives possess.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2001.006. REPORT OF INFORMATION RELATING TO CERTAIN FIRE LOSSES. (a) The state fire marshal, a fire marshal of a political subdivision of this state, the chief of a fire department in this state, or a peace officer in this state may request an insurer investigating a fire loss of property in which damages or losses exceed \$1,000 to release information in the insurer's possession relating to that loss. The insurer shall release the requested information and cooperate with the official. The requested information may include only:

- (1) an insurance policy relevant to the fire loss under investigation and any application for a policy;
- (2) policy premium payment records;
- (3) the history of the insured's previous claims for fire loss; and
- (4) material relating to the investigation of the loss, including:
 - (A) statements of any person;
 - (B) proof of loss; or
 - (C) other relevant evidence.

(b) This section does not authorize a public official or agency to adopt or require any type of periodic report by an insurer.

(c) An insurer that has reason to suspect that a fire loss to the property of a person insured by the insurer was caused by incendiary means and that receives a request for information under Subsection (a) shall:

- (1) notify the requesting official and provide the official with all relevant material acquired during the insurer's investigation of the fire loss;
- (2) cooperate with and take any action requested of the insurer by a law enforcement agency; and
- (3) permit a person ordered by a court to inspect any of the insurer's records relating to the insurance policy and the loss.

(d) In the absence of fraud or malice, an insurer or a person who provided information on the insurer's behalf is not liable for damages in a civil action or subject to criminal prosecution for an oral or written statement made or any other action taken that is necessary to supply information required under this section.

(e) An official or a department or agency employee who receives information under this section shall maintain the confidentiality of the information until the information is required to be released in a criminal or civil proceeding.

(f) An official described by Subsection (a) may be required to testify as to any information in the official's possession regarding the fire loss of property in a civil action in which a person seeks recovery for the loss from an insurer under an insurance policy.

(g) A person may not intentionally:

- (1) refuse to release information requested under Subsection (a);
- (2) refuse to notify the fire marshal of a fire loss

required to be reported under Subsection (c);

(3) refuse to provide the fire marshal with relevant information required to be provided under Subsection (c); or

(4) fail to maintain the confidentiality of information that is confidential under Subsection (e).

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2001.007. CRIMINAL PENALTY. (a) An officer or director of a fire insurance company described by Section 2001.001, or an agent or person acting on behalf of or employed by a fire insurance company described by Section 2001.001, commits an offense if the officer, director, agent, or person intentionally:

(1) performs or causes to be performed, alone or in conjunction with a corporation, company, or person, an act prohibited by a law described by Section 2001.001(a);

(2) fails to perform an act required to be performed by a law described by Section 2001.001(a);

(3) permits an act prohibited by a law described by Section 2001.001(a); or

(4) otherwise violates a law described by Section 2001.001(a).

(b) An offense under this section is a misdemeanor punishable by a fine of not less than \$300 or more than \$1,000.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2001.008. IMMUNITY FROM PROSECUTION. (a) A person is not excused from giving testimony or producing evidence when legally required at the trial of another person charged with violating a law relating to fire insurance on the ground that the testimony or evidence may incriminate the person under the laws of this state.

(b) A person may not be prosecuted or subjected to a penalty or forfeiture for or because of a transaction, matter, or thing about which the person testifies or produces evidence under this section.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April

1, 2007.

Sec. 2001.009. LIMITATION ON COMPENSATION AND EXPENSES. The total amount of necessary compensation for experts, clerical personnel, and other department employees and necessary expenses, including travel expenses, incurred by the department in implementing the laws described by Section 2001.001(a) may not exceed the amount of the assessments on the gross premiums of all fire insurance companies engaged in the business of insurance in this state.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2001.010. PUBLIC GUIDE RELATING TO COMMERCIAL PROPERTY RATING. (a) In this section, "rating agency" means a public or private legal entity that is authorized to conduct commercial property rating in this state.

(b) The commissioner shall make available to the public a generalized guide that:

(1) summarizes the procedures used by the department or other rating agency to rate nonresidential commercial buildings in this state; and

(2) specifies how different construction elements and techniques used in a building project affect the insurance rating of the completed building.

(c) The commissioner may charge a reasonable fee to cover the administrative costs of producing and distributing the guide.

(d) The commissioner shall review the information in the guide in January of each odd-numbered year and shall revise the guide as necessary to incorporate any changes that have occurred in the preceding biennium that affect the information.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

**CHAPTER 2002. POLICY PROVISIONS AND FORMS FOR FIRE INSURANCE AND
ALLIED LINES, INCLUDING RESIDENTIAL PROPERTY INSURANCE
SUBCHAPTER A. POLICY PROVISIONS**

Sec. 2002.001. POLICY FORM OR ENDORSEMENT MAKING MATERIAL CHANGE TO POLICY. (a) In this section, "material change" means a change to a policy that, with respect to a prior or existing policy:

- (1) reduces coverage;
- (2) changes conditions of coverage; or
- (3) changes the duties of the insured.

(b) An insurer may not use a policy form or endorsement to a policy form to which Article 5.35, Subchapter B of this chapter, or Subchapter B, Chapter 2301, applies that makes a material change to the policy unless:

- (1) the insured requests the material change; or
- (2) the insurer provides the policyholder in a written notice an explanation of the material change that:
 - (A) appears in a conspicuous place on the notice of the material change;
 - (B) clearly indicates each material change to the policy;
 - (C) is written in plain language; and
 - (D) is provided to the policyholder not later than the 30th day before the date on which the policy expires.

(c) Notice required by Subsection (b) may be provided to the policyholder in a notice of renewal.

(d) In addition to the notice to the policyholder provided under Subsection (b), if an insurer elects to make a material change to a policy form or use an endorsement to make a material change to a policy form, not later than the 30th day before the earliest date on which the new policy form or endorsement is used, the insurer shall provide written notice to each agent of the insurer that clearly indicates each material change being made to the policy form. An insurer may provide the notice to the agents in a single notice given to each agent of the insurer that summarizes substantially similar material changes to more than one policy form.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 1018 (H.B. 2655), Sec. 1, eff. September 1, 2011.

Acts 2017, 85th Leg., R.S., Ch. 60 (S.B. 417), Sec. 4, eff. September 1, 2017.

Sec. 2002.002. LIEN ON INSURED PROPERTY. A provision in an insurance policy issued by an insurer subject to this subtitle or Subchapter C, Chapter 5, is void if the provision states that the encumbrance of the insured property by a lien of any character at the time of or after the policy's issuance renders the policy void.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2002.003. COVERAGES FOR SPOUSES AND FORMER SPOUSES. A homeowners insurance policy or fire insurance policy promulgated under Article 5.35 or filed and in effect as provided by Subchapter B, Chapter 2301, may not be delivered, issued for delivery, or renewed in this state unless the policy contains the following language: "It is understood and agreed that this policy, subject to all other terms and conditions contained in this policy, when covering residential community property, as defined by state law, shall remain in full force and effect as to the interest of each spouse covered, irrespective of divorce or change of ownership between the spouses unless excluded by endorsement attached to this policy until the expiration of the policy or until canceled in accordance with the terms and conditions of this policy."

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2002.004. JEWELRY COVERAGE. (a) In this section, "personal property insurance" means insurance against damage to or loss of tangible personal property, including coverage provided in a homeowners insurance policy, residential fire and allied lines insurance policy, or farm and ranch owners insurance policy.

(b) This section applies to each insurer that provides personal property insurance in this state, including a county mutual insurance company, farm mutual insurance company, Lloyd's plan, and reciprocal or interinsurance exchange.

(c) An insurer that provides personal property insurance coverage in this state for jewelry may elect to pay either:

- (1) the stated value of the jewelry item; or
- (2) the actual cost of replacing the jewelry item with one of like kind and quality.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2002.005. COINSURANCE CLAUSES. (a) Except as otherwise provided by this section, an insurer subject to this subtitle or Subchapter C, Chapter 5, may not issue an insurance policy or contract covering property in this state that contains a clause that:

- (1) requires the insured to obtain or maintain a larger amount of insurance than expressed in the policy or contract; or
- (2) in any way provides that the insured is liable as a coinsurer with the insurer issuing the policy or contract for any part of the loss or damage that may be caused by fire to the property described in the policy or contract.

(b) A clause described by Subsection (a) is void.

(c) A coinsurance clause may be included in an insurance policy written on cotton, grain, or other products in the process of marketing, shipping, storing, or manufacturing.

(d) An insured may be given an option to accept an insurance policy or contract that contains a clause described by Subsection (a) covering a class of property other than the property described by Subsection (c), a private dwelling, or a stock of merchandise offered for sale at retail that has a value of less than \$10,000, if the insured is allowed a reduction in the premium rate for the policy or contract. A clause to which this subsection applies is valid and binding. The commissioner may promulgate the premium rates that apply to a coinsurance clause under this subsection.

(e) The commissioner by order may authorize or require the use of any form of coinsurance clause in connection with an insurance policy that insures against the hazards of tornado, windstorm, and hail on any class of property. The commissioner may adopt rules with reference to:

- (1) coinsurance clauses authorized or required by this subsection and the use of those clauses; and
- (2) credits in premium rates for the use of coinsurance clauses authorized or required by this subsection.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2002.006. PROVISIONS GOVERNING CERTAIN CONDITIONS OR RISKS. (a) This chapter; Sections 403.002, 2001.001-2001.006, 2001.009, and 2001.010; Subchapter H, Chapter 544; Subchapter D, Chapter 1806; Chapters 2003, 2004, 2006, and 2171; and Articles 5.25, 5.25A, 5.25-3, 5.26, 5.27, 5.28, 5.29, 5.30, 5.31, 5.32, 5.34, 5.35, 5.39, 5.40, and 5.41 govern the following in the same manner and to the same extent those provisions govern fire insurance and fire insurance rates:

(1) insurance coverage for any of the following conditions or risks:

(A) weather or climatic conditions, including lightning, tornado, windstorm, hail, cyclone, rain, or frost and freeze;

(B) earthquake or volcanic eruption;

(C) smoke or smudge;

(D) excess or deficiency of moisture;

(E) flood;

(F) the rising water of an ocean or an ocean's tributary;

(G) bombardment, invasion, insurrection, riot, civil war or commotion, military or usurped power, or any order of a civil authority made to prevent the spread of a conflagration, epidemic or catastrophe;

(H) vandalism or malicious mischief;

(I) strike or lockout;

(J) explosion, as provided by Subsection (b);

(K) water or other fluid or substance resulting from:

(i) the breakage or leakage of a sprinkler, pump, or other apparatus erected for extinguishing fire, or a water pipe or other conduit or container; or

(ii) casual water entering a building through a leak or opening in the building or by seepage through building walls; or

(L) accidental damage to a sprinkler, pump, fire apparatus, pipe, or other conduit or container described by Paragraph (K)(i);

(2) premium rates in this state for the insurance described by Subdivision (1); and

(3) all matters pertaining to the insurance described by Subdivision (1), except as provided by this section with respect to marine insurance as defined by Section 1807.001.

(b) In this section:

(1) "explosion" includes:

(A) the explosion of a pressure vessel, other than a steam boiler of more than 15 pounds pressure, in a building designed and used solely for residential purposes by not more than four families;

(B) an explosion of any kind originating outside of an insured building or outside of the building containing the insured property;

(C) the explosion of a pressure vessel that does not contain steam or that is not operated with steam coils or steam jets; and

(D) an electric disturbance causing or concomitant with an explosion in public service or public utility property; and

(2) insurance coverage for explosion does not include coverage for loss of or damage to any property of the insured resulting from the explosion of or injury to:

(A) a boiler, heater, or other fired pressure vessel;

(B) an unfired pressure vessel;

(C) a pipe or container connected with a boiler or vessel described by Paragraph (A) or (B);

(D) an engine, turbine, compressor, pump, or wheel;

(E) an apparatus generating, transmitting, or using electricity; or

(F) any other machinery or apparatus connected with or operated by a boiler, vessel, or machine described by Paragraphs (A)-(E).

(c) This section does not apply to:

(1) a farm mutual insurance company operating under Chapter 911;

(2) a county mutual insurance company operating under Chapter 912;

(3) a mutual insurance company engaged in business under Chapter 12, Title 78, Revised Statutes, before that chapter's repeal by Section 18, Chapter 40, Acts of the 41st Legislature, 1st Called

Session, 1929, as amended by Section 1, Chapter 60, General Laws, Acts of the 41st Legislature, 2nd Called Session, 1929, that retains the rights and privileges under the repealed law to the extent provided by those sections;

(4) the making of inspections or issuance of certificates of inspections on a boiler, apparatus, or machinery described by Subsection (b)(2), whether insured or otherwise; or

(5) the insurance of a vessel or craft, its cargo, marine builder's risk, marine protection and indemnity, or another risk commonly insured under a marine insurance policy, as distinguished from an inland marine insurance policy.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER B. POLICY FORMS

Sec. 2002.051. POLICY FORMS AND ENDORSEMENTS FOR RESIDENTIAL PROPERTY INSURANCE. Notwithstanding Subsections (a)-(j), Article 5.35, policy forms and endorsements for residential property insurance in this state are regulated under Subchapter A, Chapter 2301, and Article 5.13-2.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2002.052. APPLICABILITY OF OTHER LAW TO RESIDENTIAL PROPERTY INSURANCE. An insurer may continue to use a policy form or endorsement promulgated, approved, or adopted by the commissioner under Article 5.35 before June 11, 2003, on notification in writing to the commissioner that the insurer will continue to use the policy form or endorsement.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER C. ITEMS PROVIDED IN CONNECTION WITH INSURANCE POLICY

Sec. 2002.101. RATE ANALYSIS. (a) On issuing a fire insurance policy, an insurer engaged in the business of fire insurance in this

state shall provide the policyholder with a written analysis of the rate or premium charged for the policy showing the items of charge and credit that determine the rate or premium.

(b) Subsection (a) does not apply if the insurer has previously provided the policyholder with an analysis of the rate or premium.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2002.102. NOTICE OF RENEWAL. (a) In this section, "material change" means a change to a policy that, with respect to a prior or existing policy:

- (1) reduces coverage;
- (2) changes conditions of coverage; or
- (3) changes the duties of the policyholder.

(b) An insurer, including a farm mutual insurance company, county mutual insurance company, Lloyd's plan, or reciprocal or interinsurance exchange, that renews a homeowners insurance policy, fire and residential allied lines insurance policy, farm and ranch owners insurance policy, or farm and ranch insurance policy must provide the policyholder with written notice in accordance with this section of any material change in each form of the policy offered to the policyholder on renewal from the form of the policy held immediately before renewal.

(c) A notice provided under this section must:

- (1) appear in a conspicuous place in the notice of renewal;
- (2) clearly indicate each material change to the policy being made on renewal;
- (3) be written in plain language; and
- (4) be provided to the policyholder not later than the 30th day before the renewal date.

(d) In addition to the notice to the policyholder provided under this section, if an insurer elects to make a material change to a policy form on renewal, not later than the 30th day before the earliest renewal date on which the new policy form is used, the insurer shall provide written notice to each agent of the insurer that clearly indicates each material change being made to the policy form. An insurer may provide the notice to the agents in a single notice given to each agent of the insurer that summarizes

substantially similar material changes to more than one policy form.

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

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 60 (S.B. 417), Sec. 6, eff. September 1, 2017.

Sec. 2002.103. DISCLOSURE REGARDING FLOOD COVERAGE REQUIRED.

(a) In this section:

(1) "Commercial property insurance" has the meaning assigned by Section 2301.002, except that the term includes a commercial multiperil insurance policy that provides commercial property insurance coverage.

(2) "Residential property insurance" has the meaning assigned by Section 2301.002, except that the term includes a farm and ranch insurance policy and a farm and ranch owners insurance policy.

(b) This section applies to each insurer authorized to engage in the business of commercial or residential property insurance in this state, including a county mutual insurance company, farm mutual insurance company, Lloyd's plan, and reciprocal or interinsurance exchange.

(c) An insurer that issues or renews a commercial or residential property insurance policy that does not provide coverage against loss caused by flooding shall include with the policy documents provided to the policyholder at the time the policy is issued or renewed the following statement:

"Flood Insurance: You may also need to consider the purchase of flood insurance. Your insurance policy does not include coverage for damage resulting from a flood even if hurricane winds and rain caused the flood to occur. Without separate flood insurance coverage, you may have uncovered losses caused by a flood. Please discuss the need to purchase separate flood insurance coverage with your insurance agent or insurance company, or visit www.floodsmart.gov."

(d) The statement described by Subsection (c) must be conspicuous, as defined by Section 1.201, Business & Commerce Code.

(e) An insurer's failure to comply with this section does not invalidate any exclusion, including a flood exclusion, in an insurance policy subject to this section.

Added by Acts 2019, 86th Leg., R.S., Ch. 332 (S.B. 442), Sec. 1, eff. September 1, 2019.

CHAPTER 2003. PROCEDURES FOR EVALUATING FIRE LOSS RISK

SUBCHAPTER A. EVALUATING FIRE LOSS RISK

Sec. 2003.001. FIRE LOSS INFORMATION. (a) The department shall ascertain as soon as practicable the annual fire loss in this state.

(b) The department shall, in a manner that will aid in determining equitable insurance rates and methods to reduce annual fire loss and insurance rates of this state or subdivisions of this state:

(1) obtain, make, and maintain records regarding the annual fire loss in this state; and

(2) collect data concerning the annual fire loss as necessary to enable the department to classify:

(A) fire losses in this state;

(B) the causes of those fire losses;

(C) the amount of the premiums collected for fire loss for each class of risk; and

(D) the amount paid for the fire losses.

(c) The commissioner may designate one or more advisory organizations or other agencies to gather, audit, and compile the fire loss experience of insurers. The insurers shall bear the costs incurred under this subsection.

(d) To implement this section, the department may:

(1) employ clerical personnel, inspectors, experts, and other assistants; and

(2) incur other necessary expenses.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2003.002. FIRE SUPPRESSION RATINGS FOR BORDER MUNICIPALITIES. In assigning or evaluating a fire suppression rating

for a municipality at or near the border between this state and another state or the United Mexican States, the commissioner shall consider the existence and capabilities of a fire department or volunteer fire department that:

- (1) serves an adjoining or nearby municipality in the other state or the United Mexican States; and
- (2) by agreement or by long-standing practice provides fire suppression services to the municipality in this state.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2003.003. CREDIT FOR REDUCING FIRE HAZARD. The commissioner may give a locality, municipality, or other political subdivision credit for:

- (1) each fire hazard that the locality, municipality, or other political subdivision reduces or removes;
- (2) additional fire-fighting equipment, increased police protection, or any other equipment or improvement that tends to reduce the fire hazard of the locality, municipality, or other political subdivision; and
- (3) a good fire record made by the locality, municipality, or other political subdivision.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2003.004. POLICYHOLDER CREDIT FOR REDUCING HAZARD. (a) The commissioner may require an insurer to give credit to a policyholder for a hazard that the policyholder reduces or removes.

(b) For purposes of this section, the following actions constitute a reduction in hazard by a policyholder:

- (1) the installation of a new standard fire hydrant approved by the department within the required distance of a risk, as prescribed by the department; or
- (2) the use of compressed air foam technology in fire-fighting equipment.

(c) The insurer shall give credit in the proportion that the hazard is reduced or removed and shall refund to the policyholder the

proportional part of the unearned premium charged for the hazard that is reduced or removed.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER B. MUNICIPAL FIRE LOSS LISTS

Sec. 2003.051. ANNUAL LIST OF INSURED FIRE LOSSES BY MUNICIPALITY. (a) The department shall compile for each municipality in this state a list for distribution to the municipality of the insured fire and lightning losses that:

(1) exceed \$100; and

(2) are paid in the municipality for the preceding statistical year under policy forms:

(A) adopted or approved by the commissioner and authorized for use by Section 2301.052(b); or

(B) filed and in effect as provided by Section 2301.052(a).

(b) Each list must include:

(1) the name of each person recovering a loss under a policy form described by Subsection (a);

(2) the address or location where the loss occurred; and

(3) the amount paid by the insurer on the loss.

(c) The department shall develop each list from information obtained from insurer reports of individual losses during the statistical year.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2003.052. MUNICIPALITY'S REQUEST FOR LIST; RETURN REPORT.

(a) The department shall provide to a municipality a copy of the list compiled under Section 2003.051 for the municipality on the request of the municipality or the municipality's authorized agent or fire marshal.

(b) Each municipality shall investigate the information contained in the list to determine the losses actually occurring within the limits of the municipality. The municipality shall report to the department:

- (1) a list of the losses that actually occurred within the limits of the municipality;
- (2) a list of the losses that did not occur within the limits of the municipality; and
- (3) other evidence essential to establishing the losses occurring in the municipality.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2003.053. LIST CORRECTIONS; USE. The department shall:

- (1) make changes that the department considers appropriate to correct the list compiled under Section 2003.051 for a municipality; and
- (2) use the corrected list to determine the fire record credit or debit for the municipality for the next year.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2003.054. CHARGE FOR LIST AND FIRE RECORD SYSTEM. The commissioner shall set and collect a charge for compiling and providing a list under this subchapter and as the commissioner considers appropriate for administering the fire record system.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2003.055. DEPARTMENT AUTHORITY TO REQUIRE PROVISION OF FIRE LOSS INFORMATION. To accumulate statistical information for the control and prevention of fires, the department may require each municipality in this state and each insurer engaged in business in this state to provide to the department a complete and accurate report that lists all fire and lightning losses occurring in this state that are reflected in the municipality's or insurer's records.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2003.056. DISCRETIONARY PROVISION OF LIST. The department is not required to provide a list compiled under this subchapter if the fire record system is not in effect.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER C. VOLUNTARY INSPECTION PROGRAM

Sec. 2003.101. DEFINITIONS. In this subchapter:

(1) "Inspection" means a physical inspection of property for which residential property insurance is sought.

(2) "Inspection certificate" means a certificate issued under this subchapter by an inspector indicating that the condition of property meets or exceeds minimum standards.

(3) "Inspector" means a person authorized by the commissioner to perform inspections under this subchapter.

(4) "Minimum standards" means the standards adopted by the commissioner by rule regarding the insurability of property under this subchapter.

(5) "Residential property insurance" means insurance against loss to real or tangible personal property at a fixed location that is provided through a homeowners insurance policy, a residential fire and allied lines insurance policy, or a farm and ranch owners insurance policy.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2003.102. RIGHT TO VOLUNTARY INSPECTION OF PROPERTY CONDITION. A person with an insurable interest in real or tangible personal property at a fixed location who desires to purchase residential property insurance may obtain an independent inspection of the condition of the property by an inspector authorized to perform inspections under this subchapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2003.103. PLAN OF OPERATION. (a) The commissioner shall adopt a plan of operation for the voluntary inspection program.

(b) The plan of operation must include rules and standards for the voluntary inspection program, including:

- (1) the manner and scope of the inspections to be performed;
- (2) the contents of the written evaluation report;
- (3) the form of the inspection certificate to be issued;
- (4) the term during which an inspection certificate is valid;
- (5) rules for the certification or licensing of persons authorized to perform inspections under the program; and
- (6) the fee that may be charged a person requesting an inspection under the program.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2003.104. ELIGIBLE INSPECTORS. Persons who may be certified or licensed to perform inspections under this subchapter include:

- (1) a person licensed to perform real property inspections under Chapter 1102, Occupations Code; and
- (2) a designated employee or agent of a county or municipality that chooses to establish a voluntary inspection program to inspect residential properties within the territorial limits of the county or municipality.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2003.105. PRESUMPTION OF INSURABILITY. (a) The existence of an inspection certificate issued under this subchapter creates a presumption that the condition of the property inspected is adequate for the issuance of residential property insurance.

(b) If an inspection certificate is used in whole or in part to determine insurability, an insurer may require as a condition of

issuing a residential property insurance policy that the applicant for that insurance provide a written statement that there has not been a material or substantial change to the property condition since the date of the inspection certificate.

(c) An insurer who receives an inspection certificate may not use the condition of the property as grounds to refuse to issue or renew residential property insurance unless the insurer:

- (1) reinspects the property; and
- (2) specifies the areas of deficiency in the insurer's declination letter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2003.106. ENFORCEMENT. The commissioner by rule may provide for the use of any disciplinary procedure authorized by this code to:

- (1) maintain the integrity of the voluntary inspection program; or
- (2) ensure compliance with this subchapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2003.107. RULES. In addition to the plan of operation adopted under Section 2003.103, the commissioner may adopt rules that are appropriate to accomplish the purposes of this subchapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

CHAPTER 2004. RESIDENTIAL PROPERTY INSURANCE IN UNDERSERVED AREAS

Sec. 2004.001. DEFINITION. In this chapter, "residential property insurance" means insurance against loss to real or tangible personal property at a fixed location that is provided through a homeowners insurance policy, residential fire and allied lines insurance policy, or farm and ranch owners insurance policy.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2004.002. DESIGNATION OF UNDERSERVED AREAS. (a) The commissioner by rule may designate an area as an underserved area for residential property insurance.

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

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

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

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

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

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

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 1147 (H.B. 1951), Sec. 8.001, eff. September 1, 2011.

Sec. 2004.003. AUTHORIZATION FOR ISSUANCE OF INSURANCE. An insurer authorized to write property or casualty insurance in this state, including a Lloyd's plan and a reciprocal or interinsurance exchange, that writes residential property insurance in this state may write that insurance on forms adopted under this chapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2004.004. EXCLUSION OF CERTAIN COVERAGE. Insurance provided under this chapter may not include windstorm and hail insurance coverage for a risk eligible for that coverage under Chapter 2210.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2004.005. AVAILABILITY OF COVERAGE. In a designated underserved area, each insurer described by Section 2004.003 shall provide to the insurer's agents, and the agents shall offer to all insureds, the full range of coverages prescribed under this chapter subject to the insurer's applicable rates and underwriting guidelines.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2004.006. POLICY FORMS. (a) The commissioner shall adopt policy forms for residential property insurance that are specifically for use in designated underserved areas. The policy forms must include a basic policy covering fire and allied lines perils with endorsements providing additional coverage at the insured's option.

(b) An insurer writing insurance in an underserved area may use the policy forms adopted under this chapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2004.007. INAPPLICABILITY OF CERTAIN LAWS TO PREMIUMS. The premium for an insurance policy written under this chapter is not:

- (1) subject to tax under Chapter 221; and
- (2) considered net direct premiums under Section 2210.003(7).

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2004.008. RATES. Rates for coverage provided under this chapter are determined according to the provisions of this code applicable to the insurer providing the coverage.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

**CHAPTER 2005. HOME WARRANTY AND HOME
PROTECTION INSURANCE**

Sec. 2005.001. DEFINITIONS. In this chapter:

(1) "Home protection insurance" means coverage insuring a purchaser of a home protection service or product against actual property loss.

(2) "Home protection service or product" means a service or product used for the protection of residential property, including a service or product provided by a person regulated under Chapter 1702, Occupations Code.

(3) "Home warranty insurance" means coverage:

(A) insuring performance by a builder of residential property of the builder's warranty obligations to a purchaser of the residential property; or

(B) insuring against named defects arising from failure of the builder to construct residential property in accordance with specified construction standards.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2005.002. AUTHORIZATION TO WRITE CERTAIN INSURANCE. An insurer authorized to engage in the business of fire insurance and allied lines or inland marine insurance may write home warranty insurance or home protection insurance in this state.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2005.003. MANNER OF REGULATION. Home warranty insurance or home protection insurance is not inland marine insurance, but is governed in the same manner and to the same extent as inland marine insurance.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2005.004. LIMITS OF COVERAGE. The amount of coverage under a home protection insurance policy may not exceed \$2,000 for any single occurrence.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

CHAPTER 2006. PREMIUM RATE DISCOUNTS AND RATING PROGRAMS
SUBCHAPTER A. OPTIONAL PREMIUM DISCOUNT FOR USE OF INSULATING
CONCRETE FORM SYSTEM

Sec. 2006.001. DEFINITIONS. In this subchapter:

(1) "Applicant" includes:

- (A) an applicant for new insurance coverage; and
- (B) a policyholder renewing insurance coverage.

(2) "Insulating concrete form system" means a building construction system primarily used to frame exterior walls in which polystyrene foam forms are placed in the walls of a structure under construction and filled with concrete and steel reinforcing material to become a permanent part of the structure.

(3) "Insurer" means an insurer authorized to write property and casualty insurance in this state, including:

- (A) a county mutual insurance company;
- (B) a farm mutual insurance company;
- (C) a Lloyd's plan; and
- (D) a reciprocal or interinsurance exchange.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2006.002. OPTIONAL PREMIUM DISCOUNT. (a) In accordance

with the rules adopted by the commissioner under this subchapter, an insurer may grant to an applicant a discount in the applicant's homeowners insurance premiums for insured property on receipt of written verification from the applicant that the property was constructed with an insulating concrete form system.

(b) The commissioner by rule shall prescribe the requirements for determining that a structure was constructed with an insulating concrete form system.

(c) Verification under this section must comply with the requirements prescribed by the commissioner.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2006.003. PROPERTY INSPECTION. (a) If determined necessary by the commissioner, the rules adopted under this subchapter may require an inspection of the property to be insured.

(b) The applicant shall pay the costs of a required inspection.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2006.004. PREMIUM DISCOUNT; EXCEPTION. (a) The commissioner by rule shall establish the premium discount under this subchapter based on sound actuarial principles.

(b) The commissioner may approve a premium discount greater or less than the discount established by rule under Subsection (a) if:

(1) the insurer files the proposed discount with the department; and

(2) the commissioner determines that the proposed discount is actuarially justified.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2006.005. RULES. The commissioner may adopt rules as necessary to implement this subchapter in addition to other rules adopted under this subchapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER B. OPTIONAL PREMIUM DISCOUNTS AND RATING PROGRAMS FOR CERTAIN RESIDENTIAL PROPERTY INSURANCE POLICIES

Sec. 2006.051. DEFINITIONS. In this subchapter:

(1) "Affiliate" means an entity classified as an affiliate under Section 823.003.

(2) "Insurer" means an insurer authorized to write residential property insurance, including:

- (A) a county mutual insurance company;
- (B) a farm mutual insurance company;
- (C) a Lloyd's plan; and
- (D) a reciprocal or interinsurance exchange.

(3) "Residential property insurance" means property or property and casualty insurance covering a dwelling, including:

- (A) homeowners insurance;
- (B) residential fire and allied lines insurance;
- (C) farm and ranch insurance; and
- (D) farm and ranch owners insurance.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2006.052. OPTIONAL PREMIUM DISCOUNT. (a) Except as provided by Section 2006.053, an insurer that issues a residential property insurance policy may:

(1) discount the premiums that would otherwise be charged for the policy by not less than three percent if the policyholder:

- (A) has continuously been a residential property insurance policyholder with the insurer or an affiliate of the insurer; and
- (B) has not filed a residential property insurance claim during the three years before the effective date of the policy; and

(2) increase the amount of the discount by one percent for each subsequent year in which the policyholder:

- (A) has been a residential property insurance

policyholder with the insurer or an affiliate of the insurer; and
 (B) has not filed a residential property insurance claim.

(b) This section applies to an insurer that uses a tier classification or discount program that has a premium consequence based in whole or in part on claims experience, regardless of whether any of the policies that continuously covered the policyholder was a different kind of residential property insurance policy from the policy eligible for the premium discount.

(c) A residential property insurance claim under this section does not include a claim:

- (1) resulting from a loss caused by natural causes;
- (2) that is filed but is not paid or payable under the policy; or
- (3) that an insurer is prohibited from using under Section 544.353.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.040(a), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.040(a), eff. September 1, 2007.

Sec. 2006.0521. COMPLIANCE WITH OTHER LAW REQUIRED. Any change in the amount of a premium discount provided under this subchapter must comply with the requirements of Section 551.107.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.040(b), eff. September 1, 2007.

Added by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.040(b), eff. September 1, 2007.

Sec. 2006.053. APPROVAL OF CERTAIN ACTUARIALLY JUSTIFIED PREMIUM DISCOUNTS AND RATING PROGRAMS. The commissioner may approve:

- (1) a premium discount filed with the department that is greater or less than the discount specified by Section 2006.052 if the commissioner determines the discount is actuarially justified; or

(2) a rating program filed with the department that is based on claim or loss experience and is not a discount described by Section 2006.052 or Subdivision (1) if the commissioner determines the program is actuarially justified.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 569 (H.B. 2776), Sec. 3, eff. September 1, 2015.

Sec. 2006.054. LIMIT ON PREMIUM DISCOUNT. An insurer that provides a premium discount under Section 2006.052 is not required to provide the discount in an amount that exceeds 10 percent of the premiums that would otherwise be charged for the residential property insurance policy.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 569 (H.B. 2776), Sec. 3, eff. September 1, 2015.

Sec. 2006.055. RULES AND GUIDELINES. (a) The commissioner shall adopt rules as necessary to implement Section 2006.052.

(b) The commissioner by rule shall establish guidelines under which an insurer that provides a premium discount under Section 2006.052 shall determine the appropriate discount based on sound actuarial principles.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 569 (H.B. 2776), Sec. 3, eff. September 1, 2015.

CHAPTER 2007. ASSESSMENT FOR RURAL FIRE PROTECTION

Sec. 2007.001. APPLICABILITY OF CHAPTER. This chapter applies

only to an insurer that:

(1) is authorized to engage in business in this state, including a stock company, mutual insurance company, farm mutual insurance company, county mutual insurance company, Lloyd's plan, and reciprocal or interinsurance exchange; and

(2) writes a policy of:

(A) homeowners insurance;

(B) fire insurance;

(C) farm and ranch owners insurance;

(D) private passenger automobile physical damage

insurance;

(E) commercial automobile physical damage insurance; or

(F) commercial multiple peril insurance.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2007.002. ASSESSMENT. The comptroller shall assess against all insurers to which this chapter applies amounts for each state fiscal year necessary, as determined by the commissioner, to collect a combined total equal to the lesser of:

(1) the total amount that the General Appropriations Act appropriates from the volunteer fire department assistance fund account in the general revenue fund for that state fiscal year other than appropriations for contributions to the Texas Emergency Services Retirement System made under Section 614.104(d), Government Code; or

(2) \$30 million.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 932 (H.B. 3315), Sec. 20, eff. June 15, 2007.

Acts 2013, 83rd Leg., R.S., Ch. 835 (H.B. 7), Sec. 9, eff. June 14, 2013.

Acts 2015, 84th Leg., R.S., Ch. 448 (H.B. 7), Sec. 24, eff. September 1, 2015.

Sec. 2007.003. DETERMINATION OF ASSESSMENT. (a) In this

section, "net direct premium" means the gross direct premium written and reported by an insurer on annual financial statements on:

- (1) an insurance policy described by Section 2007.001(2), other than a commercial multiple peril policy; and
- (2) the nonliability portion of a commercial multiple peril policy.

(b) Each insurer shall pay a portion of the assessment in the proportion that the insurer's net direct premiums for the period for which the assessment is made bear to the aggregate net direct premiums written in this state by all insurers for that period.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2007.004. DATES OF ASSESSMENT AND PAYMENT. (a) The comptroller shall assess insurers under this chapter on or before September 1 of each year.

(b) An insurer shall pay the amount of the insurer's assessment on or after the 60th day after the date the comptroller assesses the insurer.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2007.005. RECOVERY OF ASSESSMENT. An insurer may recover an assessment under this chapter by:

- (1) reflecting the assessment as an expense in a rate filing required under this code; or
- (2) charging the insurer's policyholders.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2007.006. NOTICE TO POLICYHOLDERS. (a) An insurer that recovers an assessment by charging the insurer's policyholders under Section 2007.005 shall provide notice to each policyholder regarding the amount of the assessment being recovered.

(b) The notice may be included on:

- (1) a declarations page;
- (2) a renewal certificate; or
- (3) a billing statement.

(c) The commissioner by rule may adopt a form for providing the notice.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2007.007. VOLUNTEER FIRE DEPARTMENT ASSISTANCE FUND. The comptroller shall credit assessments collected under this chapter to the volunteer fire department assistance fund created under Section 614.104, Government Code.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2007.008. RULES; COOPERATION. (a) The comptroller and the commissioner shall adopt rules as necessary to implement this chapter.

(b) The comptroller and the department shall cooperate as necessary to implement this chapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

**CHAPTER 2008. COVERAGE FOR CERTAIN DAMAGE
TO PROPERTY BUILT WHOLLY OR PARTIALLY OVER WATER**

Sec. 2008.001. APPLICABILITY OF CHAPTER. This chapter applies only to an insurer described by Section 2251.003(a).

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1H.002, eff. April 1, 2009.

Sec. 2008.002. COVERAGE; LIMITS AND DEDUCTIBLES. (a) An insurance policy written by an insurer against loss or damage by windstorm, hurricane, or hail may include coverage for:

(1) a building or other structure that is built wholly or partially over water; and

(2) the corporeal movable property contained in a building or structure described by Subdivision (1).

(b) An insurer that writes coverage described by Subsection (a) may impose appropriate limits of coverage and deductibles for the coverage.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1H.002, eff. April 1, 2009.

SUBTITLE E. WORKERS' COMPENSATION INSURANCE

CHAPTER 2051. GENERAL PROVISIONS: WORKERS' COMPENSATION INSURANCE

SUBCHAPTER A. APPLICABILITY AND CONSTRUCTION

Sec. 2051.001. DEFINITION. In this chapter, "insurance company" means a stock company, mutual insurance company, reciprocal or interinsurance exchange, or Lloyd's plan authorized to engage in the business of workers' compensation insurance in this state.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2051.002. CONSTRUCTION OF CERTAIN LAWS. The following shall be construed and applied independently of any other law that relates to insurance rates and forms or prescribes the duties of the commissioner or the department:

(1) this chapter;

(2) Chapter 251, as that chapter relates to workers' compensation insurance; and

(3) Chapters 255, 426, 2052, 2053, and 2055.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2H.003, eff. April 1, 2009.

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.0591(f), eff. September 1, 2007.

SUBCHAPTER B. COMPENSATION AND EXPENSES

Sec. 2051.051. LIMITATION ON COMPENSATION AND EXPENSES. The total amount of necessary compensation of experts, clerical personnel, and other department employees, necessary travel expenses, and other expenses necessarily incurred to implement the purposes of the laws referenced in Sections 2051.002(1), (2), (3), (4), and (5) may not exceed the total amount assessed and collected from insurance companies writing workers' compensation insurance in this state.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER C. POLICYHOLDER DUTIES

Sec. 2051.101. DISCLOSURE BY POLICYHOLDER REQUIRED. (a) A policyholder shall fully disclose to the policyholder's insurance company:

- (1) information concerning the policyholder's ownership, change of ownership, operations, or payroll; and
- (2) the policyholder's records relating to workers' compensation insurance.

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

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER D. DUTIES AND PROHIBITED ACTS; ENFORCEMENT

Sec. 2051.151. NOTICE OF CLAIMS INFORMATION TO POLICYHOLDER REQUIRED; ADMINISTRATIVE PENALTY. (a) Except as otherwise provided by Subsection (b), an insurance company that writes workers' compensation insurance in this state shall notify a policyholder of a claim that is filed against the policyholder's policy and, after the initial notice, the company shall notify the policyholder of:

- (1) any proposal to settle the claim; or
- (2) on receipt of a written request from the policyholder, any administrative or judicial proceeding relating to the resolution of the claim.

(b) A policyholder may waive the notice required by Subsection (a).

(c) An insurance company that writes workers' compensation insurance in this state, on the written request of a policyholder, shall provide to the policyholder:

(1) a list of:

(A) claims charged against the policy; and

(B) payments made and reserves established on each

claim; and

(2) a statement explaining the effect of claims on premium rates.

(d) The insurance company shall provide the information described by Subsection (c) in writing not later than the 30th day after the date the company receives the policyholder's written request for the information. For purposes of this subsection, information is considered to be provided to the policyholder on the date the information is:

(1) received by the United States Postal Service; or

(2) personally delivered to the policyholder.

(e) An insurance company that fails to comply with this section commits an administrative violation under Subtitle A, Title 5, Labor Code.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.041(a), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.041(a), eff. September 1, 2007.

Acts 2011, 82nd Leg., R.S., Ch. 1162 (H.B. 2605), Sec. 4, eff. September 1, 2011.

Sec. 2051.152. PROHIBITED ACTS BY PERSON; ADMINISTRATIVE PENALTY. (a) A person commits an administrative violation if the person:

(1) to obtain workers' compensation insurance coverage for the person or another person, intentionally or knowingly:

(A) makes a false statement;

(B) misrepresents or conceals a material fact;

(C) makes a false entry in, fabricates, alters,

conceals, or destroys a document; or

(D) conspires to commit an act listed in Paragraph (A), (B), or (C); or

(2) intentionally and knowingly obtains or maintains:

(A) workers' compensation insurance coverage from an insurer that is not authorized to engage in business in this state; or

(B) alternative coverage from an insurer in violation of this code.

(b) An administrative violation under Subsection (a) is punishable by an administrative penalty not to exceed \$5,000 assessed in accordance with the procedures established for an administrative violation under Chapter 415, Labor Code.

(c) Each day an administrative violation under Subsection (a)(2) occurs or continues is a separate violation.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2051.153. LIABILITY OF POLICYHOLDER FOR ADDITIONAL PREMIUM. (a) If a policyholder commits an administrative violation under Section 2051.152 and obtains workers' compensation insurance coverage at a premium that is less than the premium that would have been charged if the policyholder had not committed the administrative violation, the policyholder is liable to the insurer for:

(1) the difference between the premium due and the premium actually charged; and

(2) reasonable interest and attorney's fees.

(b) For the purposes of this section, "insurer" includes the Texas Mutual Insurance Company.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2051.154. PROHIBITED ACT BY INSURER; ADMINISTRATIVE PENALTY. (a) An insurer commits an administrative violation if the insurer directly or indirectly requires a person to apply for or purchase an insurance policy, other than a workers' compensation insurance policy, as a condition of issuing a workers' compensation

insurance policy.

(b) An insurer that violates this section is subject to administrative penalties under Chapter 84.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2051.155. SANCTION OF AGENT REQUIRED. The commissioner shall impose a sanction in accordance with Chapter 82 against an agent who commits an administrative violation under Section 2051.152 or 2051.154.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2051.156. CANCELLATION OF CERTIFICATE OF AUTHORITY REQUIRED. The commissioner shall cancel an insurance company's certificate of authority to engage in the business of workers' compensation insurance in this state on a second conviction of an officer or representative of the company for violating a provision of a law referenced in Section 2051.002(1), (2), (3), (4), or (5) relating to that business.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2051.157. PENALTY FOR CERTAIN VIOLATIONS. An officer or other representative of an insurance company is subject to a fine of not less than \$100 or more than \$500 if the officer or other representative violates any provision of the following relating to the company's business:

- (1) Subchapter A or B;
- (2) Section 2051.156 or 2051.201;
- (3) Chapter 426 or 2052;
- (4) Subchapter A, C, or D, Chapter 2053; or
- (5) Section 2053.051, 2053.052, or 2053.055.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April

1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2H.004, eff. April 1, 2009.

Acts 2019, 86th Leg., R.S., Ch. 558 (S.B. 1336), Sec. 1, eff. September 1, 2019.

SUBCHAPTER E. RULES

Sec. 2051.201. RULEMAKING AUTHORITY: WORKERS' COMPENSATION INSURANCE. The commissioner may adopt and enforce all reasonable rules as are necessary to carry out the provisions of a law referenced in Section 2051.002(1), (2), (3), (4), or (5).

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

CHAPTER 2052. POLICY PROVISIONS AND FORMS FOR WORKERS' COMPENSATION INSURANCE

Sec. 2052.001. DEFINITION. In this chapter, "insurance company" means a stock company, mutual insurance company, reciprocal or interinsurance exchange, or Lloyd's plan authorized to engage in the business of workers' compensation insurance in this state.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2052.002. STANDARD POLICY FORMS AND UNIFORM POLICY; EXCEPTIONS. (a) The commissioner shall prescribe standard policy forms and a uniform policy for workers' compensation insurance.

(b) In writing workers' compensation insurance in this state, an insurance company may not use a form other than one prescribed under this section unless the form is an endorsement:

- (1) appropriate to the company's plan of operation; and
- (2) submitted to and approved by the department.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2052.003. AGREEMENT REQUIRED TO BE CONTAINED IN APPLICATION AND POLICY. (a) A contract or other agreement with respect to workers' compensation insurance coverage that is not contained in the application and policy required by this chapter violates this subtitle and is void.

(b) An insurance company that uses a contract or other agreement described by Subsection (a) engages in conduct that constitutes sufficient grounds for the revocation of the company's certificate of authority to write workers' compensation insurance in this state.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2052.004. POLICYHOLDER DIVIDENDS. (a) Subject to Subsections (b) and (c), this subtitle may not be construed to prohibit an insurance company, including the Texas Mutual Insurance Company, from issuing participating policies.

(b) A policyholder dividend under a workers' compensation insurance policy:

(1) must be approved by the department if the insurer's policyholder dividend amount exceeds 10 percent of surplus; and

(2) may not be approved by the department until the insurance company has adequate reserves.

(c) For purposes of Subsection (b), reserves must be computed on the same basis for all classes of insurance companies operating under this subtitle and Section 2051.002.

(d) An insurer must notify the department in writing of a distribution if the insurer's policyholder dividend amount is not greater than 10 percent of surplus.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2H.005, eff. April 1, 2009.

Acts 2013, 83rd Leg., R.S., Ch. 463 (S.B. 1006), Sec. 7, eff. June 14, 2013.

CHAPTER 2053. RATES FOR WORKERS' COMPENSATION INSURANCE
SUBCHAPTER A. RATE FILINGS

Sec. 2053.001. DEFINITIONS. In this subchapter:

(1) "Filer" means an insurance company that files rates, prospective loss costs, or supplementary rating information under this subchapter.

(2) "Insurance company" means a person authorized to engage in the business of workers' compensation insurance in this state. The term includes:

(A) the Texas Mutual Insurance Company;

(B) a Lloyd's plan under Chapter 941; and

(C) a reciprocal and interinsurance exchange under Chapter 942.

(2-a) "Premium" means the amount charged for a workers' compensation insurance policy, including any endorsements, after the application of individual risk variations based on loss or expense considerations.

(3) "Prospective loss cost" means that portion of a rate that:

(A) does not include a provision for expenses or profit, other than loss adjustment expenses; and

(B) is based on historical aggregate losses and loss adjustment expenses projected by development to the ultimate value of those losses and expenses and projected through trending to a future point in time.

(4) "Rate" means the cost of workers' compensation insurance per exposure unit, whether expressed as a single number or as a prospective loss cost, adjusted to account for the treatment of expenses, profit, and individual insurance company variation in loss experience, before applying individual risk variations based on loss or expense considerations. The term does not include a minimum premium.

(5) "Supplementary rating information" means any manual, rating plan or schedule, plan of rules, rating rule, classification system, territory code or description, or other similar information required to determine the applicable premium for an insured. The term includes increased limits factors, deductible relativities, and other similar factors and relativities.

(6) "Supporting information" means:

(A) the experience and judgment of the filer and the

experience or information of other insurance companies;

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

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

(D) any other information the department requires to be filed.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.042(a), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.042(a), eff. September 1, 2007.

Acts 2019, 86th Leg., R.S., Ch. 558 (S.B. 1336), Sec. 2, eff. September 1, 2019.

Sec. 2053.002. RATE STANDARDS. (a) In setting rates, an insurance company shall consider:

(1) past and prospective loss cost experience;

(2) operation expenses;

(3) investment income;

(4) a reasonable margin for profit and contingencies;

(5) the effect on premiums of individual risk variations based on loss or expense considerations; and

(6) any other relevant factor.

(b) A rate or premium established under this subchapter may not be excessive, inadequate, or unfairly discriminatory.

(c) An insurance company may:

(1) group risks by classification to establish rates and minimum premiums; and

(2) modify classification rates to produce rates for individual risks in accordance with rating plans that establish standards for measuring variations in those risks on the basis of any factor listed in Subsection (a).

(d) In setting rates that apply only to policyholders in this state, an insurance company shall use available premium, loss, claim, and exposure information from this state to the full extent that the information is actuarially credible. The insurance company may use

experience from outside this state as necessary to supplement information from this state that is not actuarially credible.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.043(a), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.043(a), eff. September 1, 2007.

Sec. 2053.003. RATE FILING AND SUPPORTING INFORMATION. (a) Each insurance company shall file with the department all rates, supplementary rating information, and reasonable and pertinent supporting information for risks written in this state.

(b) An insurance company may not make a filing described by Subsection (a) more frequently than once every six months.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2053.004. PUBLIC INFORMATION. (a) Each filing made, including any supporting information filed, under this subchapter is public information subject to Chapter 552, Government Code, including any applicable exception from required disclosure under that chapter.

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

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 309 (S.B. 978), Sec. 1, eff. September 1, 2015.

Sec. 2053.005. EFFECTIVE DATE OF RATE; HEARING. (a) A filer shall designate the date a rate proposed in a filing made under Section 2053.003 is to take effect. Subject to Subsections (b)-(d), the rate does not take effect until the department receives all necessary information required for the filing.

(b) A filing made under Section 2053.003 takes effect on the date designated by the filer under Subsection (a) unless the department, not later than the 30th day after the date the department receives the filing, notifies the filer that the filing is missing specific required information. The filer must provide the missing information not later than the 30th day after the date the filer is notified under this subsection.

(c) If the filer in good faith believes that information requested under Subsection (b) has already been provided to the department, the filer may request a hearing. The commissioner shall hold the hearing not later than the 30th day after the date the department receives the request for a hearing.

(d) The commissioner shall issue an order not later than the 30th day after the date of the hearing under Subsection (c). If the commissioner determines that the filing is still missing required information, the commissioner shall specify in the order the information that is missing.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2053.006. DISAPPROVAL OF RATE FILING; HEARING. (a) The commissioner shall disapprove a rate filing made under Section 2053.003 if the commissioner determines that the filing does not meet the standards established under this subchapter.

(b) If the commissioner disapproves a rate filing, the commissioner shall issue an order specifying in what respects the filing fails to meet the requirements of this subchapter.

(c) A filer whose rate filing is disapproved is entitled to a hearing on written request made to the department not later than the 30th day after the date the order disapproving the filing takes effect.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2053.007. DISAPPROVAL OF RATE; HEARING. (a) The commissioner may issue an order after a hearing disapproving a rate that is in effect. The commissioner must provide the insurance company that filed the rate written notice of the hearing not later than the 10th day before the date of the hearing.

(b) The commissioner shall issue an order disapproving a rate under Subsection (a) not later than the 15th day after the close of the hearing. The order must:

- (1) specify in what respects the rate fails to meet the requirements of this subchapter; and
- (2) state the date further use of the rate is prohibited.

(c) Repealed by Acts 2007, 80th Leg., R.S., Ch. 730, Sec. 3B.044, eff. September 1, 2007.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.044, eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.044, eff. September 1, 2007.

Sec. 2053.008. EFFECT OF DISAPPROVAL ORDER. (a) If a workers' compensation insurance policy is issued and the commissioner subsequently disapproves the rate or filing that governs the premium charged on the policy, the policyholder may:

- (1) continue the policy at the original rate;
- (2) cancel the policy without penalty; or
- (3) enter into an agreement with the insurance company issuing the policy to amend the policy to reflect the premium that would have been charged based on the insurance company's most recently approved rate.

(b) An amendment under Subsection (a)(3) may not take effect before the date further use of the rate is prohibited under an order issued under Section 2053.007.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2053.009. GRIEVANCE. (a) The office of public insurance counsel or an insured who is aggrieved with respect to a filing made under Section 2053.003 that is in effect may apply to the department in writing for a hearing on the filing. The application must specify the grounds for the applicant's grievance.

(b) The commissioner shall hold a hearing on an application filed under Subsection (a) not later than the 30th day after the date the department receives the application if the department determines that:

- (1) the application is made in good faith;
- (2) the applicant would be aggrieved as alleged if the grounds specified in the application were established; and
- (3) the grounds specified in the application otherwise justify holding the hearing.

(c) The department shall provide written notice of a hearing under Subsection (b) to the applicant and to each insurance company that made the filing not later than the 10th day before the date of the hearing. The notice must specify:

- (1) which of the grounds specified in the application are in question; and
- (2) whether the insurance company's entire filing will be considered at the hearing or whether the hearing is limited to consideration of the grounds specified in the application.

(d) If, after the hearing, the commissioner determines that the filing does not meet the requirements of this subchapter, the commissioner shall issue an order specifying:

- (1) in what respects the filing fails to meet those requirements;
- (2) the date the filing is no longer in effect, which must be within a reasonable period that is not less than 60 days after the date the order is issued; and
- (3) whether the order applies with respect to all insureds affected by the filing or only with respect to the applicant, if the applicant was an aggrieved insured.

(e) The department shall send copies of the order issued under Subsection (d) to the applicant and each affected insurance company.

(f) An order issued under Subsection (d) does not affect an insurance policy or contract made or issued before the expiration of

the period stated in the order.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2053.010. PENALTIES. If a workers' compensation insurance policy is issued and the commissioner subsequently disapproves the rate or filing on which the premium is based, the commissioner, after notice and the opportunity for a hearing, may:

- (1) impose sanctions under Chapter 82;
- (2) issue a cease and desist order under Chapter 83;
- (3) impose administrative penalties under Chapter 84; or
- (4) take any combination of these actions.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.045(a), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.045(a), eff. September 1, 2007.

Sec. 2053.011. EXCLUSIVE JURISDICTION. The department has exclusive jurisdiction over all rates and premiums subject to this subchapter.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.046(a), eff. September 1, 2007.

Added by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.046(a), eff. September 1, 2007.

Sec. 2053.013. REVIEW OF RATES; CONSIDERATION OF OTHER LAW. In reviewing rates under this subchapter, the commissioner shall consider any state or federal legislation that has been enacted and that may impact rates and premiums for workers' compensation insurance coverage in this state.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec.

3B.047(a), eff. September 1, 2007.

Added by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.047(a), eff. September 1, 2007.

SUBCHAPTER A-1. UNDERWRITING GUIDELINES

Sec. 2053.031. DEFINITIONS. In this subchapter:

(1) "Insurance company" has the meaning assigned by Section 2053.001.

(2) "Underwriting guideline" means a rule, standard, guideline, or practice, whether written, oral, or electronic, that is used by an insurance company or its agent to decide whether to accept or reject an application for coverage under a workers' compensation insurance policy or to determine how to classify those risks that are accepted for the purpose of determining a rate.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.048(a), eff. September 1, 2007.

Added by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.048(a), eff. September 1, 2007.

Sec. 2053.032. UNDERWRITING GUIDELINES. Each underwriting guideline used by an insurance company in writing workers' compensation insurance must be sound, actuarially justified, or otherwise substantially commensurate with the contemplated risk. An underwriting guideline may not be unfairly discriminatory.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.048(a), eff. September 1, 2007.

Added by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.048(a), eff. September 1, 2007.

Sec. 2053.033. ENFORCEMENT. This subchapter may be enforced in the manner provided by Section 38.003(g).

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.048(a), eff. September 1, 2007.

Added by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.048(a), eff. September 1, 2007.

Sec. 2053.034. FILING REQUIREMENTS. Each insurance company shall file with the department a copy of the insurance company's underwriting guidelines. The insurance company shall update its filing each time the underwriting guidelines are changed. If a group of insurance companies files one set of underwriting guidelines for the group, the group shall identify which underwriting guidelines apply to each insurance company in the group.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.048(a), eff. September 1, 2007.

Added by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.048(a), eff. September 1, 2007.

Sec. 2053.035. APPLICABILITY OF SECTION 38.003. Section 38.003 applies to this subchapter to the extent consistent with this subchapter.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.048(a), eff. September 1, 2007.

Added by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.048(a), eff. September 1, 2007.

SUBCHAPTER B. RATE ADMINISTRATION

Sec. 2053.051. HAZARD CLASSIFICATION SYSTEM. (a) For workers' compensation insurance, the department shall:

- (1) determine hazards by class; and
- (2) revise the classification system as necessary to carry out the purposes of this chapter.

(b) A stock company, mutual insurance company, reciprocal or interinsurance exchange, or Lloyd's plan authorized to engage in the business of workers' compensation insurance in this state may not use hazard classifications other than the classifications established by the department.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 558 (S.B. 1336), Sec. 3, eff. September 1, 2019.

Sec. 2053.052. EXPERIENCE RATING PLAN. (a) The commissioner shall adopt a uniform experience rating plan for workers' compensation insurance. The plan must:

(1) encourage accident prevention; and

(2) account for:

(A) the peculiar hazard and experience of individual risks, past and prospective, inside and outside this state; and

(B) any other relevant factor.

(b) The commissioner shall revise the rating plan at least once every five years.

(c) The commissioner may adopt reasonable rules and plans requiring the interchange of loss experience necessary for the application of the rating plan.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2053.054. USE OF INCURRED CLAIMS EXPERIENCE IN FUTURE RATINGS REQUIRED. (a) Regardless of a change in a policyholder's ownership, control, management, or operations, incurred claims experience must be used in future ratings to ensure that an employer does not evade an unfavorable or high-cost experience.

(b) On application by an affected party, the department may modify a rating under Subsection (a) on proof that a change in a policyholder's management or operations is clearly designed to result in a probable reduction of the insured's loss experience.

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

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2053.055. RATE ADJUSTMENT. If the commissioner determines that an insurance company's rates do not meet with the standards imposed by Section 2053.002, the commissioner may order the insurance

company to adjust the rates to meet those standards. An insurance company may appeal an order under this section in accordance with Subchapter D, Chapter 36.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2053.056. RATE HEARINGS. (a) The commissioner may conduct a public hearing each biennium to review rates to be charged for workers' compensation insurance written in this state. A public hearing under this section is not a contested case as defined by Section 2001.003, Government Code.

(b) Not later than the 30th day before the date of a public hearing conducted under Subsection (a), each insurance company subject to this subtitle shall file the insurance company's rates, supporting information, and supplementary rating information with the commissioner.

(c) The commissioner shall review the information submitted under Subsection (b) to determine the positive or negative impact of the enactment of workers' compensation reform legislation enacted by the 79th Legislature, Regular Session, 2005, on workers' compensation rates and premiums. The commissioner may consider other factors in determining whether a change in rates has impacted the premium charged to policyholders.

(d) The commissioner shall implement rules as necessary to mandate rate reductions or to modify the use of individual risk variations if the commissioner determines that the rates or premiums charged by insurance companies do not meet the rating standards as defined in this code.

(e) The commissioner shall adopt rules as necessary to mandate rate or premium reductions by insurance companies for the use of cost-containment strategies that result in savings to the workers' compensation system, including use of a workers' compensation health care network health care delivery system, as described by Chapter 1305.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.049(a), eff. September 1, 2007.

Added by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.049(a), eff. September 1, 2007.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 42 (S.B. 784), Sec. 1.01, eff. September 1, 2015.

Acts 2019, 86th Leg., R.S., Ch. 558 (S.B. 1336), Sec. 4, eff. September 1, 2019.

SUBCHAPTER C. STATISTICAL PLANS; AGENT

Sec. 2053.101. STATISTICAL PLANS FOR REPORTING LOSS EXPERIENCE AND OTHER DATA. The commissioner shall develop and may periodically modify reasonable statistical plans for workers' compensation insurance to be used by each insurance company in recording and reporting the insurance company's loss experience and other data required by the department, so that the total loss and expense experience of all insurance companies is made available at least annually in the form and detail necessary to assist in determining whether an insurance company's rates meet the standards imposed under Section 2053.002.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2053.102. TREATMENT OF PAYMENTS UNDER STATISTICAL PLAN. A statistical plan developed under Section 2053.101 must require the following payments to be reported separately and not to be considered as a loss or expense for purposes of computing a premium rate modifier or surcharge of an insured:

- (1) a direct payment made by an insurance company to influence public policy; and
- (2) any amount paid by an insurance company:
 - (A) as damages in an action against the insurance company for malice or bad faith; or
 - (B) as a fine or penalty.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2053.103. STATISTICAL AGENT. (a) The commissioner may designate or contract with a qualified organization to serve as the

statistical agent for the commissioner under this subchapter as provided by Subchapter E, Chapter 38.

(b) The statistical agent may provide to one or more advisory organizations any information provided by the agent to the commissioner under this subchapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER D. REPORTING REQUIREMENTS AND EXCHANGE OF INFORMATION

Sec. 2053.151. WORKERS' COMPENSATION CLAIMS REPORTS AND INFORMATION. (a) The commissioner by rule shall prescribe the information that must be reported on each workers' compensation claim.

(b) For purposes of Subsection (a), the commissioner shall establish standards and procedures for categorizing insurance and medical benefits required to be reported on each workers' compensation claim to ensure that the data collection methodology will yield data necessary for research and medical cost containment efforts.

(c) The commissioner by rule shall establish reporting requirements for insurance companies regarding workers' compensation claims. The commissioner may reduce or eliminate reporting requirements for insurance companies whose workers' compensation insurance business falls below a specific minimum premium volume established by the commissioner by rule.

(d) A person may not distribute or otherwise disclose a social security number or any other information collected under Subsection (a) that would disclose the identity of a claimant.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 65 (S.B. 471), Sec. 1, eff. September 1, 2007.

Sec. 2053.152. UPDATE AND TRANSMISSION OF CLAIMS REPORTS. (a) An insurance company, in accordance with the filing requirements of a statistical plan developed under Section 2053.101, shall update and

transmit to the commissioner or the commissioner's statistical agent a claims report filed under Section 2053.151.

(b) Each insurance company that writes at least one-half of one percent of the workers' compensation insurance in this state shall report the company's data in a compatible electronic format prescribed by the commissioner. The commissioner shall take necessary measures to ensure the accuracy of the data and the adequacy of the electronic format for the data.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2053.153. EXCHANGE OF INFORMATION AND CONSULTATION WITH OTHERS. To further the uniform administration of rating laws relating to workers' compensation insurance, the commissioner and each insurance company may:

(1) exchange information and experience data with the National Association of Insurance Commissioners and with insurance supervisory officials, insurance companies, and advisory organizations in other states; and

(2) consult and cooperate with a person or entity described by Subdivision (1) with respect to ratemaking and the application of rating systems.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2053.154. LOSS STATEMENT AND PAYROLL REPORT. (a) For purposes of this section, "insurance company" means a stock company, mutual insurance company, reciprocal or interinsurance exchange, or Lloyd's plan authorized to engage in the business of workers' compensation insurance in this state. The term includes the Texas Mutual Insurance Company.

(b) The department may require an insurance company to submit a sworn statement or report showing:

(1) the payroll reported to the insurance company;

(2) incurred losses by classification; and

(3) other information the department determines may be necessary to implement the department's duties.

(c) The department shall prescribe the necessary forms for a statement or report required by Subsection (b) with consideration of the methods and forms used for similar purposes in other states so that uniformity of statistics will not be affected.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER E. OPTIONAL DEDUCTIBLE PLANS

Sec. 2053.201. DEFINITION. In this subchapter, "insurance company" means a stock company, mutual insurance company, reciprocal or interinsurance exchange, or Lloyd's plan authorized to engage in the business of workers' compensation insurance in this state.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2053.202. ESTABLISHMENT OF OPTIONAL DEDUCTIBLE PLANS. (a) The department shall require each insurance company writing workers' compensation insurance in this state to offer at least three optional deductible plans adopted under this section that allow a policyholder to self-insure for the amount of the deductible.

(b) The commissioner by rule shall allow an employer to enter into an agreement with an insurer for a negotiated deductible that exceeds the highest deductible available under a plan described by Subsection (a).

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2053.203. PAYMENT OF CLAIMS; REIMBURSEMENT. (a) An insurance company issuing a deductible policy under this subchapter shall service all claims that arise during the policy period, including those claims payable, wholly or partly, from the deductible amount.

(b) A deductible policy must provide that:

(1) the insurance company issuing the policy shall pay all benefits that are payable from the deductible amount; and

(2) the policyholder shall make reimbursements periodically, rather than at the time claim costs are incurred.

(c) The commissioner shall adopt rules to provide for adequate security for reimbursement of the amount paid by an insurance company that is payable from the deductible amount.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2053.204. RATE REDUCTION. (a) The department shall perform an actuarial analysis to determine the amount of rate reduction applicable to a deductible policy under this subchapter as compared to a standard workers' compensation insurance policy without a deductible.

(b) In years subsequent to the year in which the actuarial analysis described by Subsection (a) is performed, the department shall determine the amount of rate reduction according to rating procedures adopted by the commissioner.

(c) When establishing procedures for the computation of experience modifiers, the commissioner may allow the exclusion of any claim amount paid under a deductible by an employer.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2053.205. PROHIBITED CONDUCT. A person who is employed by a policyholder who self-insures the deductible amount as provided by this subchapter may not be required to pay any portion of the deductible amount or be harassed, discharged, or otherwise discriminated against because the person, in good faith:

(1) is considering initiating or has initiated a workers' compensation claim;

(2) has retained a representative to represent the person regarding a claim;

(3) has testified or will testify at an administrative or judicial proceeding under Subtitle A, Title 5, Labor Code;

(4) has reported a hazardous working condition or hazardous practice to the Texas Workers' Compensation Commission; or

(5) has taken or is considering taking any other action

that may result in a requirement that the policyholder pay a deductible amount through a self-insurance plan.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2053.206. VIOLATION OF SUBCHAPTER. (a) A person commits an administrative violation under Subtitle A, Title 5, Labor Code, if the person engages in conduct that violates this subchapter.

(b) Liability for damages for a violation of this subchapter is determined exclusively under Subtitle A, Title 5, Labor Code.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 1162 (H.B. 2605), Sec. 5, eff. September 1, 2011.

**SUBCHAPTER F. PREMIUM INCENTIVES AND SURCHARGE
FOR SMALL EMPLOYERS**

Sec. 2053.251. DEFINITIONS. In this subchapter:

(1) "Insurance company" means a stock company, mutual insurance company, reciprocal or interinsurance exchange, or Lloyd's plan authorized to engage in the business of workers' compensation insurance in this state.

(2) "Premium" means workers' compensation insurance premium.

(3) "Small employer" means an employer:

(A) who is not experience-rated by the department for workers' compensation insurance purposes; and

(B) whose annual premium is less than \$5,000.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2053.252. PLAN FOR PREMIUM DISCOUNT AND SURCHARGE. The commissioner shall adopt a plan under which each insurance company writing workers' compensation insurance in this state shall:

- (1) grant a premium discount to a small employer who qualifies for a discount under this subchapter; and
- (2) assess a surcharge as provided by Section 2053.254.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2053.253. ELIGIBILITY FOR PREMIUM DISCOUNT. (a) A small employer who has not experienced a compensable employee lost-time injury during the most recent one-year period for which statistics are available shall receive a discount of 10 percent on the amount of the employer's premium.

(b) A small employer who has not experienced a compensable employee lost-time injury during the most recent two-year period for which statistics are available shall receive a discount of 15 percent on the amount of the employer's premium.

(c) A small employer who has experienced one or more compensable employee lost-time injuries during the most recent one-year period for which statistics are available is not eligible for a discount on the amount of the employer's premium.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2053.254. ASSESSMENT OF PREMIUM SURCHARGE. A small employer who has experienced two or more compensable employee lost-time injuries during the most recent one-year period for which statistics are available shall be assessed a surcharge of 10 percent on the amount of the employer's premium.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2053.255. MAXIMUM DISCOUNT AND ASSESSMENT. For any annual premium, a small employer may not:

- (1) receive a discount of more than 15 percent; or
- (2) be required to pay a surcharge of more than 10 percent.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2053.256. DISCOUNTS AND SURCHARGES NOT CUMULATIVE. (a) The discounts and surcharges established under this subchapter are not cumulative.

(b) A small employer is entitled to receive the discount under this subchapter in addition to any lesser deviation in the rate used to write an insurance policy under Sections 2053.051 and 2053.052(a) and (b).

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

CHAPTER 2054. TEXAS MUTUAL INSURANCE COMPANY

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 2054.001. DEFINITIONS. In this chapter:

- (1) "Board" means the board of directors of the company.
- (2) Repealed by Acts 2007, 80th Leg., R.S., Ch. 730, Sec. 3B.056, eff. September 1, 2007.
- (3) "Company" means the Texas Mutual Insurance Company.
- (4) "Workers' compensation insurance" means insurance for a risk under:
 - (A) Subtitle A, Title 5, Labor Code;
 - (B) Chapter 504, Labor Code;
 - (C) the Longshore and Harbor Workers' Compensation Act (33 U.S.C. Section 901 et seq.);
 - (D) the Federal Mine Safety and Health Act of 1977 (30 U.S.C. Section 801 et seq.);
 - (E) the Defense Base Act (42 U.S.C. Sections 1651-1654);
 - (F) the federal Employers' Liability Act (45 U.S.C. Section 51 et seq.);
 - (G) the Nonappropriated Fund Instrumentalities Act (5 U.S.C. Sections 8171-8173);
 - (H) the Outer Continental Shelf Lands Act (43 U.S.C. Section 1331 et seq.); or
 - (I) the Merchant Marine Act of 1920 (46 App. U.S.C.

Section 861 et seq.).

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.056, eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.056, eff. September 1, 2007.

Sec. 2054.002. REFERENCE TO TEXAS WORKERS' COMPENSATION INSURANCE FUND. A reference in state law to the Texas Workers' Compensation Insurance Fund means the Texas Mutual Insurance Company.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2054.003. OPERATION AS DOMESTIC MUTUAL INSURANCE COMPANY.

(a) The company operates as a domestic mutual insurance company under Chapter 883. The company is subject to that chapter, but is not subject to Chapter 826.

(b) The company:

(1) has the legal rights of a mutual insurance company operating under Chapter 883 and of an individual in this state; and
(2) may bring a suit in the company's own name without any procedural prerequisites to the exercise of that power.

(c) The company is not a state agency or executive agency or a governmental entity for any purpose.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 23 (S.B. 192), Sec. 1, eff. May 4, 2007.

Sec. 2054.004. INSURANCE COMPANY UNDER TEXAS WORKERS' COMPENSATION ACT. The company is an insurance company for purposes of Subtitle A, Title 5, Labor Code.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2054.005. APPLICABILITY OF CODE. The company is subject to this code.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2054.006. AUTHORITY OF COMMISSIONER AND DEPARTMENT. (a) The commissioner may regulate the company to the same extent that the commissioner may regulate a mutual insurance company.

(b) The company is subject to the jurisdiction of the commissioner and department in the same manner as a private insurance company.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2054.007. OPEN MEETINGS LAW AND OPEN RECORDS LAW NOT APPLICABLE. Notwithstanding any other state law, Chapters 551 and 552, Government Code, do not apply to the company.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 23 (S.B. 192), Sec. 2, eff. May 4, 2007.

Sec. 2054.008. INVESTIGATION FILES. (a) In this section, "investigation file" means information the company compiles or maintains with respect to a company investigation authorized by law.

(b) Repealed by Acts 2007, 80th Leg., R.S., Ch. 23, Sec. 6, eff. May 4, 2007.

(c) Repealed by Acts 2007, 80th Leg., R.S., Ch. 23, Sec. 6, eff. May 4, 2007.

(d) Except as provided by Subsection (e), a company

investigation file:

- (1) is confidential; and
- (2) may be disclosed only:
 - (A) in a criminal proceeding;
 - (B) in a hearing conducted by the division of workers' compensation of the department;
 - (C) on a judicial determination of good cause; or
 - (D) to a governmental agency, political subdivision, or regulatory body if the disclosure is necessary or proper for the enforcement of a law of this state, another state, or the United States.

(e) Disclosure of information in an investigation file that is contained in or derived from a claim file, an employer injury report, or an occupational disease report is governed by any confidentiality provision applicable to that information.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 23 (S.B. 192), Sec. 3, eff. May 4, 2007.

Acts 2007, 80th Leg., R.S., Ch. 23 (S.B. 192), Sec. 4, eff. May 4, 2007.

Acts 2007, 80th Leg., R.S., Ch. 23 (S.B. 192), Sec. 6, eff. May 4, 2007.

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.051(a), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.051(a), eff. September 1, 2007.

Sec. 2054.009. CONFLICTS WITH CERTAIN INSURANCE LAWS. To the extent of a conflict between this chapter and Chapter 883 or another law of this state applicable to a nonlife mutual insurance company, this chapter prevails.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER B. BOARD OF DIRECTORS

Sec. 2054.051. BOARD OF DIRECTORS; COMPOSITION. (a) The company is governed by a board composed of nine members.

(b) The governor, with the advice and consent of the senate, shall appoint five board members. The company's policyholders shall elect the remaining members.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2054.052. QUALIFICATIONS. (a) Each board member must be a resident of this state.

(b) An individual may not serve as a board member if the individual, another individual related to the individual within the second degree by consanguinity or affinity, or another individual residing in the same household with the individual:

(1) is registered or licensed under this code or is required to be registered or licensed under this code;

(2) is employed by or acts as a consultant to a person registered or licensed under this code or required to be registered or licensed under this code;

(3) owns, controls, has a financial interest in, or participates in the management of an organization registered or licensed under this code or required to be registered or licensed under this code;

(4) receives a substantial tangible benefit from the company or the department; or

(5) is an officer, employee, or consultant of an association in the field of insurance.

(c) Subsection (b) does not prohibit an individual from serving as a board member if the individual is only a policyholder or a consumer of insurance or insurance products.

(d) An individual who is ineligible to serve on the board under Subsection (b) may not serve as a board member until the first anniversary of the date the condition that makes the individual ineligible ends.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2054.053. PRESIDING OFFICER; OTHER OFFICERS. (a) The governor shall designate a board member as the presiding officer to serve in that capacity at the pleasure of the governor.

(b) The board members shall elect annually any other officers the board considers necessary to perform the board's duties.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2054.054. TERMS. (a) Board members serve staggered six-year terms, with the terms of three members expiring July 1 of each odd-numbered year.

(b) A board member whose term has expired shall continue to serve until the member's successor is appointed by the governor or is elected by the company's policyholders, as applicable.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2054.055. VACANCIES. (a) The governor shall fill a vacancy in the appointed board members by appointment with the advice and consent of the senate.

(b) A vacancy in the elected board members shall be filled as provided by the company's bylaws.

(c) If a vacancy occurs before the date the vacating member's term expires, the successor member shall be appointed or elected for a term that expires on the same date as the vacating member's term.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2054.056. GROUNDS FOR REMOVAL. (a) It is a ground for removal from the board if a member:

(1) does not have at the time of appointment or election the qualifications required by Section 2054.052;

(2) does not maintain during service on the board the qualifications required by Section 2054.052;

(3) cannot because of illness or disability discharge the

member's duties for a substantial part of the term for which the member is appointed or elected; or

(4) is absent from more than half of the regularly scheduled board meetings that the member is eligible to attend during a calendar year.

(b) The validity of a board action is not affected by the fact that it is taken when a ground for removal of a board member exists.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2054.057. PROCEDURES FOR REMOVAL. (a) If the president of the company has knowledge that a potential ground for removal of a board member exists, the president shall notify the presiding officer of the board of the potential ground.

(b) If the potential ground for removal involves an appointed board member, the presiding officer shall notify the governor and the attorney general that a potential ground for removal exists.

(c) If the potential ground for removal involves the presiding officer, the president shall notify the next highest board officer, who shall notify the governor and the attorney general that a potential ground for removal exists.

(d) If the potential ground for removal involves an elected board member, the board shall act on the potential ground for removal as provided by the company's bylaws.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2054.058. COMMITTEES AND SUBCOMMITTEES. The board may create committees and subcommittees.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2054.059. MEETINGS. (a) The board shall hold a meeting at least once each calendar quarter, at other times at the call of the presiding officer, and at times established by the company's

bylaws.

(b) A special meeting may be called by any two board members on two days' notice.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2054.060. QUORUM. Five board members constitute a quorum.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2054.061. COMPENSATION. A board member is entitled to receive:

- (1) fees for service on the board commensurate with industry standards; and
- (2) actual and necessary travel expenses and any other expense incurred in performing the member's duties.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER C. MANAGEMENT OF COMPANY

Sec. 2054.101. GENERAL POWERS OF BOARD. The board has full authority over the company and may:

- (1) perform any act necessary or convenient to administer the company or in connection with the company's insurance business; and
- (2) function in all aspects as the governing body of a domestic mutual insurance company.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2054.102. GENERAL DUTIES OF BOARD RELATING TO WORKERS' COMPENSATION INSURANCE. The board shall:

- (1) provide for engaging in the business of workers'

compensation insurance and for the delivery in this state of workers' compensation insurance to the same extent as any other insurance company engaging in the business of workers' compensation insurance in this state;

(2) propose rates for workers' compensation insurance issued by the company; and

(3) exercise any other authority necessary to engage in the business of workers' compensation insurance.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2054.103. APPOINTMENT OF PRESIDENT. (a) The board shall appoint a president who serves at the pleasure of the board.

(b) The president must have proven successful experience as an executive at the general management level in the business of insurance.

(c) The president shall receive compensation as set by the board.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2054.104. APPOINTMENT OF INTERNAL AUDITOR. The board shall appoint an internal auditor who serves at the pleasure of the board.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2054.105. PERSONAL LIABILITY OF BOARD MEMBERS, OFFICERS, AND EMPLOYEES. In connection with the administration, management, or conduct of the company, the company's business, or a related matter, a board member, the president, or an officer or employee of the company is not personally liable in the individual's private capacity for an act performed or a contract or other obligation entered into or undertaken in the individual's official capacity in good faith and without intent to defraud.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2054.106. PRINCIPAL OFFICE. The board shall maintain the company's principal office in Travis County.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2054.107. CERTAIN RELATIONSHIPS WITH OTHER INSURERS PROHIBITED. Except as provided by Section 2054.602, the company may not have:

- (1) an affiliate, spin-off, or subsidiary that writes a line of insurance other than workers' compensation insurance; or
- (2) interlocking boards of directors with an insurer that writes a line of insurance other than workers' compensation insurance.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2021, 87th Leg., R.S., Ch. 1019 (H.B. 3752), Sec. 1, eff. September 1, 2021.

Sec. 2054.108. PROGRAM AND FACILITY ACCESSIBILITY. (a) The company shall comply with federal and state laws that relate to program and facility accessibility.

(b) The president shall prepare and maintain a written plan that describes the manner in which an individual who does not speak English can be provided reasonable access to the company's programs and services.

(c) The board shall develop and implement policies that provide the public with a reasonable opportunity to appear before the board and to speak on any issue under the company's jurisdiction.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER D. OPERATION OF COMPANY; FINANCIAL ADMINISTRATION

Sec. 2054.151. PURPOSES OF COMPANY. The company shall:

- (1) serve as a competitive force in the marketplace;
- (2) guarantee the availability of workers' compensation insurance in this state; and
- (3) serve as an insurer of last resort as provided by Subchapter H.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2054.152. PAYMENT OF TAXES, FEES, AND OTHER CHARGES. The company shall pay the following in the same manner as a domestic mutual insurance company authorized to engage in the business of insurance and to write workers' compensation insurance in this state:

- (1) taxes, including maintenance and premium taxes;
- (2) fees; and
- (3) payments due in lieu of taxes.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2054.153. MEMBERSHIP IN TEXAS PROPERTY AND CASUALTY INSURANCE GUARANTY ASSOCIATION. (a) In this section, "association" means the Texas Property and Casualty Insurance Guaranty Association.

(b) The company is:

- (1) a member of and protected by the association; and
- (2) subject to assessment under Chapter 462.

(c) Notwithstanding Subsection (b), the company is liable only for an assessment by the association regarding a claim with a date of injury occurring on or after January 1, 2000, and the association, with respect to an insolvency of the company, is liable only for a claim with a date of injury occurring on or after that date.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2054.154. COMPANY ASSETS; STATE LIABILITY. (a) All

money, revenues, and other assets of the company belong solely to the company and are governed by the laws applicable to domestic mutual insurance companies.

(b) The state:

(1) covenants with the company's policyholders, persons receiving workers' compensation benefits, and the company's creditors that the state will not borrow, appropriate, or direct payments from the company's money, revenues, or other assets for any purpose; and

(2) has no liability or responsibility to those policyholders, persons receiving benefits, or creditors if the company is placed in conservatorship or receivership or becomes insolvent.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2054.155. REQUIRED RESERVES. The company shall establish and maintain reserves for losses on an actuarially sound basis in accordance with Chapter 426.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2054.156. RATIO OF CERTAIN PREMIUMS TO SURPLUS. The company shall maintain a ratio of net written premiums on policies written after reinsurance to surplus of not more than three to one.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2054.157. DISSOLUTION PROHIBITED. The company may not be dissolved.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER E. EXAMINATIONS, REPORTS, AND FILINGS

Sec. 2054.201. EXAMINATION BY DEPARTMENT. (a) The department shall examine the company in the manner and under the conditions specified by Chapters 86 and 401 for the examination of insurers.

(b) The company shall pay the costs of the examination.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2054.202. PROVIDING INFORMATION TO LEGISLATURE. The company shall provide requested information to each appropriate legislative committee in the manner requested by the committee.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2054.203. ANNUAL ACCOUNTING OF MONEY RECEIVED AND DISBURSED. Each year, the company shall prepare a complete and detailed written report accounting for all money the company received and disbursed during the preceding fiscal year.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2054.204. ANNUAL STATEMENTS. (a) The company shall file annual statements with the department in the same manner as is required of other workers' compensation insurance companies.

(b) The department shall include in the department's annual report under Section 32.021 a report on the company's condition.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.052(a), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.052(a), eff. September 1, 2007.

Sec. 2054.205. PUBLICATION AND FILING OF AUDITED REPORT. The board shall:

(1) publish an independently audited report analyzing the company's activities and fiscal condition during the preceding fiscal year; and

(2) file the audited report with the department for submission simultaneously with its annual financial report.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2054.206. ADDITIONAL REPORTS. The company shall file with the department all reports required of other workers' compensation insurance companies.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.053(a), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.053(a), eff. September 1, 2007.

Sec. 2054.207. PERIODIC REPORTS TO BOARD. The president shall make periodic reports to the board regarding:

(1) the company's status; and

(2) the company's investments.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER F. GENERAL POWERS AND DUTIES RELATING TO INSURANCE

Sec. 2054.251. RATEMAKING AUTHORITY. (a) Except as provided by this section, the board may propose rates to be charged by the company for insurance.

(b) The board shall engage the services of an independent actuary who is a member in good standing with the Casualty Actuarial Society or the American Academy of Actuaries to develop and recommend

actuarially sound rates.

(c) The company is subject to the requirements of Subchapter A, Chapter 2053, and shall include the recommendations of the independent actuary as part of the company's filing under that subchapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2054.252. AMOUNTS OF RATES. Rates charged by the company for insurance must be set in amounts sufficient, when invested, to:

- (1) carry all claims to maturity;
- (2) meet the reasonable expenses of conducting the company's business; and
- (3) maintain a reasonable surplus.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2054.253. MULTITIERED PREMIUM SYSTEMS. (a) Notwithstanding any other provision of this code or another insurance law of this state, the company may establish multitiered premium systems to price workers' compensation insurance policies to:

- (1) insureds in the company's competitive programs; and
- (2) insureds to whom policies are offered by the company under Subchapter H.

(b) The systems may provide for a higher or lower premium payment by an insured based on the company's evaluation of the underwriting characteristics of the individual risk and the appropriate premium to be charged for the policy coverages.

(c) The systems must be filed in accordance with Subchapter A, Chapter 2053.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.0531, eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.0531,

eff. September 1, 2007.

Sec. 2054.254. CASH DIVIDENDS; CREDIT ON RENEWAL PREMIUM. (a) The company may pay a cash dividend or allow a credit on the renewal premium for a policyholder insured with the company, other than a policyholder insured under Subchapter H.

(b) Payment of a cash dividend or allowance of a credit:

(1) must be made in accordance with criteria approved by the board, which may consider the policyholder's safety record and performance; and

(2) may be made only with the department's prior approval.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2054.255. APPOINTMENT OF AGENT NOT REQUIRED. (a) Notwithstanding any other provision of this code or another insurance law of this state, the company is not required to appoint a general property and casualty agent to act as an agent for the company.

(b) An agent who transacts business with the company acts as an agent for the applicant and not as an agent for the company, unless the company and the agent have entered into a written agreement for the agent to act on behalf of the company.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2054.256. WORK PRODUCT INFORMATION. (a) Information submitted to the company by an insurance agent on behalf of an employer, including a policy expiration date, is the work product of the agent. The company may not use the information in any marketing or direct sales activity.

(b) The company may not provide to an insurance agent information obtained from another insurance agent.

(c) This section does not prevent:

(1) an employer from designating another insurance agent or the company as the agent of record; or

(2) the company from using information submitted to the

company under this section for underwriting or a fraud investigation.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 23 (S.B. 192), Sec. 5, eff. May 4, 2007.

Sec. 2054.257. PAYMENT OF COMMISSION TO AGENT. The company shall pay an insurance agent a reasonable commission on a workers' compensation insurance policy that is written through the agent.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER G. ISSUANCE OF COVERAGE

Sec. 2054.301. APPLICATION FOR COVERAGE. An application to the company for workers' compensation insurance coverage must be:

- (1) made on the form prescribed by the company; and
- (2) submitted directly by the applicant or by a general property and casualty agent on behalf of the applicant.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2054.302. POLICY FORMS. The company shall use the uniform policy and standard policy forms prescribed by the department under Section 2052.002.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2054.303. DENIAL OF COVERAGE BASED ON CREDIT RISK. The company may refuse to write insurance coverage for an applicant that the company identifies as a credit risk unless the applicant, before a policy is issued:

- (1) pays the total estimated premium and related charges;

or

(2) provides security for payment of the total estimated premium and related charges.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2054.304. CANCELLATION AND NONRENEWAL. The company may cancel or refuse to renew coverage on a policyholder as provided by Section 406.008, Labor Code.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER H. COMPANY AS INSURER OF LAST RESORT

Sec. 2054.351. INSURER OF LAST RESORT. (a) Except as provided by Section 2054.304 and this subchapter, the company may not refuse to insure a risk that tenders:

- (1) the necessary premium; and
- (2) any applicable accident prevention service fee.

(b) If an applicant would be rejected for workers' compensation insurance under the company's underwriting standards, the company may not reject the risk, but shall insure the risk at a higher premium as provided by the company's requirements. The company may require the risk to meet other conditions considered necessary to protect the company's interests.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2054.352. REQUIRED DECLINATION OF CERTAIN RISKS. (a) In this section, "good faith" means honesty in fact in any conduct or transaction.

(b) The company shall decline to insure a risk if:

- (1) insuring the risk would cause the company to exceed the premium-to-surplus ratios established by Section 2054.156; or
- (2) the risk is not, in good faith, entitled to insurance through the company.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2054.353. REQUIRED INSURANCE OF CERTAIN COMMONLY OWNED OR CONTROLLED ENTITIES. If the company suspects fraud or identifies conditions that may result in acts of fraud, the company may require an applicant for workers' compensation insurance coverage who is identified as a risk for purposes of Section 2054.351(b) to insure all business entities that are commonly owned or controlled by the applicant.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2054.354. DEVELOPMENT AND PUBLICATION OF CERTAIN INFORMATION. (a) The company shall develop statistical and other information as necessary to allow the company to distinguish between the company's:

- (1) writings in the voluntary market; and
- (2) writings as the insurer of last resort.

(b) Repealed by Acts 2019, 86th Leg., R.S., Ch. 558 (S.B. 1336), Sec. 6, eff. July 1, 2020.

(c) On request, the company shall report statistical or other information developed under Subsection (a) to:

- (1) the department; or
- (2) any successor entity for research and oversight of the workers' compensation system of this state.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 558 (S.B. 1336), Sec. 6, eff. July 1, 2020.

SUBCHAPTER I. APPEALS

Sec. 2054.401. APPEAL OF CERTAIN ACTIONS AND DECISIONS. (a) An act or decision by the company to deny, cancel, or refuse to renew a policy or risk insured under Subchapter H may be appealed to the

board not later than the 30th day after the date the affected party receives actual notice that the act occurred or the decision was made.

(b) The company shall:

(1) not later than the 30th day after the date the request for hearing is made, hear the appeal; and

(2) not later than the 10th day before the date of the hearing, notify the appellant in writing of the time and place of the hearing.

(c) Not later than the 30th day after the last day of the hearing, the board shall affirm, reverse, or modify the act or decision appealed to the board.

(d) Unless the board specifically orders otherwise, a hearing under this section does not suspend the operation of an act or decision of the company.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2054.402. REVIEW OF BOARD DECISION BY COMMISSIONER. (a) A board decision under Section 2054.401 is subject to review by the commissioner in the manner provided by Chapter 2001, Government Code.

(b) The commissioner's review of a board decision does not suspend the operation of an act or decision of the company unless the commissioner specifically orders the suspension on a showing by an aggrieved party of:

(1) immediate, irreparable injury, loss, or damage; and

(2) probable success on the merits.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2054.403. APPEAL OF COMMISSIONER'S DECISION. (a) A person aggrieved by a decision of the commissioner under Section 2054.402 may appeal the decision to a district court.

(b) Judicial review under this section is governed by the substantial evidence rule.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April

1, 2007.

SUBCHAPTER J. CONTROL OF FRAUD AND OTHER VIOLATIONS

Sec. 2054.451. IDENTIFICATION AND INVESTIGATION PROGRAM FOR FRAUD AND OTHER VIOLATIONS. (a) The company shall develop and implement a program to identify and investigate acts of fraud and violations of this code relating to workers' compensation insurance by applicants, policyholders, claimants, agents, insurers, health care providers, or other persons.

(b) The company shall cooperate with the division of workers' compensation of the department to compile and maintain information necessary to detect practices or patterns of conduct that violate this code relating to workers' compensation insurance or that violate Subtitle A, Title 5, Labor Code.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.054(a), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.054(a), eff. September 1, 2007.

Sec. 2054.452. INVESTIGATIONS; COORDINATION. (a) The company may investigate cases of suspected fraud and violations of this code relating to workers' compensation insurance.

(b) The company may:

(1) coordinate the company's investigations with those conducted by the division of workers' compensation of the department to avoid duplication of efforts; and

(2) refer to the division of workers' compensation of the department a case that is not otherwise resolved by the company so that the division may:

(A) perform any further investigation necessary under the circumstances;

(B) conduct administrative violation proceedings; and

(C) assess and collect penalties and restitution.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April

1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.054(b), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.054(b), eff. September 1, 2007.

Sec. 2054.453. RESTITUTION PAYABLE TO COMPANY. Restitution collected under Section 2054.452(b) must be paid to the company.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2054.454. DEPOSIT AND USE OF PENALTIES COLLECTED BY DIVISION. A penalty collected under Section 2054.452(b):

(1) must be deposited in the Texas Department of Insurance operating account; and

(2) may be appropriated only to the division of workers' compensation of the department to offset the costs of the program under Section 2054.451.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.054(c), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.054(c), eff. September 1, 2007.

Sec. 2054.455. FUNDING AGREEMENTS FOR CRIMINAL PROSECUTIONS. The company may enter into funding agreements with local prosecutors to prosecute offenses against the company.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2054.456. IMMUNITY FOR CERTAIN ACTIONS. The company, the

board, and company employees are not liable in a civil action for an action taken in good faith in executing a duty under this subchapter, including identifying or referring a person for investigation of or prosecution for a possible administrative violation or criminal offense.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER K. ACCIDENT PREVENTION

Sec. 2054.501. DEFINITION. In this subchapter, "division" means the division of workers' compensation of the department.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.055(a), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.055(a), eff. September 1, 2007.

Sec. 2054.502. REQUIREMENTS FOR PREVENTION OF INJURIES. The company may make and enforce requirements for the prevention of injuries to an employee of a policyholder or applicant for insurance under this chapter. On reasonable notice, a policyholder or applicant shall grant representatives of the company or the department free access to the premises of the policyholder or applicant during regular working hours for purposes of this section.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.055(b), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.055(b), eff. September 1, 2007.

Sec. 2054.503. GROUNDS FOR CANCELLATION OR DENIAL OF COVERAGE.

A failure or refusal by a policyholder or applicant for insurance to comply with a requirement prescribed by the company under Section 2054.502, or a failure or refusal to fully disclose all information pertinent to insuring or servicing the policyholder or applicant, constitutes sufficient grounds for the company to cancel a policy or deny an application.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2054.504. SAFETY CONSULTATION FOR CERTAIN INSUREDS. (a) A policyholder who is insured under Subchapter H shall obtain a safety consultation:

(1) if the policyholder:

(A) has a Texas experience modifier greater than 1.25;

(B) has a national experience modifier greater than 1.25 and estimated premium allocable to this state of \$2,500 or more; or

(C) does not have an experience modifier but has had a loss ratio greater than 0.70 in at least two of the three most recent policy years for which information is available; or

(2) as required by the company, if the policyholder:

(A) has been in business for less than three years; and

(B) meets the criteria established by the company for a safety consultation.

(b) The criteria under Subsection (a)(2)(B) may include:

(1) the number and classification of employees;

(2) the policyholder's industry; and

(3) the policyholder's previous workers' compensation experience in this state or another jurisdiction.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2054.505. SAFETY CONSULTATION PROCEDURES. Not later than the 30th day after the effective date of a policy, the policyholder shall obtain a safety consultation required under Section 2054.504 from a safety consultant. The safety consultant must be:

(1) the company;

- (2) the division; or
- (3) a professional source approved for that purpose by the division.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2054.506. SAFETY CONSULTANT REPORT. A safety consultant acting under this subchapter shall file a written report with the division and the policyholder specifying any hazardous condition or practice identified in the safety consultation.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.055(c), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.055(c), eff. September 1, 2007.

Sec. 2054.507. ACCIDENT PREVENTION PLAN. (a) If a safety consultant identifies a hazardous condition or practice, the policyholder and the safety consultant shall develop a specific accident prevention plan that addresses the condition or practice.

(b) The safety consultant may approve an existing accident prevention plan.

(c) The policyholder shall comply with the accident prevention plan.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2054.508. ACCIDENT INVESTIGATIONS; OTHER MONITORING. The division may:

(1) investigate an accident that occurs at a work site of a policyholder for whom an accident prevention plan was developed under Section 2054.507; and

(2) otherwise monitor as the division determines necessary

the implementation of the accident prevention plan.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2054.509. FOLLOW-UP INSPECTION. (a) Not earlier than the 90th day after or later than the sixth month after the date an accident prevention plan is developed under Section 2054.507, the division shall conduct a follow-up inspection of the policyholder's premises in accordance with rules adopted by the commissioner of workers' compensation.

(b) The division may require the participation of the safety consultant who performed the initial consultation and developed the accident prevention plan.

(c) If the commissioner of workers' compensation determines that a policyholder has complied with the terms of the accident prevention plan or has implemented other accepted corrective measures, the commissioner of workers' compensation shall certify that determination.

(d) If the commissioner of workers' compensation determines that a policyholder has failed or refuses to implement the accident prevention plan or other suitable hazard abatement measures, the policyholder may elect to cancel coverage not later than the 30th day after the date of the determination.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.055(d), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.055(d), eff. September 1, 2007.

Sec. 2054.510. CANCELLATION OF COVERAGE BY COMPANY; IMPOSITION OF ADMINISTRATIVE PENALTY. (a) If a policyholder described by Section 2054.509(d) does not elect to cancel coverage as provided by that section:

- (1) the company may cancel the coverage; or
- (2) the commissioner of workers' compensation may impose an

administrative penalty on the policyholder.

(b) The amount of an administrative penalty under Subsection (a)(2) may not exceed \$5,000. Each day of noncompliance constitutes a separate violation.

(c) In imposing an administrative penalty, the commissioner of workers' compensation may consider any matter that justice may require and shall consider:

(1) the seriousness of the violation, including the nature, circumstances, consequences, extent, and gravity of the prohibited act;

(2) the history and extent of previous administrative violations;

(3) the demonstrated good faith of the violator, including actions taken to rectify the consequences of the prohibited act;

(4) any economic benefit resulting from the prohibited act; and

(5) the penalty necessary to deter future violations.

(d) A penalty collected under this section:

(1) must be deposited in the general revenue fund; and

(2) may be appropriated to the division to offset the costs of implementing and administering this subchapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.055(e), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.055(e), eff. September 1, 2007.

Sec. 2054.511. CONTINUING COMPLIANCE WITH SUBCHAPTER. The procedures established under this subchapter must be followed each year the policyholder meets the criteria established by Section 2054.504(a)(1).

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2054.512. FEES FOR SERVICES. The division shall:

(1) charge a policyholder for the reasonable cost of services provided to the policyholder under Sections 2054.505, 2054.506, 2054.507, 2054.509, and 2054.510(a); and

(2) set the fees for the services at a cost-reimbursement level, including a reasonable allocation of the division's administrative costs.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.055(f), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.055(f), eff. September 1, 2007.

Sec. 2054.513. ENFORCEMENT OF SUBCHAPTER. The division shall enforce compliance with this subchapter through the administrative violation proceedings under Chapter 415, Labor Code.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.055(g), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.055(g), eff. September 1, 2007.

SUBCHAPTER L. PUBLIC INTEREST INFORMATION AND COMPLAINT PROCEDURES

Sec. 2054.551. PUBLIC INTEREST INFORMATION. (a) The company shall prepare information of public interest describing the functions of the company and the procedures by which complaints are submitted to and resolved by the company.

(b) The company shall make the information available to the public and appropriate state agencies.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2054.552. COMPLAINTS. (a) The company shall establish methods by which consumers and service recipients are notified of the name, mailing address, and telephone number of the company for the purpose of directing a complaint to the company.

(b) The company may provide for the notice:

- (1) by a supplement or endorsement to a written policy;
- (2) on a sign prominently displayed in the place of business of each regional office of the company; or
- (3) in a bill for services provided by the company.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2054.553. COMPLAINT RECORD. (a) The company shall keep information about each written complaint filed with the company. The information must include:

- (1) the date the complaint is received;
- (2) the name of the complainant;
- (3) the subject matter of the complaint;
- (4) a record of each person contacted in relation to the complaint;
- (5) a summary of the results of the review or investigation of the complaint; and
- (6) for a complaint for which the company takes no action, an explanation of the reason the complaint was closed without action.

(b) For each written complaint the company receives and has authority to resolve, the company shall:

- (1) provide the company's policies and procedures relating to complaint investigation and resolution to the person filing the complaint and each person or entity that is a subject of the complaint; and
- (2) at least quarterly and until final disposition of the complaint, notify the person filing the complaint and each person or entity that is a subject of the complaint of the status of the complaint unless the notification would jeopardize an undercover investigation.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

**SUBCHAPTER M. SUBSIDIARIES AUTHORIZED TO PROVIDE HEALTH BENEFIT
COVERAGE**

Sec. 2054.601. DEFINITION. In this subchapter, "alternative health benefit coverage" means health benefit coverage:

- (1) provided by a subsidiary of the company that is not authorized to engage in the business of insurance in this state;
- (2) offered only to:
 - (A) individuals;
 - (B) small businesses with not more than 250 full-time equivalent employees; or
 - (C) the company's policyholders or their employees; and
- (3) that is not:
 - (A) provided through an insurance policy or other product the offering or issuance of which constitutes the business of insurance in this state; or
 - (B) benefit coverage subject to the laws governing workers' compensation in this state.

Added by Acts 2021, 87th Leg., R.S., Ch. 1019 (H.B. [3752](#)), Sec. 2, eff. September 1, 2021.

Sec. 2054.602. HEALTH BENEFIT COVERAGE OFFERED BY SUBSIDIARY AUTHORIZED. (a) The company may create, acquire, or otherwise own or operate one or more subsidiaries that offer accident or health insurance or another type of health benefit coverage or health benefit plan as provided by this subchapter.

- (b) A subsidiary of the company may offer in this state:
 - (1) accident or health insurance or another type of health benefit plan authorized under this code, in accordance with a certificate of authority issued to the subsidiary under this code; or
 - (2) alternative health benefit coverage as described by Section 2054.601.

(c) A subsidiary of the company may not offer or issue an occupational policy for an employer or an employer's employees covering an occupational bodily injury, disease, or death that explicitly provides liability coverage to an employer that elects not to maintain workers' compensation insurance coverage under Chapter 406, Labor Code.

Added by Acts 2021, 87th Leg., R.S., Ch. 1019 (H.B. [3752](#)), Sec. 2,

eff. September 1, 2021.

Sec. 2054.603. CONSIDERATIONS AND GUIDING PRINCIPLES FOR DEVELOPING HEALTH BENEFIT COVERAGE OFFERINGS. (a) In developing health benefit coverage or health benefit plan options to be offered through a subsidiary of the company, the company shall fully explore all health coverage options that may be offered under this subchapter and place emphasis on:

- (1) increasing competition in the health insurance market;
- (2) utilizing innovations that improve the quality of health care while lowering health care costs;
- (3) ensuring adequacy of benefits and access to care for individuals in this state with preexisting conditions;
- (4) issuing coverage in a manner that does not discriminate against individuals with preexisting conditions;
- (5) leveraging federal tax credits that may be available for private health benefit plans to the greatest extent possible to increase the affordability of health benefit plans;
- (6) ensuring transparency and coherence of costs and coverage to inform individuals shopping for health benefits;
- (7) reducing incidences of medical debt faced by individuals in this state and uncompensated care faced by providers in this state; and
- (8) ensuring equitable costs regardless of gender or prospects of pregnancy or childbirth.

Added by Acts 2021, 87th Leg., R.S., Ch. 1019 (H.B. [3752](#)), Sec. 2, eff. September 1, 2021.

Sec. 2054.604. RULES. Except with respect to alternative health benefit coverage as described by Section 2054.601 or a subsidiary of the company offering alternative health benefit coverage, the commissioner may adopt rules as necessary to implement this subchapter.

Added by Acts 2021, 87th Leg., R.S., Ch. 1019 (H.B. [3752](#)), Sec. 2, eff. September 1, 2021.

Sec. 2054.605. EXEMPTION FROM OTHER INSURANCE LAWS. A provision of this code, other than this chapter, does not apply to alternative health benefit coverage as described by Section 2054.601 unless alternative health benefit coverage is expressly mentioned in the other law.

Added by Acts 2021, 87th Leg., R.S., Ch. 1019 (H.B. 3752), Sec. 2, eff. September 1, 2021.

Sec. 2054.606. SUBSIDIARY NOT ENGAGED IN BUSINESS OF INSURANCE. Notwithstanding any other provision of this code, for the purposes of offering alternative health benefit coverage as described by Section 2054.601, a subsidiary of the company that acts in accordance with this subchapter is not an insurer and is not engaging in the business of insurance in this state.

Added by Acts 2021, 87th Leg., R.S., Ch. 1019 (H.B. 3752), Sec. 2, eff. September 1, 2021.

Sec. 2054.607. RISK TRANSFER OR COVERAGE. A subsidiary of the company that offers health benefit coverage under this subchapter may contract with an outside company authorized to engage in the business of insurance in this state that is not under common control with the company or the subsidiary to:

(1) transfer to the outside company all or a portion of the subsidiary's risks arising from health benefit coverage offered under this subchapter; or

(2) obtain insurance coverage from the outside company guarantying the subsidiary's obligations arising from health benefit coverage offered under this subchapter.

Added by Acts 2021, 87th Leg., R.S., Ch. 1019 (H.B. 3752), Sec. 2, eff. September 1, 2021.

CHAPTER 2055. GROUP PURCHASE OF WORKERS' COMPENSATION INSURANCE COVERAGE

Sec. 2055.001. DEFINITION. In this chapter, "business entity" means a business enterprise owned by a single person or a

corporation, organization, business trust, trust, partnership, joint venture, association, or other business entity.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.0591(b), eff. September 1, 2007.

Redesignated from Labor Code, Section 406A.001 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.0591(a)(2), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.0591(b), eff. September 1, 2007.

Sec. 2055.002. CERTIFICATION PROGRAM. (a) The department shall:

(1) maintain a certification program for groups organized under this chapter; and

(2) issue certificates of approval to eligible business entities authorizing formation and maintenance of a group.

(b) The commissioner by rule shall adopt forms, criteria, and procedures for issuing certificates of approval to groups under this chapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 17, eff. April 1, 2007.

Redesignated from Labor Code, Section 406A.002 by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.0591(a)(2), eff. September 1, 2007.

Redesignated from Labor Code, Section 406A.002 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.0591(a)(2), eff. September 1, 2007.

Sec. 2055.003. FORMATION OF GROUP. (a) On receipt of a certificate of approval issued by the department under this chapter, two or more business entities or two or more members of a trade association may join together to form a group to purchase individual workers' compensation insurance policies covering each member of the group.

(b) To be eligible to join a group, a business entity must:

(1) be engaged in a business pursuit that is the same as or similar to the other business entities participating in the group as determined by the department; or

(2) be a member of the same trade association as the other business entities participating in the group.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 17, eff. April 1, 2007.

Redesignated from Labor Code, Section 406A.003 by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.0591(a)(2), eff. September 1, 2007.

Redesignated from Labor Code, Section 406A.003 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.0591(a)(2), eff. September 1, 2007.

Sec. 2055.004. PLAN OF OPERATION. (a) A group shall:

(1) adopt a plan of operation; and

(2) file a copy of the plan of operation with the department.

(b) The plan of operation must include:

(1) provisions governing the composition and selection of a governing board;

(2) the methods for administering the group; and

(3) guidelines governing the workers' compensation insurance coverage obtained by the group that include provisions governing:

(A) the payment of premiums;

(B) the distribution of discounts; and

(C) the methods for providing risk management.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 17, eff. April 1, 2007.

Redesignated from Labor Code, Section 406A.004 by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.0591(a)(2), eff. September 1, 2007.

Redesignated from Labor Code, Section 406A.004 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.0591(a)(2), eff. September 1, 2007.

Sec. 2055.005. GROUP PURCHASE AUTHORIZED. A group certified under this chapter may purchase individual workers' compensation insurance policies covering each member of the group from any insurer authorized to write workers' compensation insurance in this state.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 17, eff. April 1, 2007.

Redesignated from Labor Code, Section 406A.005 by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.0591(a)(2), eff. September 1, 2007.

Redesignated from Labor Code, Section 406A.005 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.0591(a)(2), eff. September 1, 2007.

Sec. 2055.006. POLICY RATES. Rates for policies purchased under this chapter must be computed using manual rules and rates. The department shall determine any experience rating factor that must be applied to those policies as provided by the commissioner by rule.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 17, eff. April 1, 2007.

Redesignated from Labor Code, Section 406A.006 by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.0591(a)(2), eff. September 1, 2007.

Redesignated from Labor Code, Section 406A.006 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.0591(a)(2), eff. September 1, 2007.

Sec. 2055.007. GROUP DISCOUNT. (a) A group that purchases a policy under this chapter is entitled to any premium or volume discount that would be applicable to a policy of the combined premium amount.

(b) A group shall apportion any discount or policyholder dividend received on workers' compensation insurance coverage among the members of the group according to a formula adopted in the plan of operation for the group.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 17, eff. April 1, 2007.

Redesignated from Labor Code, Section 406A.007 by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.0591(a)(2), eff. September 1, 2007.

Redesignated from Labor Code, Section 406A.007 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.0591(a)(2), eff. September 1, 2007.

Sec. 2055.008. APPLICABILITY OF OTHER LAW. (a) A group established under this chapter is entitled to any deviation applicable under Section 2052.004, 2053.051, or 2053.052(a) or (b).

(b) A member of a group is not subject to the discounts and surcharges established under Subchapter F, Chapter 2053.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.0591(c), eff. September 1, 2007.

Redesignated from Labor Code, Section 406A.008 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.0591(a)(2), eff. September 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.0591(c), eff. September 1, 2007.

SUBTITLE F. OTHER COVERAGE

CHAPTER 2101. COVERAGE FOR AIRCRAFT

Sec. 2101.001. APPLICABILITY OF CHAPTER. This chapter applies only to aircraft hull and aircraft liability insurance.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2101.002. FILING OF POLICY FORMS AND ENDORSEMENTS MAY BE REQUIRED. If the commissioner finds that a public need exists to regulate the insurance subject to this chapter, the commissioner by order may require each insurer issuing that insurance in this state to file with the department each policy form and endorsement the insurer uses to write the insurance.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2101.003. DISAPPROVAL OF POLICY FORM OR ENDORSEMENT. (a) The commissioner may disapprove the use of a policy form or endorsement filed under this chapter.

(b) After the commissioner disapproves a policy form or endorsement, an insurer may not use the form or endorsement.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2101.004. CERTAIN CONTRACTS OR OTHER AGREEMENTS VOID. (a) A contract or other agreement is void if the contract or agreement is not written into:

(1) the application for an insurance policy subject to this chapter; or

(2) the policy.

(b) A contract or other agreement that is void under Subsection (a) is:

(1) a violation of this chapter; and

(2) sufficient cause to revoke the insurer's certificate of authority to write aircraft insurance in this state.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2101.005. RULES. When the commissioner acts under this chapter, the commissioner may adopt any rules that are necessary to carry out the provisions of this chapter or Chapter 251 or 256.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBTITLE G. POOLS, GROUPS, PLANS, AND SELF-INSURANCE
CHAPTER 2151. TEXAS AUTOMOBILE INSURANCE PLAN ASSOCIATION
SUBCHAPTER A. GENERAL PROVISIONS

Sec. 2151.001. DEFINITIONS. In this chapter:

(1) "Association" means the Texas Automobile Insurance Plan Association.

(2) "Authorized insurer" means an insurer authorized by the department to write automobile liability coverage under this title. The term includes a county mutual insurance company organized under Chapter 912.

(3) "Insurance" means an insurance policy that meets the requirements of Chapter 601, Transportation Code.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 312 (S.B. 1554), Sec. 1, eff. September 1, 2015.

SUBCHAPTER B. TEXAS AUTOMOBILE INSURANCE PLAN ASSOCIATION

Sec. 2151.051. NATURE AND COMPOSITION OF ASSOCIATION. (a) The Texas Automobile Insurance Plan Association is a nonprofit corporate body composed of all authorized insurers.

(b) Each authorized insurer must be a member of the association as a condition of the insurer's authority to write automobile liability insurance in this state.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2151.052. AUTHORITY OF GOVERNING COMMITTEE. The association is administered by a governing committee under a plan of operation.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2151.053. MEMBERSHIP OF GOVERNING COMMITTEE. The governing committee is composed of 15 members selected as follows:

(1) eight members who represent the interests of insurers, elected by the association members according to a method the members

determine;

(2) five public members, nominated by the office of public insurance counsel and selected by the commissioner; and

(3) two members who are general or personal lines property and casualty agents, as required by the plan of operation.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 548 (S.B. 1263), Sec. 2.13, eff. September 1, 2007.

Sec. 2151.054. ELIGIBILITY TO SERVE AS INSURER REPRESENTATIVE.

To be eligible to serve on the governing committee as a representative of insurers, an individual must be a full-time employee of an authorized insurer.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2151.055. INELIGIBILITY TO SERVE AS PUBLIC MEMBER. An

individual may not serve on the governing committee as a public member if the individual, another individual related to that individual within the second degree by consanguinity or affinity, or another individual residing in the same household with that individual:

(1) is required to be registered or licensed under this code or another insurance law of this state;

(2) is employed by or acts as a consultant to a person required to be registered or licensed or required to hold a certificate of authority under this code or another insurance law of this state;

(3) is the owner of, has a financial interest in, or participates in the management of an organization required to be registered or licensed or required to hold a certificate of authority under this code or another insurance law of this state;

(4) is an officer, employer, or consultant of an association in the field of insurance; or

(5) is required to register as a lobbyist under Chapter

305, Government Code.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2151.056. IMMUNITY FROM LIABILITY. (a) The association, a member of the governing committee, or an employee of the association is not personally liable for:

(1) an act performed in good faith within the scope of the person's authority as determined under this chapter or the plan of operation; or

(2) damages occasioned by the person's official act or omission except an act or omission that is corrupt or malicious.

(b) The association shall provide counsel to defend an action brought against a member of the governing committee or an employee because of the person's official act or omission regardless of whether the person has terminated service with the association when the action is instituted.

(c) This section is cumulative of and does not affect or modify a common law or statutory privilege or immunity.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2151.057. COMMITTEE MEETINGS BY TELEPHONE AND VIDEOCONFERENCE. (a) Chapter 551, Government Code, applies to a meeting of the governing committee.

(b) Notwithstanding Chapter 551, Government Code, or any other law, the governing committee may meet by telephone conference call, videoconference, or other similar telecommunication method for any meeting purpose, including conducting a vote or establishing a quorum, regardless of the subject matter discussed or considered.

(c) A meeting authorized by this section is subject to the notice requirements that apply to other meetings of the governing committee under Chapter 551, Government Code.

(d) The notice of a meeting authorized by this section must:

(1) specify that the location of the meeting is a location at which at least one member of the governing committee is physically present; and

(2) state clear instructions and requirements for electronic attendance by a member of the committee.

(e) Each part of a meeting authorized by this section must be audible to the public at the location specified by Subsection (d).

(f) Two-way audio communication must be available during the entire meeting between all members of the governing committee attending a meeting authorized by this section, and if the two-way audio communication is disrupted so that a quorum of the committee is no longer participating in the meeting, the meeting may not continue until the two-way audio communication is reestablished.

Added by Acts 2013, 83rd Leg., R.S., Ch. 95 (S.B. 733), Sec. 2, eff. May 18, 2013.

SUBCHAPTER C. POWERS AND DUTIES OF ASSOCIATION

Sec. 2151.101. POWERS OF NONPROFIT CORPORATION. (a) The association has the powers granted to a nonprofit corporation under the Business Organizations Code.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2151.102. ASSIGNMENT OF INSURANCE; ELIGIBILITY. (a) The association shall provide for the assignment of insurance to an authorized insurer for a person required by Chapter 601, Transportation Code, to show proof of financial responsibility for the future.

(b) An applicant is not eligible for insurance through the association unless the applicant and the servicing agent certify as part of the application to the association that the applicant has been rejected for insurance by at least two insurers that are authorized to engage in business in this state and that are writing automobile insurance in this state.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2151.103. ASSESSMENTS. (a) The association may assess

authorized insurers to provide money to operate the association.

(b) The amount assessed against an authorized insurer must be in proportion to the insurer's writing of automobile liability insurance in this state.

(c) The association may bring an action to collect an assessment against an authorized insurer that does not pay the assessment within a reasonable time. In addition, the association may report to the commissioner an authorized insurer's failure to pay the assessment to the association. The commissioner may institute a disciplinary action against the insurer under Chapter 82.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 95 (S.B. 733), Sec. 1, eff. May 18, 2013.

SUBCHAPTER D. PLAN OF OPERATION

Sec. 2151.151. CONTENTS OF PLAN OF OPERATION; AMENDMENTS. (a) The plan of operation must:

(1) provide for the efficient, economical, fair, and nondiscriminatory administration of the association; and

(2) provide a means by which insurance may be provided in accordance with Section 2151.102(a).

(b) Subject to the commissioner's approval, the governing committee may amend the plan of operation.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2151.152. CORRECTIVE ACTION TO PLAN OF OPERATION. If the commissioner at any time believes that any part of the plan of operation is inconsistent with the purposes of Chapter 601, Transportation Code, the commissioner shall notify the governing committee in writing so that the governing committee may take corrective action.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2151.153. INCENTIVE PROGRAMS. (a) The plan of operation must include an incentive program to target underserved geographic areas, which the commissioner by rule shall designate. In designating underserved areas, the commissioner shall consider with respect to an area:

- (1) the availability of insurance;
- (2) the number of uninsured drivers;
- (3) the number of drivers insured through the association;

and

- (4) any other relevant factor.

(b) The plan of operation may include other incentive programs to encourage authorized insurers to write insurance on a voluntary basis and to minimize the use of the association as a means to obtain insurance.

(c) The incentive programs are effective on the commissioner's approval.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 95 (S.B. 733), Sec. 3, eff. May 18, 2013.

Sec. 2151.154. ASSIGNMENT DISTRIBUTION PLAN. (a) The plan of operation must include a voluntary, competitive limited assignment distribution plan that allows an authorized insurer to contract directly with a servicing carrier to accept assignments to the servicing carrier by the association.

(b) A servicing carrier must be authorized to write automobile insurance in this state and must:

- (1) have written automobile liability insurance in this state for at least five years; or
- (2) be currently engaged as a servicing carrier for assigned risk automobile business in at least one other state.

(c) After notice and hearing, the commissioner may prohibit an insurer from acting as a servicing carrier.

(d) An authorized insurer and a servicing carrier shall

determine through negotiation the terms of a contract described by this section, including the buy-out fee.

(e) The governing committee may:

(1) adopt reasonable rules for the conduct of business under a contract described by this section; and

(2) establish reasonable standards of eligibility for servicing carriers.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.058, eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.058, eff. September 1, 2007.

SUBCHAPTER E. RATES FOR INSURANCE; HEARING

Sec. 2151.201. RATE STANDARDS. Rates for insurance provided under this chapter must be:

(1) just, reasonable, adequate, not excessive, not confiscatory, and not unfairly discriminatory for the risks to which the rates apply; and

(2) sufficient to carry all claims to maturity and meet the expenses incurred in the writing and servicing of the business.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2151.202. RATE FILINGS. (a) The association shall file with the department rates to be charged for insurance provided through the association for approval by the commissioner.

(b) The association may not file rates under this section more than once in any 12-month period.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 95 (S.B. 733), Sec. 4, eff. May 18, 2013.

Sec. 2151.2021. FILE AND USE. The association may use a rate, excluding a rate described by Section 2151.2041, on the later of the date specified by the association in the filing or the date the rate is approved or considered approved under this subchapter.

Added by Acts 2013, 83rd Leg., R.S., Ch. 95 (S.B. 733), Sec. 5, eff. May 18, 2013.

Sec. 2151.2022. COMMISSIONER ACTION ON CERTAIN RATE FILINGS.

(a) Not later than the 30th day after the date the association files a rate, excluding a rate described by Section 2151.2041, the commissioner shall:

(1) approve the rate if the commissioner determines that the rate meets the standards under Section 2151.201; or

(2) disapprove the rate if the commissioner determines that the rate does not meet the standards under Section 2151.201.

(b) If the commissioner fails to act as required under Subsection (a) on or before the 30th day after the date the rate is filed, the rate is considered approved on the 31st day after the date of filing unless the approval period is extended under Subsection (c).

(c) The commissioner may extend the approval period under Subsection (a) for one additional period not to exceed 30 days. The commissioner and the association may agree to extend the approval period for additional periods not to exceed 30 days. If the commissioner does not affirmatively approve or disapprove the rate before the extended period expires, the rate is considered approved on the day after the date the extended period expires.

Added by Acts 2013, 83rd Leg., R.S., Ch. 95 (S.B. 733), Sec. 5, eff. May 18, 2013.

Sec. 2151.2023. NOTICE OF RATE APPROVAL OR DISAPPROVAL. The commissioner shall give written notice by first class mail or electronic mail to the association of the approval or disapproval by the commissioner of the rate filed under Section 2151.202 or that the rate is considered approved under Section 2151.2022.

Added by Acts 2013, 83rd Leg., R.S., Ch. 95 (S.B. 733), Sec. 5, eff. May 18, 2013.

Sec. 2151.203. RECORDING AND REPORTING OF PREMIUM, LOSS, AND EXPENSE EXPERIENCE. (a) The commissioner shall adopt reasonable rules and statistical plans for the recording and reporting of premium, loss, and expense experience and other required data by each authorized insurer. The premium, loss, and expense experience must be reported separately for business assigned to the insurer.

(b) Each authorized insurer shall use the statistical plans adopted under this section to record and report premium, loss, and expense experience and other required data in accordance with the rules adopted by the commissioner.

(c) In approving rates under this subchapter, the commissioner shall consider the reports collected under the statistical plan regarding aggregated premiums earned and losses and expenses incurred in the writing of automobile insurance through the association.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2151.204. NOTICE OF FILING. (a) The department shall file with the secretary of state for publication in the Texas Register notice that a filing has been made under Section 2151.202 not later than the seventh day after the date the filing is received by the department.

(b) The notice must include information relating to:

(1) the availability of the filing for public inspection at the department during regular business hours;

(2) the procedures for obtaining copies of the filing;

(3) procedures for making written comments related to the filing; and

(4) the time, place, and date of the hearing scheduled under Section 2151.206.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2151.2041. HEARING ON CERTAIN RATE FILINGS. If the association files a rate under Section 2151.202 that exceeds 105 percent of the current average rate for each coverage written through the association on the date of the filing, the commissioner shall conduct a hearing under Section 2151.206.

Added by Acts 2013, 83rd Leg., R.S., Ch. 95 (S.B. 733), Sec. 6, eff. May 18, 2013.

Sec. 2151.205. OPPORTUNITY TO REVIEW FILING. Before approving, disapproving, or modifying a filing described by Section 2151.2041, the commissioner must provide to all interested persons a reasonable opportunity to:

- (1) review the filing;
- (2) obtain a copy of the filing on payment of any legally required copying cost; and
- (3) submit to the commissioner written comments, analyses, or information related to the filing.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 95 (S.B. 733), Sec. 7, eff. May 18, 2013.

Sec. 2151.206. HEARING ON FILING. (a) Not later than the 45th day after the date the department receives a filing described by Section 2151.2041, the commissioner shall schedule a hearing at which interested persons may present written or oral comments relating to the filing.

(b) The association, the public insurance counsel, and any other interested person or entity that submits proposed changes or actuarial analyses may ask questions of any person testifying at the hearing.

(c) A hearing held under this section is not a contested case hearing under Chapter 2001, Government Code.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 95 (S.B. 733), Sec. 8, eff. May 18, 2013.

Sec. 2151.207. ACTION OF COMMISSIONER ON FILING. (a) After the conclusion of the hearing under Section 2151.206, the commissioner shall approve, disapprove, or modify the filing in writing.

(b) If the commissioner disapproves a filing, the commissioner shall state in writing the reasons for the disapproval and the criteria to be met by the association to obtain approval.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2151.208. AMENDED FILING. The association may file with the commissioner an amended filing to comply with the commissioner's comments not later than the 10th day after the date the association receives the commissioner's written disapproval under Section 2151.2023 or 2151.207.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 95 (S.B. 733), Sec. 9, eff. May 18, 2013.

Sec. 2151.209. OPPORTUNITY TO REVIEW AMENDED FILING. Before approving or disapproving an amended filing, the commissioner must provide to all interested persons a reasonable opportunity, in the same manner an opportunity is provided under Section 2151.205, to:

- (1) review the amended filing;
- (2) obtain a copy of the amended filing on payment of any legally required copying cost; and
- (3) submit to the commissioner written comments or information related to the amended filing.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April

1, 2007.

Sec. 2151.210. HEARING ON AMENDED FILING. (a) The commissioner may hold a hearing in the manner provided by Section 2151.206 not later than the 20th day after the date the department receives an amended filing.

(b) Not later than the 10th day after the date the hearing on the amended filing is concluded, the commissioner shall approve or disapprove the amended filing.

(c) Not later than the 30th day after the date the amended filing is received by the department, the commissioner shall disapprove the amended filing or the filing is considered approved.

(d) The requirements provided under Sections 2151.204 and 2151.207 apply to a hearing conducted under this section.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2151.211. APPEAL. (a) A person aggrieved by a decision of the commissioner under this subchapter may appeal the decision not later than the 30th day after the date of the decision.

(b) An appeal of a commissioner's decision under this subchapter must be made in accordance with Subchapter D, Chapter 36.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2151.212. HEARINGS BY DEPARTMENT. Subchapter B, Chapter 40, does not apply to this subchapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

CHAPTER 2152. GROUP INSURANCE IN UNDERSERVED AREAS

Sec. 2152.001. DEFINITION. In this chapter, "residential property insurance" means insurance against loss to real or tangible personal property at a fixed location that is provided through a

homeowners policy, residential fire and allied lines policy, or farm and ranch owners policy.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2152.002. DESIGNATION OF UNDERSERVED AREAS. (a) The commissioner by rule may designate an area as an underserved area for personal automobile insurance or residential property insurance.

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

(1) whether the insurance described by Subsection (a) is not reasonably available to a substantial number of insurable risks and the availability of insurance in general; and

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

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2152.003. AUTHORIZATION FOR ISSUANCE OF GROUP INSURANCE IN UNDERSERVED AREA. An insurer authorized to write property or casualty insurance in this state, including a Lloyd's plan and a reciprocal or interinsurance exchange, that writes personal automobile insurance or residential property insurance in this state may write the personal automobile insurance or residential property insurance on a group basis in an underserved area designated by the commissioner.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2152.004. EXCLUSION OF CERTAIN COVERAGE. Group insurance provided under this chapter may not include windstorm and hail insurance coverage for a risk eligible for that coverage under Chapter 2210.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April

1, 2007.

Sec. 2152.005. FORMATION OF GROUP. A group may be formed solely to purchase insurance subject to this chapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2152.006. RATES. Rates for coverage provided under this chapter are subject to the applicable statutes relating to the insurers providing the coverage.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2152.007. POLICY FORMS AND CERTIFICATES. The commissioner shall adopt policy forms and certificates for use in underserved areas designated by the commissioner under this chapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2152.008. RULES. In addition to other rules adopted under this chapter, the commissioner may adopt any rules that are appropriate and necessary to implement this chapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

**CHAPTER 2153. GROUP MARKETING OF AUTOMOBILE INSURANCE FOR PERSONS
OVER 55 YEARS OF AGE**

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 2153.001. DEFINITIONS. In this chapter:

(1) "Group automobile insurance" means automobile insurance that:

(A) covers individuals who are over 55 years of age;

and

(B) is offered under a group marketing plan.

(2) "Group marketing" means the marketing of group automobile insurance to an eligible group under Section 2153.052.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2153.002. APPLICABILITY OF CERTAIN PROVISIONS. Sections 4001.051 and 4001.053 do not apply to a group participating in a group marketing plan under this chapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2153.003. RULES. The commissioner may adopt any rules necessary to carry out the provisions of this chapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER B. CONDITIONS FOR ISSUANCE OF GROUP AUTOMOBILE INSURANCE

Sec. 2153.051. AUTHORIZATION FOR ISSUANCE OF GROUP AUTOMOBILE INSURANCE. An insurer may issue group automobile insurance in this state if the conditions of Sections 2153.054(b), 2153.055-2153.059, and 2153.103 are met.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2153.052. ELIGIBILITY OF GROUP. (a) To be eligible for group marketing, a group must:

(1) have existed for at least six months before the date the group automobile insurance is purchased; and

(2) be organized for a purpose other than to become an insurance group under this chapter.

(b) The group may include any group that is actuarially

credible for underwriting purposes.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2153.053. ELIGIBILITY OF GROUP MEMBER. A member of a group described by Section 2153.052 is eligible to participate in a group marketing plan if the member is:

- (1) in good standing with the group;
- (2) over 55 years of age; and
- (3) authorized to operate a motor vehicle in this state.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2153.054. GUARANTEED ISSUE. (a) An insurer shall issue group automobile insurance:

- (1) on a guaranteed basis under a single insurance program; and
- (2) without individual underwriting selection or individual proof of insurability.

(b) An insurer that issues group automobile insurance and the insured group shall accept for participation in the group marketing plan any member of the group who is eligible under Section 2153.053 and who wants to participate.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2153.055. INSURER QUALIFICATIONS. To qualify to write group automobile insurance, an insurer:

- (1) must be authorized to engage in the business of automobile insurance in this state;
- (2) must also be engaged in the business of writing automobile insurance for independent individual risks; and
- (3) may not be organized solely to provide group automobile insurance.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2153.056. VEHICLES COVERED. A group marketing plan must provide that a motor vehicle is eligible for group automobile insurance coverage only if the vehicle is owned by a group member or the member's spouse jointly or severally.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2153.057. INDIVIDUAL POLICIES. An insurer shall issue an individual policy to each participating group member.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2153.058. GROUP PAYMENT OF PREMIUMS. An insurer shall provide group automobile insurance under an agreement under which the group periodically pays the premiums on the policies to the insurer.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2153.059. LIMITATIONS ON CANCELING INSURANCE. (a) An insurer may not cancel the insurance of a group member unless:

- (1) the member fails to pay the premiums; or
- (2) the insurance for the entire group is canceled.

(b) An insurer that cancels insurance under Subsection (a) shall provide to each group member whose insurance is canceled the same notice of cancellation the insurer provides for cancellation of individual automobile insurance policies.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER C. RECORDS, RATES, AND FORMS

Sec. 2153.101. MAINTENANCE OF RECORDS. An insurer that writes insurance under a group marketing plan shall maintain separate experience data on the group marketing plan business, including complete records of premium income, losses, and expenses, so that the experience may be fairly ascertained.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2153.102. RATES. Rates for group automobile insurance are determined in the manner provided by Chapter 2251 and Article 5.13-2, to the extent that those laws apply.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2153.103. POLICY FORMS. An insurer that writes group automobile insurance shall use policy forms:

- (1) prescribed by the commissioner and authorized for use by Section 2301.052(b); or
- (2) filed and in effect as provided by Section 2301.052(a).

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

CHAPTER 2154. VOLUNTEER FIRE DEPARTMENT MOTOR VEHICLE SELF-INSURANCE PROGRAM

Sec. 2154.001. DEFINITIONS. In this chapter:

- (1) "Fund" means the volunteer fire department self-insurance fund established under Section 2154.005.
- (2) "Program" means the volunteer fire department motor vehicle self-insurance program administered under this chapter.
- (3) "Service" means the Texas Forest Service of The Texas A&M University System.
- (4) "Volunteer fire department" means a fire department operated by the fire department's members on a not-for-profit basis. The term includes a fire department that is exempt from federal

income tax under Section 501(a), Internal Revenue Code of 1986, by being listed as an exempt organization in Section 501(c)(3) of that code.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2154.002. MOTOR VEHICLE SELF-INSURANCE PROGRAM. (a) The service shall administer a volunteer fire department self-insurance program that:

- (1) identifies and evaluates risks arising from the use of motor vehicles by volunteer fire departments;
- (2) maintains a loss-prevention and loss-control program to reduce risks arising from the use of motor vehicles by volunteer fire departments;
- (3) consolidates and administers volunteer fire department risk management and self-insurance programs; and
- (4) provides motor vehicle self-insurance coverage in accordance with Section 2154.003.

(b) The service may employ staff to administer the program.

(c) The director of the service may adopt rules to implement and administer the program.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2154.003. SELF-INSURANCE POOL; COVERAGE. (a) The program shall administer a self-insurance pool to provide coverage for motor vehicles a volunteer fire department uses for fire fighting.

(b) The coverage may indemnify an official, employee, member, or volunteer of a volunteer fire department for liability arising from the use of a covered motor vehicle in performing the person's fire-fighting duties. The maximum limits of coverage are:

- (1) for bodily injury or death:
 - (A) \$100,000 for each person; and
 - (B) \$300,000 for each single occurrence; and
- (2) for injury to or destruction of property, \$100,000 for each single occurrence.

(c) Self-insurance coverage provided under this section may be

funded only from money available from the fund.

(d) The director of the service may establish:

(1) eligibility requirements for participation in coverage under this section; and

(2) equipment and safety standards for the motor vehicles to be covered under this section.

(e) Coverage limits of self-insurance provided under this section must be based on the liquidity of the fund after deducting the cost of administering this chapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2154.004. PARTICIPATION IN SELF-INSURANCE POOL. (a) To participate in coverage provided under Section 2154.003, a volunteer fire department must submit a written request to the program.

(b) The director of the program shall approve the request for participation if each motor vehicle to be covered meets the eligibility requirements and equipment and safety standards established under Section 2154.003(d).

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2154.005. VOLUNTEER FIRE DEPARTMENT SELF-INSURANCE FUND.

(a) The fund is an account in a depository selected by the board of regents of The Texas A&M University System in the manner provided by Section 51.003, Education Code, for funds subject to the control of institutions of higher education under Section 51.002, Education Code.

(b) The fund is composed of:

(1) money collected under Section 2154.007; and

(2) interest accruing on money in the fund.

(c) Money in the fund may be spent only for:

(1) funding self-insurance under the program; or

(2) administering this chapter, including paying the salaries and expenses of staff for the program and the fund.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April

1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.059(a), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.059(a), eff. September 1, 2007.

Sec. 2154.006. LIMITATION ON STATE'S LIABILITY. The state's liability for a loss covered by self-insurance provided under this chapter is limited to the assets of the fund, and the state is not otherwise liable for that loss.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2154.007. SELF-INSURANCE FEE. (a) The service may assess and collect a reasonable fee from participating volunteer fire departments to provide self-insurance coverage under this chapter. In establishing the amount of the fee, the service shall consider the amount that could be charged to the volunteer fire department for similar insurance coverage provided to that department in accordance with this code.

(b) Fees collected under this section shall be deposited to the credit of the fund.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2154.008. LEGAL REPRESENTATION. (a) The service may employ an attorney to represent a volunteer fire department or an official, employee, member, or volunteer of a volunteer fire department in a liability action for which insurance coverage is provided under this chapter.

(b) The attorney general may not provide the services described by Subsection (a).

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

CHAPTER 2171. COMMERCIAL GROUP PROPERTY INSURANCE

Sec. 2171.001. DEFINITION. In this chapter, "large risk" means an insured described by Section 2301.004.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2171.002. AUTHORIZATION FOR ISSUANCE. An insurer may write commercial group property insurance for:

(1) a group of businesses that constitutes a large risk if the members of the group have clearly identifiable underwriting characteristics; or

(2) an association that constitutes a large risk if the members of the association are engaged in similar undertakings.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2171.003. POLICY FORM FILINGS. (a) An insurer shall file a policy form with the commissioner before using the form for a group of businesses or an association described by Section 2171.002 in which each member of the group or association is not a large risk.

(b) A filing made under this section is for informational purposes only.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2171.004. RATE FILINGS. An insurer shall file with the commissioner in accordance with Chapter 2251 the following information for commercial group property insurance written under this chapter in this state:

- (1) rates;
- (2) supplementary rating information; and
- (3) pertinent supporting information.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2171.005. IDENTIFICATION OF INSURED REQUIRED. An insurer filing a policy form under Section 2171.003 or rates and related information under Section 2171.004 shall clearly identify the group of businesses or the association to be insured.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

CHAPTER 2201. RISK RETENTION GROUPS AND PURCHASING GROUPS
SUBCHAPTER A. GENERAL PROVISIONS

Sec. 2201.001. PURPOSE OF CHAPTER. The purpose of this chapter is to:

- (1) regulate the formation and operation of risk retention groups and purchasing groups in this state formed under:
 - (A) the Product Liability Risk Retention Act of 1981 (15 U.S.C. Section 3901 et seq.); or
 - (B) the Liability Risk Retention Act of 1986 (15 U.S.C. Section 3901 et seq.); and
- (2) protect the public by the appropriate regulation of groups described by Subdivision (1) to the extent permitted by law.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2201.002. GENERAL DEFINITIONS. In this chapter:

- (1) "Agent" includes the terms "agent" and "broker" as used in the Liability Risk Retention Act of 1986 (15 U.S.C. Section 3901 et seq.).
- (2) "Hazardous financial condition" means a condition in which a risk retention group, based on the group's present or reasonably anticipated financial condition and although the group is not yet financially impaired or insolvent, is unlikely to be able to:
 - (A) meet obligations to policyholders with respect to known claims and reasonably anticipated claims; or
 - (B) pay other obligations in the normal course of

business.

(3) "Insurance" means primary insurance, excess insurance, reinsurance, surplus lines insurance, and any other arrangement for transferring and distributing risk that is determined to be insurance under the laws of this state.

(4) "State" means any state of the United States or the District of Columbia.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2201.003. LIABILITY DEFINED. (a) In this chapter, except as provided by Subsection (b) or as otherwise provided by this chapter:

(1) "Completed operations liability" means liability, including liability for activities that are completed or abandoned before the date of the occurrence giving rise to the liability, arising out of the installation, maintenance, or repair of any product at a site that is not owned or controlled by:

(A) a person who performs that work; or

(B) a person who hires an independent contractor to perform that work.

(2) "Liability" means legal liability for damages, including costs of defense, legal costs, fees, and other claims expenses, incurred because of personal injury, property damage, or other damage or loss to another person resulting from or arising out of:

(A) a product, trade, or business, regardless of whether the business operates for profit;

(B) operations, premises, or services, including professional services; or

(C) any activity of:

(i) a state or local government; or

(ii) an agency or political subdivision of a state or local government.

(3) "Product liability" means liability for damages incurred because of any personal injury, death, emotional harm, consequential economic damage, or property damage, including damage resulting from the loss of use of property, arising out of the

manufacture, design, importation, distribution, packaging, labeling, lease, or sale of a product, but does not include the liability of any person for those damages if the product involved was in the possession of that person when the incident giving rise to the claim occurred.

(b) In this chapter, "liability" does not include:

(1) liability for damages incurred because of personal injury, property damage, or other damage or loss resulting from a personal, familial, or household activity or responsibility; or

(2) an employer's liability with respect to the employer's employees other than legal liability under the Federal Employers' Liability Act (45 U.S.C. Section 51 et seq.).

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2201.004. AGENT LICENSE REQUIRED. (a) A person, firm, partnership, or corporation may not act or offer to act as an agent for, or aid in any manner in the solicitation, negotiation, or placement of insurance on behalf of, a risk retention group or purchasing group operating in this state or a group member in this state without first obtaining a license as an agent under:

(1) Chapter 4051, if a resident of this state; or

(2) Chapter 4056, if a nonresident of this state.

(b) A person, firm, partnership, or corporation must comply with Chapter 981 before the person, firm, partnership, or corporation, on behalf of a purchasing group or a group member in this state:

(1) acts or offers to act as an agent for an insurer not authorized to engage in business in this state; or

(2) aids in any manner in the solicitation, negotiation, or placement of insurance with an insurer not authorized to engage in business in this state.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2201.005. EXEMPTION FROM CERTAIN REQUIREMENTS. (a) A provision of Chapter 981, 4055, or 4056 does not apply to an agent

described by Subsection (b) if the provision:

- (1) requires residency in this state;
- (2) requires countersignatures;
- (3) prohibits the solicitation of insurance in this state by a nonresident or the payment of commissions to a nonresident; or
- (4) prohibits a nonresident from acting as a surplus or excess lines agent.

(b) The exemption provided by Subsection (a) applies to an agent licensed under Chapter 981, 4055, or 4056 who is acting on behalf of a risk retention group or purchasing group operating in this state or a group member in this state in providing or placing liability insurance for risks located in this state.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2201.006. AUTHORITY OF COMMISSIONER. (a) To enforce the laws of this state, the commissioner may use any authority provided by this code that is not specifically preempted by the Product Liability Risk Retention Act of 1981, as amended by the Liability Risk Retention Act of 1986 (15 U.S.C. Section 3901 et seq.), including the authority to investigate, issue a subpoena, conduct a deposition or hearing, issue an order, and impose a penalty.

(b) The commissioner shall rely on the procedural laws and rules of this state with regard to an investigation, an administrative proceeding, or litigation.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2201.007. ANNUAL REPORT TO COMMISSIONER. An agent licensed as required by Section 2201.004 shall report to the commissioner not later than March 1 of each year the activities and scope of services being provided to a risk retention group or purchasing group. The report must be made in accordance with rules adopted by the commissioner.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2201.008. RULES. The commissioner may adopt rules relating to risk retention groups and purchasing groups that are necessary to carry out this chapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER B. RISK RETENTION GROUP QUALIFICATIONS

Sec. 2201.051. GENERAL QUALIFICATIONS OF RISK RETENTION GROUP. A risk retention group must be a corporation or other limited liability association that:

- (1) is organized primarily to assume and spread, and engages primarily in assuming and spreading, all or any portion of the liability exposure of the group's members; and
- (2) otherwise meets the qualifications of this subchapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2201.052. NAME OF GROUP. A risk retention group must include in its name the phrase "risk retention group."

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2201.053. STATUS AS LIABILITY INSURER REQUIRED. A corporation or other limited liability association must be chartered and authorized to engage in the business of insurance as a liability insurer under the laws of any state to act as a risk retention group.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2201.054. QUALIFICATIONS REGARDING AUTHORITY OF CERTAIN ENTITIES TO ENGAGE IN BUSINESS. (a) In this section, "completed

operations liability" and "product liability" have the meanings assigned by the Product Liability Risk Retention Act of 1981 (15 U.S.C. Section 3901 et seq.) before the effective date of the Liability Risk Retention Act of 1986 (15 U.S.C. Section 3901 et seq.).

(b) Notwithstanding Section 2201.053, a corporation or other limited liability association may be considered a risk retention group if:

(1) before January 1, 1985, the corporation or association:

(A) was chartered and authorized to engage in the business of insurance under the laws of Bermuda or the Cayman Islands; and

(B) had certified to the commissioner, director, or superintendent of insurance of at least one state that it satisfied the capitalization requirements of that state; and

(2) since January 1, 1985, the corporation or association has been continuously engaged in business solely to continue to provide insurance to cover completed operations liability or product liability.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2201.055. QUALIFICATIONS REGARDING MEMBERSHIP. (a) A risk retention group must be composed of members who are engaged in similar or related businesses or activities with respect to the liability to which those members are exposed by virtue of any related, similar, or common product, trade, business, operations, premises, or services.

(b) A risk retention group must have:

(1) as members, only persons who are provided insurance by the group; or

(2) as the sole owner, an organization that has:

(A) as members, only persons who comprise the membership of the group; and

(B) as owners, only persons who comprise the membership of the group and are provided insurance by the group.

(c) A risk retention group may not exclude a person from membership in the group solely to provide a competitive advantage for

group members over that person.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2201.056. AUTHORIZED ACTIVITIES. (a) A risk retention group may provide:

(1) liability insurance for assuming and spreading all or any portion of the liability of the group's members; and

(2) reinsurance with respect to the liability of another risk retention group, or a member of that group, engaged in businesses or activities that meet the requirements of Section 2201.055(a) for membership in the group providing reinsurance.

(b) A risk retention group may not engage in activities that include providing insurance other than the insurance described by Subsection (a).

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

**SUBCHAPTER C. RISK RETENTION GROUPS
CHARTERED IN THIS STATE**

Sec. 2201.101. ELIGIBILITY REQUIREMENTS. Except as otherwise provided by this chapter, a risk retention group that applies to be chartered in this state must:

(1) be chartered and authorized to engage in the business of insurance under Chapter 822, 861, 883, or 942; and

(2) comply with all the laws, rules, and requirements, including Chapter 804, applicable to insurers authorized to engage in business under those chapters and with Subchapter D to the extent those requirements do not limit the laws, rules, or requirements of this state.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2201.102. CHARTER APPLICATION. (a) A risk retention group that applies to be chartered in this state shall provide to the

commissioner with the application for charter the following in accordance with rules adopted by the commissioner:

- (1) the group's name;
- (2) the identity of the group's initial members;
- (3) the identity of the individuals who organized the group or who will provide administrative services or otherwise influence or control the group's activities;
- (4) the amount and nature of initial capitalization;
- (5) the coverages to be afforded; and
- (6) the states in which the group intends to operate.

(b) Immediately on receipt of an application for charter, the commissioner shall provide summary information concerning the filing, including the information provided under Subsection (a), to the National Association of Insurance Commissioners.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2201.103. PLAN OF OPERATION; REVISIONS. (a) Except as provided by Subsection (b), before a risk retention group chartered in this state may offer insurance in any state, the group must submit to the commissioner for approval a plan of operation as described by Section 2201.202.

(b) A risk retention group is not required to submit a plan of operation under this section with respect to any kind or classification of liability insurance that:

(1) was defined in the Product Liability Risk Retention Act of 1981 (15 U.S.C. Section 3901 et seq.), as that Act existed before October 27, 1986; and

(2) was offered before October 27, 1986, by any risk retention group that had been chartered and operating for at least three years before that date.

(c) The risk retention group must submit a revision of the group's plan of operation to the commissioner and the commissioner must approve the revision before the group:

(1) offers an additional line of insurance in this state or in any other state; or

(2) effects a change in the group's operations as described in the plan of operation.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2201.104. FILING FEE. (a) In addition to all other fees imposed on an insurer chartered and authorized to engage in business under Chapter 822, 861, 883, or 942, a risk retention group chartered in this state shall pay a filing fee in an amount not to exceed \$1,000 as set by rules adopted by the commissioner.

(b) Fees collected under this section shall be deposited to the credit of the Texas Department of Insurance operating account to pay expenses incurred by the commissioner under Sections 2201.102 and 2201.103.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

**SUBCHAPTER D. RISK RETENTION GROUPS
NOT CHARTERED IN THIS STATE**

Sec. 2201.151. COMPLIANCE REQUIRED. A risk retention group chartered and authorized to engage in business in another state, Bermuda, or the Cayman Islands shall comply with this subchapter to engage in business as a risk retention group in this state.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2201.152. PREREQUISITES TO OFFERING INSURANCE. (a) Before offering insurance in this state, a risk retention group not chartered in this state must submit to the commissioner:

(1) a statement that:

(A) identifies the state or states in which the group is chartered and authorized to engage in business as a liability insurer, the date of charter, and the group's principal place of business; and

(B) provides any other information the commissioner requires to verify that the group qualifies as a risk retention group under Subchapter B, including information on the group's membership;

(2) except as provided by Subsection (b), a copy of the

group's plan of operation, as described by Section 2201.202, and revisions of that plan submitted to the state in which the group is chartered and authorized to engage in business; and

(3) a statement of registration that designates the commissioner as the group's agent for the purpose of receiving service of legal documents or process as provided by Chapter 804.

(b) A risk retention group is not required to submit a plan of operation under this section with respect to any line or classification of liability insurance that:

(1) was defined in the Product Liability Risk Retention Act of 1981 (15 U.S.C. Section 3901 et seq.), as that Act existed before October 27, 1986; and

(2) was offered before October 27, 1986, by any risk retention group that had been chartered and operating for at least three years before that date.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2201.153. REQUIREMENTS FOR CONTINUING BUSINESS. (a) A risk retention group not chartered in this state that engages in business in this state shall submit to the commissioner:

(1) a copy of the group's financial statement submitted to the state in which the group is chartered and authorized to engage in business;

(2) a copy of each examination of the group as certified by the commissioner, director, or superintendent of insurance of another state or other public official conducting the examination;

(3) on the commissioner's request, a copy of any audit performed with respect to the group; and

(4) any other information required to verify that the group continues to qualify as a risk retention group under Subchapter B.

(b) A financial statement submitted under Subsection (a)(1) must:

(1) be certified by an independent public accountant; and

(2) contain a statement of opinion on loss and loss adjustment expense reserves made:

(A) under criteria established by the National Association of Insurance Commissioners; and

(B) by a member of the American Academy of Actuaries or a qualified loss reserve specialist.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2201.154. FILING FEES. (a) The commissioner by rule shall impose a filing fee in an amount not to exceed \$500 for filing the items described by Sections 2201.152(a)(1) and (2).

(b) The commissioner by rule may impose a filing fee in an amount not to exceed \$500 for filing the financial statement under Section 2201.153(a)(1). A risk retention group shall provide to the comptroller all information the comptroller requests in connection with the reporting, collection, enforcement, and administration of the fee.

(c) Fees collected under this section shall be deposited to the credit of the Texas Department of Insurance operating account.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2201.155. PAYMENT OF TAXES. (a) A risk retention group not chartered in this state is liable for the payment of premium and maintenance taxes and taxes on premiums of direct business for risks located in this state and shall report to the commissioner the net premiums written for risks located in this state. The group is subject to taxation, and any fine or penalty related to that taxation, on the same basis as a foreign admitted insurer in accordance with Chapters 4, 201, 202, 203, 221, 222, 224, 227, 228, and 251-257.

(b) A risk retention group shall provide to the comptroller all information the comptroller requests in connection with the reporting, collection, enforcement, and administration of taxes under this section.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2H.006,

eff. April 1, 2009.

Sec. 2201.156. EXAMINATION OF FINANCIAL CONDITION; DISSOLUTION OR DELINQUENCY PROCEEDINGS. (a) A risk retention group not chartered in this state must submit to an examination by the commissioner to determine the group's financial condition if the commissioner of insurance of the jurisdiction in which the group is chartered and authorized to engage in business has not initiated an examination on or before the 60th day after the date the commissioner of this state requests an examination.

(b) The commissioner shall:

(1) coordinate the examination under Subsection (a) to avoid unjustified repetition; and

(2) conduct the examination in an expeditious manner under Sections 401.051, 401.052, 401.054-401.062, 401.103-401.106, 401.151, 401.152, 401.155, and 401.156 and Chapters 86 and 803 in accordance with the National Association of Insurance Commissioners Financial Condition Examiner's Handbook.

(c) A risk retention group not chartered in this state that engages in business in this state must comply with an order issued in a voluntary dissolution proceeding or in a delinquency proceeding commenced by the commissioner or by a commissioner of another jurisdiction if, after an examination under this section, there is a finding that the group is financially impaired.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2201.157. APPLICABILITY OF STATE LAWS PROHIBITING CERTAIN ACTS OR PRACTICES. (a) A risk retention group not chartered in this state shall comply with the laws of this state relating to deceptive, false, or fraudulent acts or practices, including Chapters 541 and 543.

(b) A risk retention group not chartered in this state and the group's agents and representatives shall comply with Chapter 542.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2201.158. INJUNCTIVE RELIEF. (a) A risk retention group not chartered in this state must comply with the terms of an injunction issued by a court of this state or any other state based on a finding that the group is in a hazardous financial condition or is financially impaired.

(b) Injunctive relief must be issued by a court if the commissioner seeks to enjoin a risk retention group not chartered in this state from:

(1) violating the law of this state prohibiting deceptive, false, or fraudulent acts or practices;

(2) soliciting or selling insurance to a person who is not eligible for membership in the group; or

(3) soliciting or selling insurance or operating when the group is in a hazardous financial condition or is financially impaired.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

**SUBCHAPTER E. PROVISIONS REGULATING GENERAL OPERATION
OF RISK RETENTION GROUPS**

Sec. 2201.201. SCOPE OF AUTHORITY. A risk retention group may engage in the business of insurance in this state only:

(1) as a risk retention group; and

(2) to conduct the activities described in this chapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2201.202. PLAN OF OPERATION. A plan of operation submitted to the commissioner under Section 2201.103 or 2201.152 must be in the form of an analysis that presents the expected activities and results of a risk retention group, including, at a minimum:

(1) information sufficient to verify that the group's members are engaged in businesses or activities that are similar or related with respect to the liability to which those members are exposed by virtue of any related, similar, or common product, trade, business, operations, premises, or services;

(2) for each state in which the group intends to operate,

the coverages, deductibles, coverage limits, rates, and rating classification systems for each line of insurance the group intends to offer;

(3) historical and expected loss experience of the proposed members and national experience of similar exposures to the extent that this experience is reasonably available;

(4) pro forma financial statements and projections;

(5) appropriate opinions, including a determination of minimum premium or participation levels required to begin operations and to prevent a hazardous financial condition, by:

(A) a qualified, independent casualty actuary who is a member in good standing of the American Academy of Actuaries; or

(B) an individual who the commissioner recognizes as having comparable training and experience;

(6) identification of management, underwriting and claims procedures, marketing methods, managerial oversight methods, and investment policies; and

(7) other matters prescribed by the insurance laws of the state in which the group is chartered.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2201.203. AGENT TO VERIFY AUTHORITY. Before placing business with a risk retention group, each agent shall secure from the appropriate insurance regulatory authority a certified copy of the certificate of authority verifying that the insurer is authorized in the insurer's domiciliary jurisdiction to write the liability insurance policy the agent proposes to procure from the insurer.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2201.204. APPLICABILITY OF CERTAIN REQUIREMENTS FOR LIABILITY INSURERS. A risk retention group authorized to engage in business in this state under Subchapter C or D must participate on the same basis as a liability insurer holding a certificate of authority to engage in the business of insurance in this state in:

(1) the Texas Windstorm Insurance Association;

- (2) joint underwriting associations;
- (3) mandatory liability and assigned risk pools; and
- (4) residual market facilities.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2201.205. RISK RETENTION GROUP PARTICIPATION IN INSOLVENCY GUARANTY FUND PROHIBITED. A risk retention group may not be required or permitted to join or contribute financially to any insurance insolvency guaranty fund or similar mechanism in this state. A risk retention group, and any of the group's insureds or claimants against an insured, may not receive any benefit from an insurance insolvency guaranty fund or similar mechanism in this state for a claim arising under an insurance policy issued by the group.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2201.206. REQUIRED NOTICE. (a) Any policy issued by a risk retention group must contain in 10-point type on the front page and on the declarations page the following notice:

NOTICE

This policy is issued by your risk retention group. Your risk retention group may not be subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not available for your risk retention group.

(b) Each person, firm, partnership, or corporation licensed under Chapter 981, 4051, or 4056 shall inform each prospective insured on business to be placed with a risk retention group of the notice required by Subsection (a).

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2201.207. PROHIBITED ACTIVITIES. A risk retention group may not:

- (1) solicit or sell insurance to any person who is not eligible for membership in the group;
- (2) solicit or sell insurance or operate if the group is in a hazardous financial condition or is financially impaired; or
- (3) engage in business in this state if an insurer is directly or indirectly a member or owner of the group, unless all of the group members are insurers.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2201.208. INJUNCTIVE RELIEF. An order issued by a United States district court enjoining a risk retention group from soliciting or selling insurance or operating in any state, in all states, or in any territory or possession of the United States on a finding that the group is in a hazardous financial condition, is financially impaired, or is insolvent is enforceable in the courts of this state.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2201.209. PENALTIES. (a) A risk retention group that is authorized to engage in business in this state under Subchapter C or D and that violates this chapter is subject to all sanctions and penalties applicable to an insurer that holds a certificate of authority under Chapters 822 and 861, including revocation of the authority to engage in business in this state.

(b) A risk retention group not chartered in this state that violates this chapter is also subject to any fine or penalty applicable to a foreign admitted insurer generally, including revocation of the authority to engage in business in this state.

(c) A risk retention group engaging in business in this state that is not authorized to engage in business under Subchapter C or D is considered an unauthorized insurer and is subject to Section 823.457, Subchapters A-P, Chapter 442, and Chapters 101, 441, 804, and 801, other than Section 801.056.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER F. PURCHASING GROUPS

Sec. 2201.251. GENERAL QUALIFICATIONS OF PURCHASING GROUP. (a) A purchasing group must:

(1) have as one of the group's purposes the purchase of liability insurance on a group basis;

(2) be composed of members whose businesses or activities are similar or related with respect to the liability to which those members are exposed by virtue of any related, similar, or common product, trade, business, operations, premises, or services; and

(3) purchase group liability insurance only for the group's members and only to cover the members' similar or related liability exposure as described in Subdivision (2).

(b) A purchasing group may be domiciled in any state.

(c) Notwithstanding any other provision of this code, a purchasing group composed primarily of employees of a political subdivision, including a county, municipality, or school district, may purchase first-party indemnity coverage, in addition to the liability coverage described in Subsection (a)(3), on a group basis for other risks to which members may be exposed provided that the aggregate coverage limit per group member for the risk does not exceed three percent of the per member coverage limit for liability coverage.

(d) A purchasing group shall notify the commissioner of the group's intent to purchase coverage described by Subsection (c) not later than the 60th day before the date the policy that includes the coverage is initially issued.

(e) Subsection (d) does not apply to a purchasing group described by Subsection (c) that was providing to its members coverage described by Subsection (c) on January 1, 2013, and has continued to provide that coverage without lapse.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 476 (S.B. 1125), Sec. 1, eff. September 1, 2013.

Sec. 2201.252. DETERMINATION OF LOCATION. (a) For purposes of this subchapter, a purchasing group is considered to be located in the state in which the highest aggregate premiums are in force on the date the group insurance policy is written or renewed. The group's location is ascertained on each placement or renewal of insurance by the group with an insurer or risk retention group.

(b) For purposes of this section, a group insurance policy is considered to be renewed annually.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2201.253. LIMITATIONS ON AUTHORITY. (a) A purchasing group located in this state may not purchase liability insurance from a risk retention group that is not chartered in a state or from an insurer that does not hold a certificate of authority to engage in the business of insurance in this state unless the purchase is effected through a licensed agent acting under Chapter 981.

(b) A purchasing group may not offer insurance policy coverage declared unlawful by the Texas Supreme Court.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2201.254. APPLICATION OF STATE LAW. (a) A purchasing group meeting the criteria established under the Liability Risk Retention Act of 1986 (15 U.S.C. Section 3901 et seq.) is exempt from any law of this state that:

- (1) relates to the creation of groups for the purchase of insurance;
- (2) requires countersignatures;
- (3) prohibits group purchasing; or
- (4) discriminates against a purchasing group or the group's members.

(b) An insurer is exempt from any law of this state that prohibits providing or offering to provide to a purchasing group or the group's members advantages based on the group's or members' loss

and expense experience that are not afforded to other persons with respect to rates, policy forms, coverages, or other matters.

(c) A purchasing group is subject to all other applicable laws of this state.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2201.255. NOTICE TO COMMISSIONER; FILING FEE. (a) Before engaging in business in this state, a purchasing group must provide notice to the commissioner. The notice must:

- (1) identify the state in which the group is domiciled;
- (2) specify the lines and classifications of liability insurance the group intends to purchase;
- (3) specify the method by which and the persons, if any, through whom insurance will be offered to group members whose risks are located in this state;
- (4) identify the insurer from which the group intends to purchase group insurance and the domicile of that insurer;
- (5) identify the group's principal place of business and, if ascertainable at the time of filing, the group's location; and
- (6) provide other information the commissioner requires to verify that the group qualifies as a purchasing group under Section 2201.251.

(b) The commissioner by rule shall impose a filing fee in an amount not to exceed \$100 for filing notice under this section. Fees collected under this subsection shall be deposited to the credit of the Texas Department of Insurance operating account.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2201.256. REGISTRATION REQUIREMENT; FEES. (a) A purchasing group shall register with and designate the commissioner or other appropriate authority as the group's agent solely for the purpose of receiving service of legal documents or process unless the group:

- (1) was domiciled before April 1, 1986, in any state of the United States and is domiciled on and after October 27, 1986, in any

state of the United States;

(2) before October 27, 1986, purchased the group's insurance from an insurer authorized to engage in business in any state, and after October 27, 1986, purchased the group's insurance from an insurer authorized to engage in business in any state;

(3) was a purchasing group under the requirements of the Product Liability Risk Retention Act of 1981 (15 U.S.C. Section 3901 et seq.) before October 27, 1986; and

(4) does not purchase insurance that was not authorized for purposes of an exemption under that Act as effective before October 27, 1986.

(b) The commissioner by rule may impose a fee in an amount not to exceed \$50 for each document served on the commissioner and forwarded to the purchasing group. Fees collected under this subsection shall be deposited to the credit of the Texas Department of Insurance operating account.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2201.257. PAYMENT OF PREMIUM TAXES. (a) Premiums paid for coverage of risks located in this state by a purchasing group or any group member are subject to taxation at the same rate and subject to the same interest, fines, and penalties for nonpayment that apply to premiums paid for similar coverage by other insureds.

(b) Title 3 is used to compute applicable tax rates for a purchasing group or any group member that pays premiums for coverage of risks located in this state to:

(1) an insurer holding a certificate of authority to engage in the business of insurance in this state; or

(2) a risk retention group authorized to engage in business in this state.

(c) To the extent that a purchasing group or group member pays premiums as described by Subsection (b), the insurer or risk retention group receiving those premiums shall remit the tax to the department.

(d) Chapter 225 is used to compute applicable tax rates for a purchasing group or any group member that pays premiums for coverage of risks located in this state to an eligible surplus lines insurer.

If a purchasing group or member pays those premiums, the surplus lines agent shall report and remit the tax. If the agent does not remit the tax, the purchasing group shall remit the tax.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2201.258. PURCHASING GROUP PARTICIPATION IN INSOLVENCY GUARANTY FUND PROHIBITED; EXCEPTION. (a) A claim against a purchasing group or a group member may not be paid from any insurance insolvency guaranty fund or similar mechanism in this state.

(b) A purchasing group, a group member, or any claimant against the group or group member may not receive any benefit from an insurance insolvency guaranty fund or similar mechanism in this state for a claim arising under an insurance policy procured through the group unless the policy is underwritten by an insurer authorized to engage in business in this state that, at the time of the policy's issuance:

- (1) has capital and surplus of at least \$25 million; or
- (2) is a member of a company group that has combined capital and surplus of at least \$25 million.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2201.259. REQUIRED NOTICE. (a) A purchasing group that obtains liability insurance from an insurer or a risk retention group shall provide notice to each group member that has a risk located in this state that the risk is not protected by an insurance insolvency guaranty fund in this state and that the insurer or risk retention group may not be subject to all the insurance laws and rules of this state.

(b) Each person, firm, partnership, or corporation licensed under Chapter 981, 4051, or 4056 shall inform each prospective insured on business to be written through a purchasing group of the notice required by Subsection (a).

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

CHAPTER 2202. JOINT UNDERWRITING
SUBCHAPTER A. GENERAL PROVISIONS

Sec. 2202.001. DEFINITIONS. In this chapter:

(1) "Insurer" means any insurance company, corporation, reciprocal or interinsurance exchange, mutual association, county mutual insurance company, Lloyd's plan, or other insurer authorized to engage in business in this state. The term does not include an insurer that writes only life, health, or accident insurance, variable life insurance, or variable annuity contracts.

(2) "Joint underwriting association" means a voluntary unincorporated association of insurers authorized to engage in business in this state that has been authorized by the association's member insurers to act on behalf of the member insurers in joint underwriting or in issuing syndicate insurance policies on a several, but not joint, basis.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2202.002. INAPPLICABILITY OF CHAPTER. This chapter does not apply to the transaction of life, health, or accident insurance business.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2202.003. DEPOSIT OF FEES. Fees collected under this chapter shall be deposited to the credit of the Texas Department of Insurance operating account.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2202.004. CERTAIN APPROPRIATIONS FROM GENERAL REVENUE FUND PROHIBITED. The legislature may not appropriate money from the general revenue fund to administer this chapter, other than fees

collected under this chapter and deposited to the credit of the Texas Department of Insurance operating account.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER B. AUTHORITY TO ACT AS JOINT UNDERWRITING ASSOCIATION

Sec. 2202.051. CERTIFICATE OF AUTHORITY REQUIRED. An association of insurers may not act as a joint underwriting association in this state on behalf of the association's member insurers unless the association holds a certificate of authority issued under this chapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2202.052. APPLICATION FOR CERTIFICATE OF AUTHORITY. (a) An association of insurers that applies for a certificate of authority under this chapter must file a written application on forms prescribed by the commissioner.

(b) The application must include:

(1) the names and addresses of the association's officers and directors;

(2) a copy of the association's constitution, articles of agreement or association, bylaws, rules, powers of attorney, or other agreements governing the association's activities;

(3) a list of the insurers authorized to engage in business in this state who are association members and the addresses of those insurers' principal administrative offices;

(4) the name and address of a resident of this state who will act as the association's agent for receipt of notices or orders of the commissioner and for service of process; and

(5) other information as required by the commissioner.

(c) At least one officer of the association must swear to the application.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2202.053. ISSUANCE OF CERTIFICATE OF AUTHORITY. The commissioner shall issue a certificate of authority to a joint underwriting association that complies with the requirements of this chapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2202.054. TERM OF CERTIFICATE OF AUTHORITY. Unless renewed, a certificate of authority issued under this chapter expires on the third anniversary of the date the certificate is issued.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2202.055. RENEWAL OF CERTIFICATE OF AUTHORITY. (a) An applicant for the renewal of a certificate of authority must file an application for renewal with the commissioner and pay the renewal fee on or before the date the certificate expires.

(b) The applicant shall file a list of the names and addresses of the association's officers and directors and a list of the association's member insurers with the application for renewal. At least one officer of the association must swear to the list.

(c) A renewed certificate of authority expires on the third anniversary of the renewal date.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2202.056. FEE FOR CERTIFICATE OF AUTHORITY. (a) An applicant for the issuance or renewal of a certificate of authority must pay a nonrefundable fee in an amount set by the commissioner when the applicant files the application.

(b) The fee may not exceed \$200.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2202.057. RECIPROCITY. The commissioner may waive any requirement for a certificate of authority for an applicant who holds a certificate of authority from another state if the other state has requirements for a certificate of authority that are substantially equivalent to the requirements of this state.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

**SUBCHAPTER C. POWERS AND DUTIES OF JOINT UNDERWRITING
ASSOCIATION**

Sec. 2202.101. AUTHORITY TO ACT. A joint underwriting association may:

- (1) act only on behalf of association members who are authorized to engage in business in this state; and
- (2) engage in only those activities the association is authorized to perform by the association members.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2202.102. NOTIFICATION OF CERTAIN INFORMATION REQUIRED. An association holding a certificate of authority under this chapter shall notify the commissioner of a change in the information required to be filed under Section 2202.052 not later than the 30th day after the date the change takes effect.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2202.103. MAINTENANCE OF INFORMATION. (a) A joint underwriting association shall maintain at the association's principal administrative office adequate records of all transactions.

(b) The association shall maintain the records in accordance with prudent recognized industry standards of recordkeeping.

(c) The commissioner or the commissioner's designated representative is entitled to access to records maintained under Subsection (a) for examination, audit, and inspection.

(d) Trade secrets, including the identity and addresses of policyholders and certificate holders, are confidential, except that the commissioner may use information otherwise confidential in proceedings instituted against an association.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER D. AUDIT AND EXAMINATION REQUIREMENTS

Sec. 2202.151. ANNUAL AUDIT. An independent certified public accountant shall annually audit the books of accounts of a joint underwriting association as provided by Subchapter A, Chapter 401. A copy of the audit must be filed with the commissioner.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2202.152. EXAMINATION BY COMMISSIONER. (a) The commissioner may require an examination of a joint underwriting association as often as the commissioner considers necessary. The association shall pay the reasonable costs of the examination on presentation to the association of a detailed account of the costs of the examination.

(b) The association's officers and employees may be examined under oath at any time and shall exhibit on request all books, records, accounts, documents, or agreements governing the association's operations.

(c) Instead of the examination, the commissioner may accept the report of an examination made by the insurance supervisory official of another state under the laws of that state.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER E. DISCIPLINARY ACTIONS AND PROCEDURES; ENFORCEMENT

Sec. 2202.201. GROUNDS FOR DENIAL OF CERTIFICATE OF AUTHORITY OR FOR DISCIPLINARY ACTION. The commissioner may deny an application

for a certificate of authority or discipline a certificate holder under this subchapter if the commissioner finds that the applicant or certificate holder, or an officer or director of an applicant or certificate holder:

- (1) wilfully violated or participated in the violation of this chapter or any other insurance law of this state;
- (2) intentionally made a material misstatement in the original or renewal application;
- (3) obtained or attempted to obtain the certificate by fraud or misrepresentation;
- (4) misappropriated, converted to a personal or other inappropriate use, or illegally withheld money required to be held in a fiduciary capacity;
- (5) has been convicted of a felony or convicted of a misdemeanor of which criminal fraud is an essential element; or
- (6) is incompetent or untrustworthy.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2202.202. DENIAL OF CERTIFICATE OF AUTHORITY OR DISCIPLINARY ACTION. If the commissioner finds that a ground for a denial of a certificate of authority or disciplinary action under Section 2202.201 exists, the commissioner may:

- (1) deny the application for the certificate; or
- (2) suspend, revoke, or refuse to renew the certificate of authority.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2202.203. NOTICE AND HEARING. (a) Before the commissioner may deny an application for a certificate of authority or discipline a certificate holder under this subchapter, the commissioner must:

- (1) give notice by certified mail to the applicant or certificate holder; and
- (2) set a date on which the applicant or certificate holder may appear to be heard and produce evidence.

(b) A hearing under Subsection (a) may not be set for a date that is earlier than the 20th day or later than the 30th day after the date the notice is mailed.

(c) The notice must contain specific reasons for the hearing and a list of the matters to be considered at the hearing.

(d) At the hearing, the commissioner or a department employee designated to conduct the hearing may:

(1) administer oaths, require the appearance of witnesses, and examine any person under oath; and

(2) on the commissioner's initiative or on the request of the applicant or certificate holder, require the production of books, records, or papers relevant to the inquiry.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2202.204. ISSUANCE OF ORDER. On the termination of the hearing, the findings shall be written and filed with the department. The commissioner shall issue an order showing the findings approved by the commissioner and shall send the order by certified mail to the applicant or certificate holder.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2202.205. APPEAL. If the commissioner denies an application for a certificate of authority as provided by this chapter or suspends, revokes, or refuses to renew a certificate at a hearing as provided by this chapter, the applicant or certificate holder may appeal the commissioner's action as provided by Subchapter D, Chapter 36.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2202.206. APPLICATION AFTER DENIAL, REFUSAL, OR REVOCATION. (a) Except as provided by Subsection (b), an applicant for a certificate of authority or certificate holder whose

certificate of authority has been denied, refused, or revoked under this chapter may not file another application for a certificate of authority before the first anniversary of the effective date of the denial, refusal, or revocation.

(b) If an applicant or certificate holder seeks judicial review of a denial, refusal, or revocation, the applicant or certificate holder may not file another application for a certificate of authority before the first anniversary of the date of a final court order or decree affirming the denial, refusal, or revocation.

(c) If an applicant files an application after the date specified by this section, the commissioner may refuse the application unless the applicant shows good cause why the denial of the previous application or the refusal to renew or the revocation of the original certificate of authority should not be a bar to the issuance of a new certificate.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2202.207. ADDITIONAL SANCTIONS; INJUNCTION. (a) An association that violates this chapter or a rule or order adopted under this chapter is subject to sanctions under Chapter 82.

(b) The attorney general, a district or county attorney, or the commissioner may institute proceedings for an injunction or any other proceeding necessary to enforce this chapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

**CHAPTER 2203. MEDICAL LIABILITY INSURANCE JOINT UNDERWRITING
ASSOCIATION**

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 2203.001. SHORT TITLE. This chapter may be cited as the Texas Medical Liability Insurance Underwriting Association Act.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2203.002. DEFINITIONS. In this chapter:

(1) "Assisted living facility" means a for-profit or not-for-profit assisted living facility.

(2) "Association" means the joint underwriting association established under this chapter.

(3) "Board of directors" means the board of directors of the association.

(4) "Health care provider" means:

(A) a person, partnership, professional association, corporation, facility, or institution licensed or chartered by this state to provide health care, as defined in Section 74.001(a)(10), Civil Practice and Remedies Code, as:

(i) a registered nurse, dentist, podiatrist, pharmacist, chiropractor, or optometrist;

(ii) a hospital;

(iii) a nursing home;

(iv) a radiation therapy center that is independent of any other medical treatment facility, is licensed by the Department of State Health Services in that agency's capacity as the Texas Radiation Control Agency under Chapter 401, Health and Safety Code, and is in compliance with the regulations adopted under that chapter;

(v) a blood bank that is a nonprofit corporation chartered to operate a blood bank and is accredited by the American Association of Blood Banks;

(vi) a nonprofit corporation that is organized for the delivery of health care to the public and is certified under Chapter 162, Occupations Code;

(vii) a health center, as defined by 42 U.S.C. Section 254b, as amended; or

(viii) an assisted living facility; or

(B) an officer, employee, or agent of an entity listed in Paragraph (A) acting in the course and scope of that person's office, employment, or agency.

(5) "Medical liability insurance" means primary and excess liability insurance coverage against:

(A) the legal liability of the insured; and

(B) loss, damage, or expense incident to a claim arising out of the death or injury of a person as the result of negligence in rendering or failing to render professional service by

a health care provider or physician who is in a category eligible for coverage by the association.

(6) "Net direct premiums" means gross direct premiums written on automobile liability and other liability insurance written under this code, less:

(A) policyholder dividends;

(B) return premiums for the unused or unabsorbed portion of premium deposits; and

(C) return premiums on canceled contracts written on the liability risks.

(7) "Nursing home" means a for-profit or not-for-profit nursing home.

(8) "Physician" means a person licensed to practice medicine in this state.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2203.003. IMMUNITY. Liability does not exist on the part of, and a cause of action does not arise against, the association, an association agent or employee, an insurer, an agent licensed under this code, the commissioner or department, or an authorized representative of the commissioner or department for a statement made in good faith by any of them:

(1) in a report or communication concerning risks insured or to be insured through the association; or

(2) at an administrative hearing conducted in connection with the report or communication.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2203.004. APPLICABILITY OF OTHER LAW. The association is subject to Sections 401.051, 401.052, 401.054-401.062, 401.151, 401.152, 401.155, and 401.156 and Subchapter A, Chapter 86.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2203.005. RELATIONSHIP TO SURPLUS LINES INSURANCE. The association is not an authorized insurer for purposes of Chapter 981 with respect to medical liability insurance for physicians.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER B. ASSOCIATION ADMINISTRATION AND OPERATION

Sec. 2203.051. PURPOSE OF ASSOCIATION. The association provides medical liability insurance on a self-supporting basis.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2203.052. BOARD OF DIRECTORS. (a) The association is governed by a board of directors composed of the following nine members:

(1) five representatives of insurers that are required to be association members, elected by association members;

(2) one physician, appointed by the Texas Medical Association or a successor to that association;

(3) one representative of hospitals, appointed by the Texas Hospital Association or a successor to that association; and

(4) two public members, appointed by the commissioner.

(b) The board members serve one-year terms beginning on October 1 of each year.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2203.053. PLAN OF OPERATION. (a) The association operates under a plan of operation adopted by the commissioner.

(b) The plan of operation must:

(1) provide for economic, fair, and nondiscriminatory administration;

(2) provide for the prompt and efficient provision of medical liability insurance; and

(3) contain other provisions, including provisions relating

to:

- (A) the establishment of necessary facilities;
- (B) the association's management;
- (C) the assessment of members and policyholders to defray losses and expenses;
- (D) the administration of the policyholder's stabilization reserve funds;
- (E) commission arrangements;
- (F) reasonable and objective underwriting standards;
- (G) the acceptance, assumption, and cession of reinsurance;
- (H) the appointment of servicing insurers; and
- (I) procedures for determining amounts of insurance to be provided by the association.

(c) The plan of operation must direct that any revenue exceeding expenditures that remains in the association's funds at the close of the association's fiscal year, after the association reimburses members' contributions in accordance with Section 2203.255(a), be added to the association's reserves.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2203.054. AMENDMENTS TO PLAN OF OPERATION. Amendments to the plan of operation:

- (1) shall be made at the commissioner's direction; or
- (2) may be made by the board of directors, subject to the commissioner's approval.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2203.055. JOINT UNDERWRITING ASSOCIATION MEMBERSHIP. (a) The association is composed of each insurer, including a Lloyd's plan and a reciprocal or interinsurance exchange, authorized to write and writing liability insurance, including automobile liability insurance, on a direct basis in this state, other than:

- (1) a farm mutual insurance company authorized under Chapter 911; and

(2) a county mutual insurance company authorized under Chapter 912.

(b) An insurer that is a member of the association must remain a member as a condition of the insurer's authority to engage in the business of the insurance described by Subsection (a).

(c) Each association member participates in the writings, expenses, and losses of the association in the proportion that the net direct premiums of the member, excluding the portion of premiums attributable to the operation of the association, written during the preceding calendar year bears to the aggregate net direct premiums written in this state by all association members.

(d) The association shall annually determine a member's participation in the association on the basis of the net direct premiums written by the member during the preceding calendar year, as reported in the annual statements and other reports the member files as required by the department.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2203.056. ANNUAL STATEMENT; ADDITIONAL INFORMATION. (a) Not later than March 1 of each year, the association shall file with the department a statement that contains information regarding the association's transactions, condition, operations, and affairs during the preceding calendar year.

(b) The statement must:

(1) contain the matters and information required by the department; and

(2) be in the form approved by the department.

(c) The department at any time may require the association to provide additional information regarding the association's transactions or condition, or any related matter considered to be:

(1) material; and

(2) of assistance in evaluating the scope, operation, and experience of the association.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER C. ELIGIBILITY FOR COVERAGE

Sec. 2203.101. GENERAL ELIGIBILITY. (a) The commissioner shall by order establish the categories of physicians and health care providers that are eligible to obtain insurance coverage from the association. The commissioner may revise the order to:

(1) include as eligible for that coverage other categories of physicians and health care providers; or

(2) exclude from eligibility for that coverage particular categories of physicians and health care providers.

(b) If a category of physicians or health care providers is excluded from eligibility to obtain insurance coverage from the association, the commissioner may determine, after notice of at least 10 days and a hearing, that medical liability insurance is not otherwise available. On that determination, the previously excluded category is eligible to obtain insurance coverage from the association.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2203.102. INSURER OF LAST RESORT FOR CERTAIN NURSING HOMES AND ASSISTED LIVING FACILITIES. (a) A nursing home or assisted living facility not otherwise eligible for insurance coverage from the association under Section 2203.101 is eligible for that coverage if the home or facility demonstrates, in accordance with the requirements of the association, that the home or facility:

(1) made a verifiable effort to obtain insurance coverage from authorized insurers and eligible surplus lines insurers; and

(2) was unable to obtain substantially equivalent insurance coverage and rates.

(b) In consultation with the Department of Aging and Disability Services, the commissioner by rule shall adopt minimum rating standards for for-profit nursing homes and for-profit assisted living facilities that must be met before a for-profit nursing home or for-profit assisted living facility may obtain insurance coverage through the association. The standards must promote the highest practical level of care for residents of the nursing homes and assisted living facilities.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April

1, 2007.

Sec. 2203.1021. VOLUNTEER HEALTH CARE PROVIDERS. (a) In this section:

(1) "Charitable organization" has the meaning assigned by Section 84.003, Civil Practice and Remedies Code.

(2) "Volunteer health care provider" has the meaning assigned by Section 84.003, Civil Practice and Remedies Code.

(b) The association shall make available medical liability insurance or appropriate health care liability insurance covering a volunteer health care provider for the legal liability of the person against any loss, damage, or expense incident to a claim arising out of the death or injury of any person as the result of negligence in rendering or the failure to render professional service while acting in the course and scope of the person's duties as a volunteer health care provider as described by Chapter 84, Civil Practice and Remedies Code.

(c) A volunteer health care provider who is serving as a direct service volunteer of a charitable organization is eligible to obtain from the association the liability insurance made available under this section. A volunteer health care provider who obtains coverage under this section is subject to Section 2203.302 and the other provisions of this chapter in the same manner as physicians who are eligible to obtain medical liability insurance from the association.

(d) This section does not affect the liability of a volunteer health care provider who is serving as a direct service volunteer of a charitable organization. Section 84.004(c), Civil Practice and Remedies Code, applies to the volunteer health care provider without regard to whether the volunteer health care provider obtains liability insurance under this section.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 3B.060(a), eff. September 1, 2007.

Added by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. [3167](#)), Sec. 9.060(a), eff. September 1, 2007.

Sec. 2203.103. ELIGIBILITY OF OTHER HEALTH CARE PRACTITIONERS AND FACILITIES. (a) In this section:

(1) "Health care" includes a medical or health care service, including an examination, treatment, medical diagnosis, or evaluation, and care provided in an inpatient, outpatient, or residential setting.

(2) "Health care facility" means a facility providing health care, other than a facility described by Section 2203.002(4).

(3) "Health care practitioner" means an individual, other than an individual described by Section 2203.002(4), who:

(A) is licensed to provide health care; or

(B) is not licensed to provide health care but provides health care under the direction or supervision of a licensed individual.

(b) After notice and opportunity for hearing, the commissioner may:

(1) determine that appropriate liability insurance coverage written by insurers authorized to engage in business in this state is not reasonably available to a type of health care practitioner or health care facility; and

(2) by order designate that type of health care practitioner or health care facility to be included as a health care provider eligible to receive coverage under this chapter.

(c) A health care practitioner or facility designated under Subsection (b) is entitled to receive insurance coverage under this chapter in accordance with Chapter 1901 in the same manner as other health care providers described by Section 2203.002 and Section 1901.001.

(d) The commissioner's order may indicate whether a health care practitioner or facility designated under Subsection (b) is included under the policyholder's stabilization reserve fund established under Section 2203.301 or 2203.303 or whether a separate policyholder's stabilization reserve fund is created. A separate policyholder's stabilization reserve fund established under this subsection operates in the same manner as a policyholder's stabilization reserve fund created under Section 2203.303.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2203.104. APPLICATION FOR COVERAGE. (a) A health care

provider or physician included in a category eligible for insurance coverage by the association is entitled to apply to the association for the coverage. An agent authorized under Chapter 4051 may apply on behalf of an applicant.

(b) The association shall issue a medical liability insurance policy to an applicant:

(1) if the association determines that:

(A) the applicant meets the underwriting standards of the association prescribed by the plan of operation; and

(B) there is no unpaid and uncontested premium, policyholder's stabilization reserve fund charge, or assessment due from the applicant for prior insurance, as shown by the insured's failure to pay or to object in writing to the charges on or before the 30th day after the date of the billing; and

(2) on receipt of the premium and the policyholder's stabilization reserve fund charge, or the portion of the premium and charge prescribed by the plan of operation.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER D. ASSOCIATION COVERAGE

Sec. 2203.151. POWERS RELATING TO MEDICAL LIABILITY INSURANCE COVERAGE. (a) Under this chapter and the plan of operation, the association, on behalf of the association members, may:

(1) issue, or cause to be issued, medical liability insurance policies to applicants, including primary, excess, and incidental coverages, subject to the limits specified in the plan of operation and Section 2203.152;

(2) underwrite medical liability insurance and adjust and pay losses related to that insurance, or appoint servicing insurers to perform those functions;

(3) either or both accept and refuse the assumption of reinsurance from association members; and

(4) cede and purchase reinsurance.

(b) The association may provide general liability insurance coverage to be issued in connection with medical liability insurance issued by the association.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April

1, 2007.

Sec. 2203.152. POLICY LIMITS. The association may not issue one or more policies insuring an individual or organization for an amount exceeding \$1 million for each occurrence and \$3 million in the aggregate for a year.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2203.153. FOLLOWING FORM EXCESS LIABILITY COVERAGE. Excess liability insurance coverage written for a physician or health care provider by the association under this chapter must be written as following form excess liability insurance to the physician's or provider's primary insurance coverage.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2203.154. PUNITIVE DAMAGES EXCLUDED. The association may not issue or renew a medical liability insurance policy for a physician or health care provider under this chapter that includes coverage for punitive damages assessed against the physician or health care provider.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2203.155. INSTALLMENT PLAN. The association may offer an installment payment plan for insurance coverage obtained through the association.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2203.156. TERM OF POLICY; NOTICE OF CERTAIN CHANGES. (a)

A policy issued by the association must be for a term of one year or less, as determined by the association.

(b) Section 1901.253 does not apply to a medical liability insurance policy issued by the association for a term of less than one year.

(c) The association shall ensure that appropriate written notice is provided to the insured for a policy described by Subsection (b) if the association intends to:

- (1) increase the premiums on the policy; or
- (2) cancel or not renew the policy for a reason other than for nonpayment of premiums or because the insured is no longer licensed.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER E. RATES AND POLICY FORMS

Sec. 2203.201. APPLICABILITY OF OTHER LAW TO RATES AND POLICY FORMS. (a) Except as provided by Subsection (b) and subject to Section 2203.203, the following laws govern the rates, rating plans, rating rules, rating classifications, territories, and policy forms applicable to the insurance written by the association and related statistics:

- (1) Section 36.002(1);
- (2) Subchapter B, Chapter 5;
- (3) Subchapters A and C, Chapter 1806;
- (4) Subchapter A, Chapter 2301;
- (5) Chapter 251, as that chapter relates to casualty insurance and fidelity, guaranty, and surety bond insurance;
- (6) Chapter 253;
- (7) Chapters 2251 and 2252; and
- (8) Subtitle B.

(b) If a provision of a law described by Subsections (a)(1)-(8) conflicts with a provision of this chapter, this chapter prevails.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2203.202. RATE STANDARDS. (a) In determining rates,

rating plans, rating rules, rating classifications, territories, and policy forms, the association shall consider:

- (1) the past and prospective loss and expense experience for medical professional liability insurance, inside and outside this state, of all of the association members;
 - (2) trends in the frequency and severity of losses;
 - (3) the association's investment income; and
 - (4) other information the commissioner may require.
- (b) Rates, rating plans, and rating rules must be based on:
- (1) the association's loss and expense experience; and
 - (2) other information based on that experience the department considers appropriate.
- (c) The resultant premium rates must be:
- (1) actuarially sound; and
 - (2) computed to be self-supporting.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2203.203. DISCOUNT FOR CERTAIN HEALTH CARE PROVIDERS. (a) The rates applicable to professional liability insurance coverage provided by the association for not-for-profit nursing homes and not-for-profit assisted living facilities must reflect a discount of 30 percent from the rates for the same coverage provided to others in the same category of insureds.

- (b) The commissioner shall ensure compliance with this section.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER F. FINANCIAL PARTICIPATION BY MEMBERS AND POLICYHOLDERS

Sec. 2203.251. DEFICIT RECOUPMENT. (a) This section applies to a deficit sustained in a single year by the association with respect to:

- (1) physicians and health care providers, other than nursing homes and assisted living facilities; or
- (2) a nursing home or assisted living facility.

(b) The deficit must be recouped in accordance with the plan of operation and the rating plan in effect when the deficit is sustained

under one or more of the following procedures, in this sequence:

(1) a contribution from the policyholder's stabilization reserve fund established under Section 2203.301 or the policyholder's stabilization reserve fund established under Section 2203.303, as appropriate, until the respective fund is exhausted;

(2) an assessment on the policyholders in accordance with Section 2203.252; or

(3) an assessment on the members in accordance with Sections 2203.055(c) and (d) and 2203.253.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2203.252. ASSESSMENT OF POLICYHOLDERS FOR DEFICIT RECOUPMENT. (a) Each policyholder within the group of physicians and health care providers, other than nursing homes and assisted living facilities, or within the group of nursing homes and assisted living facilities, has contingent liability for a proportionate share of an assessment made under this chapter of policyholders in the applicable group.

(b) If a deficit, as computed under the plan of operation, is sustained with respect to a group described by Subsection (a) in a single year, the board of directors shall levy an assessment only on the policyholders in the applicable group who held policies in force at any time during the two most recently completed calendar years:

(1) before the date the assessment is levied; and

(2) in which the association was issuing policies.

(c) The aggregate amount of an assessment under Subsection (b) must be equal to the amount of the deficit not recouped under Section 2203.251(b)(1) from the applicable policyholder's stabilization reserve fund. Subject to Subsection (d), each policyholder in the applicable group shall be assessed for a portion of the deficit that reflects the proportion that the earned premium on the policies of that policyholder bears to the total earned premium for all policies of the association in the applicable group in the two most recently completed calendar years.

(d) The maximum aggregate assessment on each policyholder in the applicable group may not exceed the annual premium for the liability insurance policy most recently in effect.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2203.253. LIMITATION ON REIMBURSEMENT BY MEMBER FOR DEFICIT RECOUPMENT. (a) An association member is not obligated in a single year to reimburse the association for the member's proportionate share of the deficits from the association's operations in that year in an amount that exceeds one percent of the member's policyholder surplus. The aggregate amount not reimbursed in accordance with this subsection shall be reallocated among the other association members. The association shall reallocate that amount in accordance with the method of determining a member's participation under Sections 2203.055(c) and (d), after excluding the total net direct premiums of all members not sharing in the excess deficits.

(b) If the deficits from the association's operations allocated to all association members in a calendar year exceed one percent of all members' respective policyholder surplus, the association shall allocate to each member the amount of the deficits in accordance with the method of determining a member's participation under Sections 2203.055(c) and (d).

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2203.254. CONTRIBUTION BY MEMBERS FOR SOUND FINANCIAL OPERATION. If sufficient funds are not available for the sound financial operation of the association, each association member shall contribute to the financial requirements of the association in accordance with Sections 2203.055(c) and (d), 2203.252, and 2203.253, as authorized and considered necessary by the department. A contribution under this section is in addition to:

(1) an assessment paid in accordance with the plan of operation under Section 2203.053(b); and

(2) a contribution from a policyholder's stabilization reserve fund.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2203.255. REIMBURSEMENT OF ASSESSMENT OR CONTRIBUTION; PREMIUM TAX CREDIT. (a) Subject to commissioner approval, the association shall reimburse an assessment or contribution, with interest at a rate approved by the commissioner, to:

(1) the association members; or

(2) the state, to the extent that the members have recouped their assessments using premium tax credits as provided by Subsection (c).

(b) Pending recoupment or reimbursement of an assessment or contribution paid by a member to the association, the unrepaid balance of the assessment or contribution may be reflected in the member's books and records as an admitted asset of the member for all purposes, including exhibition in an annual statement under Section 862.001.

(c) To the extent a member has paid one or more assessments and has not received reimbursement from the association in accordance with Subsection (a), a credit against premium taxes under Chapter 221 is allowed at a rate of 20 percent a year for five successive years following the year in which the deficit was sustained. At the member's option, the tax credit may be taken over an additional number of years.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2203.256. STANDARDS FOR RECOUPMENT PROVISIONS. A provision for recoupment must be based on:

(1) the association's loss and expense experience; and

(2) other information based on that experience the department considers appropriate.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER G. POLICYHOLDER'S STABILIZATION RESERVE FUNDS

Sec. 2203.301. POLICYHOLDER'S STABILIZATION RESERVE FUND FOR PHYSICIANS AND CERTAIN HEALTH CARE PROVIDERS. (a) The policyholder's stabilization reserve fund for physicians and health care providers other than nursing homes and assisted living

facilities is collected and administered by the association as provided by this section, Section 2203.302, and the plan of operation.

(b) The policyholder's stabilization reserve fund shall be:

(1) credited with all policyholder's stabilization reserve fund charges collected under Section 2203.302;

(2) charged with any deficit sustained by physicians and health care providers, other than nursing homes and assisted living facilities, from the association's operation during the previous year;

(3) treated as a liability of the association along with, and in the same manner as, premium and loss reserves; and

(4) valued annually by the board of directors as of the close of the preceding year.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2203.302. POLICYHOLDER'S STABILIZATION RESERVE FUND CHARGE FOR PHYSICIANS AND CERTAIN HEALTH CARE PROVIDERS. (a) Each policyholder other than a nursing home or assisted living facility shall pay annually into the policyholder's stabilization reserve fund under Section 2203.301 a charge that:

(1) is in an amount established annually by advisory directors chosen by physicians and health care providers, other than nursing homes and assisted living facilities, eligible for insurance through the association in accordance with the plan of operation;

(2) is in proportion to each premium payment due for liability insurance through the association; and

(3) is separately stated in the policy.

(b) A charge stated in a policy as required by Subsection (a)(3) is not:

(1) a part of premiums; or

(2) subject to premium taxation or a servicing fee, acquisition cost, or any other similar charge.

(c) If the association offers an installment payment plan for coverage obtained through the association, the association may:

(1) permit payment of the policyholder's stabilization reserve fund charge under this section on an installment basis; or

(2) require the policyholder to pay the charge as an annual lump sum.

(d) Collections of the policyholder's stabilization reserve fund charge under this section shall continue until the net balance of the policyholder's stabilization reserve fund under Section 2203.301 is not less than the projected sum of premiums for physicians and health care providers, other than nursing homes and assisted living facilities, to be written in the year following the valuation date.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2203.303. POLICYHOLDER'S STABILIZATION RESERVE FUND FOR NURSING HOMES AND ASSISTED LIVING FACILITIES. (a) The policyholder's stabilization reserve fund for nursing homes and assisted living facilities is collected and administered by the association as provided by this section, Section 2203.304, and the plan of operation.

(b) The policyholder's stabilization reserve fund shall be:

(1) credited with:

(A) all policyholder's stabilization reserve fund charges collected under Section 2203.304; and

(B) the net earnings on liability insurance policies issued to nursing homes and assisted living facilities;

(2) charged with any deficit sustained by nursing homes and assisted living facilities from the association's operation during the previous year;

(3) treated as a liability of the association along with, and in the same manner as, premium and loss reserves; and

(4) valued annually by the board of directors as of the close of the preceding year.

(c) The policyholder's stabilization reserve fund under this section, and any earnings of the fund, are state funds and shall be held by the comptroller outside the state treasury on behalf of, and with legal title in, the department. No part of the fund or the earnings of the fund may inure to the benefit of an association member, a policyholder, or another individual. The fund assets may be used in accordance with the association's plan of operation only

to implement this chapter and for the purposes of the association, including to make payment to satisfy, wholly or partly, the liability of the association regarding a claim made on a policy written by the association.

(d) Notwithstanding Sections 11, 12, and 13, Article 21.49-3, the policyholder's stabilization reserve fund under this section may be terminated only by law.

(e) Notwithstanding Section 11, Article 21.49-3, on termination of the policyholder's stabilization reserve fund under this section, all assets of the fund shall be transferred to the general revenue fund to be appropriated for purposes related to ensuring the provision of the kinds of liability insurance coverage that the association may provide under this chapter to nursing homes and assisted living facilities.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2203.304. POLICYHOLDER'S STABILIZATION RESERVE FUND CHARGE FOR NURSING HOMES AND ASSISTED LIVING FACILITIES. (a) Each policyholder that is a nursing home or assisted living facility shall pay annually into the policyholder's stabilization reserve fund under Section 2203.303 a charge that:

(1) is in an amount established annually by advisory directors chosen by nursing homes and assisted living facilities eligible for insurance through the association in accordance with the plan of operation;

(2) is in proportion to each premium payment due for liability insurance through the association; and

(3) is separately stated in the policy.

(b) A charge stated in a policy as required by Subsection (a)(3) is not:

(1) a part of premiums; or

(2) subject to premium taxation or a servicing fee, acquisition cost, or any other similar charge.

(c) If the association offers an installment payment plan for coverage obtained through the association, the association may:

(1) permit payment of the policyholder's stabilization reserve fund charge under this section on an installment basis; or

(2) require the policyholder to pay the charge as an annual lump sum.

(d) Collections of the policyholder's stabilization reserve fund charge under this section shall continue only until the net balance of the policyholder's stabilization reserve fund under Section 2203.303 is not less than the projected sum of premiums for nursing homes and assisted living facilities to be written in the year following the valuation date.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2203.305. SEPARATE FUNDS. The policyholder's stabilization reserve fund for physicians and health care providers other than nursing homes and assisted living facilities described by Section 2203.301 is separate from the policyholder's stabilization reserve fund for nursing homes and assisted living facilities described by Section 2203.303.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER H. REVENUE BOND PROGRAM

Sec. 2203.351. PURPOSE. The legislature finds that the issuance of bonds to provide a method to raise funds to provide professional liability insurance for nursing homes and assisted living facilities in this state through the association is to benefit the public and to further a public purpose.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2203.352. DEFINITIONS. In this subchapter:

(1) "Board" means the board of directors of the Texas Public Finance Authority.

(2) "Bond resolution" means the resolution or order authorizing bonds to be issued under this subchapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2203.353. APPLICABILITY OF OTHER LAWS. The following laws apply to bonds issued under this subchapter to the extent consistent with this subchapter:

- (1) Chapters 1201, 1202, 1204, 1205, 1231, 1232, and 1371, Government Code; and
- (2) Subchapter A, Chapter 1206, Government Code.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2203.354. ISSUANCE OF BONDS AUTHORIZED. On behalf of the association and subject to Section 2203.355, the Texas Public Finance Authority shall issue revenue bonds to:

- (1) fund the policyholder's stabilization reserve fund for nursing homes and assisted living facilities under Section 2203.303;
- (2) pay costs related to issuing the bonds; and
- (3) pay other costs related to the bonds as determined by the board.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2203.355. LIMITATION ON AMOUNT OF BONDS. The Texas Public Finance Authority may issue on behalf of the association bonds in a total amount not to exceed \$75 million.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2203.356. TERMS OF ISSUANCE. (a) Bonds issued under this subchapter may be issued at a public or private sale.

(b) Bonds must:

- (1) be issued in the name of the association; and
- (2) mature not more than 10 years after the date issued.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2203.357. CONTENTS OF BOND RESOLUTION; ADMINISTRATION OF ACCOUNTS. (a) In a bond resolution, the board may:

(1) provide for the flow of funds and the establishment, maintenance, and investment of funds and special accounts with regard to the bonds, including an interest and sinking fund account, a reserve account, and other accounts; and

(2) make additional covenants with regard to the bonds and the designated income and receipts of the association pledged to the payment of the bonds.

(b) The association shall administer the accounts in accordance with this chapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2203.358. SOURCE OF PAYMENT. (a) Bonds issued under this subchapter are payable only from:

(1) the surcharge fee established under Section 2203.359;

or

(2) other sources the association is authorized to levy and charge and from which the association is authorized to collect in connection with paying any portion of the bonds.

(b) The bonds are obligations solely of the association and do not create a pledge, gift, or loan of the faith, credit, or taxing authority of this state.

(c) Each bond must:

(1) include a statement that the state is not obligated to pay any amount on the bond and that the faith, credit, and taxing authority of this state are not pledged, given, or loaned to those payments; and

(2) state on the bond's face that the bond:

(A) is payable solely from the revenue pledged for that purpose; and

(B) is not a legal or moral obligation of the state.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April

1, 2007.

Sec. 2203.359. SURCHARGE FEE. (a) A surcharge fee is assessed against:

- (1) each association member; and
- (2) the association.

(b) The commissioner shall set the surcharge fee in an amount sufficient to pay all debt service on the bonds issued under this subchapter. Each association member and the association shall pay the surcharge fee as required by the commissioner by rule.

(c) The comptroller shall collect the surcharge fee and the department shall reimburse the comptroller in the manner described by Section 201.052.

(d) The commissioner, in consultation with the comptroller, may coordinate payment and collection of the surcharge fee with other payments made by association members and collected by the comptroller.

(e) Except as provided by Subsection (f), as a condition of engaging in the business of insurance in this state, an association member agrees that, if the member leaves the liability insurance market in this state, the member remains obligated to pay the member's share of the surcharge fee assessed under this section until the bonds are retired. The amount assessed against a member under this subsection must be:

- (1) proportionate to the member's share of the liability insurance market, including automobile liability insurance, in this state as of the last complete reporting period before the date the member ceases to engage in the liability insurance business in this state; and

- (2) based on the member's gross premiums for liability insurance, including automobile liability insurance, for the member's last reporting period.

(f) An association member is not required to pay the proportionate amount under Subsection (e) in any year in which the surcharge fee assessed against association members continuing to write liability insurance in this state is sufficient to service the bond obligation.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. [2017](#)), Sec. 2, eff. April

1, 2007.

Sec. 2203.360. EXEMPTION FROM TAXATION. Bonds issued under this subchapter, any interest from the bonds, and all assets pledged to secure the payment of the bonds are exempt from taxation by the state or a political subdivision of this state.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2203.361. AUTHORIZED INVESTMENTS. Bonds issued under this subchapter are authorized investments under Subchapter B, Chapter 424, and Subchapter D, Chapter 425.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2203.362. STATE PLEDGE REGARDING BOND OWNER RIGHTS AND REMEDIES. (a) The state pledges to and agrees with the owners of bonds issued in accordance with this subchapter that the state will not limit or alter the rights vested in the association to fulfill the terms of agreements made with the owners or impair the rights and remedies of the owners until the following obligations are fully discharged:

- (1) the bonds;
- (2) any bond premium;
- (3) interest; and
- (4) all costs and expenses related to an action or proceeding by or on behalf of the owners.

(b) The association may include the state's pledge and agreement under Subsection (a) in an agreement with the owners of the bonds.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2203.363. PAYMENT ENFORCEABLE BY MANDAMUS. A writ of

mandamus and any other legal or equitable remedy are available to a party in interest to require the association or another party to fulfill an agreement or perform a function or duty under:

- (1) this subchapter;
- (2) the Texas Constitution; or
- (3) a bond resolution.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER I. APPEALS

Sec. 2203.401. DEFINITION. In this subchapter, "act" includes a ruling or decision.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2203.402. APPEAL TO BOARD OF DIRECTORS; HEARING. (a) A person insured or applying for insurance under this chapter, the person's authorized representative, or an affected insurer that may be aggrieved by an act of the association may appeal to the board of directors not later than the 30th day after the date the act occurs. At the time the person is notified of the act, the association shall provide to the person written notice of the person's right to appeal under this subsection.

(b) The board of directors shall:

(1) hear an appeal brought under Subsection (a) not later than the 30th day after the date the board of directors receives the appeal; and

(2) give not less than 10 days' written notice of the time and place of the hearing to the person bringing the appeal or the person's authorized representative.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2203.403. DECISION OF BOARD OF DIRECTORS. (a) Not later than the 10th day after the date of the hearing under Section

2203.402(b), the board of directors shall affirm, reverse, or modify the board's previous action or the appealed act.

(b) At the time the person is notified of the final action of the board of directors, the association shall provide to the person written notice of the person's right to appeal under Section 2203.404.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2203.404. APPEAL TO COMMISSIONER; HEARING. (a) Not later than the 30th day after the date of the final action of the board of directors under Section 2203.403, a person insured or applying for insurance aggrieved by that final action may appeal to the commissioner by making a written request for a hearing.

(b) The appeal shall be heard not later than the 30th day after the date the appeal is received. The person bringing the appeal or the person's authorized representative must be given written notice of the time and place of the hearing on or before the 10th day before the date of the hearing.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2203.405. COMMISSIONER'S DECISION. (a) Not later than the 30th day after the date of the hearing under Section 2203.404, the commissioner shall affirm, reverse, or modify the appealed act.

(b) Pending the hearing and decision, the commissioner may suspend or postpone the effective date of a rule or of the act appealed.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2203.406. APPEAL OF COMMISSIONER'S DECISION. (a) The association or a person aggrieved by an order or decision of the commissioner may appeal in accordance with Subchapter D, Chapter 36.

(b) At the time the person is notified of the commissioner's

order or decision, the commissioner shall provide to the person written notice of the person's right to appeal under this section.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

CHAPTER 2204. TEXAS INSURANCE EXCHANGE
SUBCHAPTER A. GENERAL PROVISIONS

Sec. 2204.001. DEFINITIONS. In this chapter:

- (1) "Directors" means the board of directors of the exchange.
- (2) "Exchange" means the Texas Insurance Exchange.
- (3) "Member" means a person, firm, corporation, or underwriting syndicate authorized by the directors to insure or reinsure risks through the exchange.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2204.002. EXEMPTION. (a) This chapter, Chapters 251 and 261, and rules adopted by the commissioner or comptroller, as applicable, apply to the exchange, a member, and insurance and reinsurance written through the exchange, except to the extent exempted by rules adopted by the commissioner or comptroller, as applicable.

(b) An exemption may not be:

- (1) unfairly discriminatory; or
- (2) detrimental to the solvency of an insurer authorized to engage in the business of insurance in this state.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2204.003. RULES. The commissioner shall adopt rules for the operation and management of the exchange.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER B. OPERATION AND MANAGEMENT

Sec. 2204.051. PURPOSE OF EXCHANGE; SPECIFIC AUTHORIZATION FOR CERTAIN INSURANCE. (a) The exchange shall provide a facility for underwriting:

- (1) reinsurance of any kind of insurance;
- (2) direct insurance of any kind of risk located entirely outside the United States;
- (3) direct insurance of any kind of risk that:
 - (A) is located in another state; and
 - (B) qualifies for placement under the excess and surplus lines requirements of the jurisdiction in which the risk is located; and
- (4) a risk located in this state that has been submitted to and certified as rejected by a committee representing at least three and not more than seven insurers authorized to engage in the business of insurance in this state and subject to conditions imposed by rules adopted by the commissioner.

(b) For purposes of Chapter 101, insurance or reinsurance a member writes to cover a risk described by Subsection (a)(4) is considered to be specifically authorized by the laws of this state.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2204.052. OPERATION OF EXCHANGE. The exchange shall operate under:

- (1) a constitution and bylaws adopted by the exchange and approved by the department; and
- (2) rules adopted by the commissioner under Section 2204.003.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2204.053. CONSTITUTION AND BYLAWS. (a) In this section:

- (1) "Principal office" means an office at which officers and personnel who are engaged in administration, underwriting, claims

adjustment, policyholders' service, marketing, accounting, recordkeeping, and support services are located.

(2) "Subscriber" means a person, firm, corporation, or other organization that, on payment of fees or dues required by the constitution and bylaws, the directors designate as a subscriber.

(b) The constitution and bylaws of the exchange must provide for:

(1) the election of nine directors, four of whom represent the public interest and are not members, subscribers, or agents of the exchange;

(2) the locations of the principal offices of the exchange and the members in this state for transacting business described by Section 2204.051(a);

(3) the submission by the exchange, members, and applicants for membership in the exchange of financial information required by rules adopted by the commissioner;

(4) the establishment and maintenance by the exchange of a security fund in a form and amount specified by rules adopted by the commissioner;

(5) the voting power of members; and

(6) members' rights and duties, including the manner of conducting business, financial stability, dues, membership fees, mandatory arbitration, and any other matter necessary or appropriate to conduct business authorized by this chapter.

(c) For an agent transacting business on the exchange to participate in the operation and management of the exchange, the constitution and bylaws of the exchange must provide for the voting power and other rights granted to a nonprofit corporation under the Business Organizations Code.

(d) In a manner that complies with the requirements adopted under this section, the exchange may, with the department's approval, amend the exchange's constitution or bylaws in accordance with the terms of the constitution and bylaws.

(e) The constitution, a bylaw, or an amendment to the constitution or a bylaw is invalid without the department's approval.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2204.054. DIRECTORS. (a) The directors shall operate and manage the exchange in accordance with rules adopted under Section 2204.003.

(b) The directors shall be elected by the members and any other person authorized by the exchange's constitution and bylaws to vote in an election of directors.

(c) At least two-thirds of the directors must be citizens of the United States.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER C. FINANCES

Sec. 2204.101. TAXES. (a) Except as provided by this section and Chapters 251 and 261, the exchange is not subject to state or local taxes that are measured by income, premiums, or gross receipts.

(b) A direct premium written, procured, or received by a member through the exchange on a risk located in this state is:

(1) considered written, procured, or received by the exchange; and

(2) subject to the premium taxes imposed under Subtitle B, Title 3.

(c) Premium taxes shall be reported, paid, and administered as provided by Subtitle B, Title 3.

(d) The exchange and the members are considered insurers for purposes of:

(1) Sections 201.052, 201.053, and 201.054;

(2) Chapters 4, 202, 203, 221, 222, 224, 227, 228, 251, 257, and 1109; and

(3) Section 171.0525, Tax Code.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2H.007, eff. April 1, 2009.

Sec. 2204.102. INVESTMENTS IN MEMBER OR AGENT. (a) The commissioner by rule may establish limitations on investments in a

member.

(b) An investment, directly or indirectly, in a member by an agent transacting business on the exchange or in an agent transacting business on the exchange by a member is limited in the aggregate to:

(1) less than 20 percent of the total investment in the member or agent; or

(2) a lesser amount provided by a rule adopted by the commissioner.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2204.103. COVERAGE BY GUARANTY FUNDS. (a) The performance of a contractual obligation of the exchange or a member entered into under this chapter is not covered by an insurance guaranty fund provided by the laws of this state.

(b) This section does not apply to the security fund established under Section 2204.053(b)(4).

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

**CHAPTER 2205. TEXAS CHILD-CARE FACILITY LIABILITY POOL
SUBCHAPTER A. GENERAL PROVISIONS**

Sec. 2205.001. DEFINITIONS. In this chapter:

(1) "Board" means the board of trustees of the pool.

(2) "Child-care facility" has the meaning assigned by Section 42.002, Human Resources Code.

(3) "Fund" means the Texas child-care facility liability fund.

(4) "Pool" means the Texas Child-Care Facility Liability Pool.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2205.002. POOL NOT ENGAGED IN BUSINESS OF INSURANCE. (a) Except as provided by this section and Section 2205.003(b), the pool

is not engaged in the business of insurance under this code or other state law, and this code and other state insurance laws do not apply to the pool.

(b) The pool is subject to:

(1) this chapter;

(2) the requirements of this code or commissioner rules relating to reporting liability claims information; and

(3) the requirements of Chapter 2251 and Article 5.13-2 relating to making, filing, and approving rates.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2205.003. DEPARTMENT AND COMMISSIONER SUPERVISION. (a)

The pool is subject to the department's continuing supervision relating to the pool's solvency.

(b) The commissioner may set minimum requirements to ensure the capability of the pool to satisfy the pool's obligations.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER B. CREATION OF POOL

Sec. 2205.051. CREATION OF POOL. (a) The Texas Child-Care Facility Liability Pool is created when the governing bodies of 10 or more child-care facilities agree in writing to participate in the pool.

(b) The pool provides liability insurance coverage for child-care facilities as provided by this chapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2205.052. PARTICIPATION IN POOL. A child-care facility is entitled to coverage from the pool if the facility:

(1) submits a complete application;

(2) provides other information required by the pool;

(3) meets the underwriting standards established by the

pool; and

- (4) pays the premiums required for the coverage.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2205.053. SELECTION OF TEMPORARY BOARD. At the time the governing bodies of the child-care facilities enter into the written agreement under Section 2205.051, the governing bodies shall select nine individuals to:

- (1) serve as the temporary board; and
- (2) draft the plan of operation for the pool.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER C. PLAN OF OPERATION

Sec. 2205.101. TIME FOR CREATION OF PLAN OF OPERATION. (a) Not later than the 30th day after the date the last member of the temporary board is selected, the temporary board shall meet to prepare a plan of operation for the pool.

(b) The temporary board shall complete and adopt the plan of operation not later than the 90th day after the date the last member of the temporary board is selected.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2205.102. CONTENTS OF PLAN OF OPERATION. (a) Subject to the requirements of this chapter, the plan of operation must include:

- (1) the organizational structure of the pool, including:
 - (A) the method of selecting the board;
 - (B) the board's methods of procedure and operation; and
 - (C) a summary of the methods for managing and operating the pool;

(2) a description of the contributions and other financial arrangements necessary to cover the initial expenses of the pool and estimates, supported by statistical information, of the amounts of

those contributions or other financial arrangements;

- (3) underwriting standards and procedures for evaluating risks;
- (4) a requirement that each participant in the pool receive continuing training in the methods of controlling liability losses;
- (5) procedures for purchasing reinsurance;
- (6) procedures and guidelines for:
 - (A) establishing premium rates for and maximum limits of excess liability coverage available from the pool;
 - (B) negotiating and paying settlements, defending claims, and paying judgments; and
 - (C) managing and investing the fund;
- (7) procedures for:
 - (A) processing and paying claims; and
 - (B) defraying losses or expenses of the pool;
- (8) guidelines for nonrenewal of coverage;
- (9) the minimum capital and surplus to be maintained by the pool; and
- (10) the minimum standards for reserve requirements for the pool.

(b) The plan of operation may include any matter relating to the organization and operation of the pool or to the pool's finances.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2205.103. APPROVAL OF PLAN OF OPERATION. (a) On completion of the plan of operation, the temporary board shall submit the plan to the department for examination, suggested changes, and final approval.

(b) The department shall approve the plan of operation on the determination that the pool is able and will continue to be able to pay valid claims made against the pool.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER D. BOARD OF TRUSTEES

Sec. 2205.151. GOVERNANCE OF POOL. (a) The pool is governed

by a board of trustees composed of nine members selected as provided by the plan of operation.

(b) Not later than the 15th day after the date the department approves the plan of operation, the initial regular board must be selected as provided by the plan of operation. The members of the initial regular board shall take office not later than the 30th day after the date the plan of operation is adopted.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2205.152. TERMS; VACANCY. (a) Board members serve two-year terms. The terms expire as provided by the plan of operation.

(b) A vacancy on the board shall be filled as provided by the plan of operation.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2205.153. PERFORMANCE BOND REQUIRED. (a) Each board member shall execute a bond in the amount required by the plan of operation. The bond must be payable to the pool and conditioned on the faithful performance of the member's duties.

(b) The pool shall pay the cost of the bond executed under this section.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2205.154. COMPENSATION. A board member is not entitled to compensation for the member's service on the board.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2205.155. OFFICERS; MEETINGS. (a) The board shall elect from the board's membership a presiding officer and other officers as

provided by the plan of operation.

(b) Each officer serves a one-year term that expires as provided by the plan of operation.

(c) The board shall meet at the call of the presiding officer and at times established by the board's rules.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2205.156. GENERAL POWERS AND DUTIES OF BOARD. (a) The board shall:

(1) approve contracts, other than liability insurance contracts issued by the pool to child-care facilities; and

(2) adopt premium rate schedules and policy forms for the pool.

(b) The board may:

(1) adopt rules as necessary for the operation of the pool;

(2) delegate specific responsibilities to the pool manager;

and

(3) with the department's approval, amend the plan of operation as necessary to ensure the orderly management and operation of the pool.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2205.157. IMMUNITY OF BOARD MEMBERS FROM CERTAIN LIABILITIES. A board member is not liable:

(1) with respect to a claim or judgment for which coverage is provided by the pool; or

(2) for a claim or judgment against a child-care facility covered by the pool.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER E. OPERATION OF POOL

Sec. 2205.201. GENERAL POWERS AND DUTIES OF POOL. (a) The

pool shall:

- (1) issue primary and excess liability coverage to each child-care facility entitled to coverage under this chapter;
- (2) collect premiums for coverage issued or renewed by the pool;
- (3) process and pay valid claims;
- (4) maintain detailed information regarding the pool; and
- (5) establish a plan to conduct loss control training or contract with an outside entity to establish continuing training and inspections programs designed to reduce the potential liability losses of pool participants.

(b) The pool may:

- (1) enter into contracts;
- (2) purchase reinsurance;
- (3) cancel or refuse to renew coverage; and
- (4) perform any other act necessary to implement this chapter, the plan of operation, or a rule adopted by the board.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2205.202. POOL MANAGER; PERFORMANCE BOND REQUIRED. (a) The board shall appoint a pool manager who serves at the pleasure of the board, and the board shall supervise the pool manager's activities.

(b) The pool manager shall execute a bond in the amount determined by the board. The bond must be payable to the pool and conditioned on the faithful performance of the pool manager's duties.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2205.203. GENERAL POWERS AND DUTIES OF POOL MANAGER. (a) The pool manager shall direct the general operation of the pool and perform other duties as directed by the board.

(b) The pool manager shall:

- (1) receive and approve applications for liability coverage from the pool;
- (2) negotiate contracts for the pool; and

(3) prepare proposed policy forms for board approval.

(c) The pool manager may refuse to renew the coverage of a child-care facility insured by the pool that fails to meet the guidelines included in the plan of operation.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2205.204. PERSONNEL. (a) The pool manager may employ or contract with persons as necessary to assist the board and the pool manager in implementing the powers and duties of the pool.

(b) The board must approve:

- (1) the compensation paid to a pool employee; and
- (2) a contract made with a person under this section.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2205.205. PERFORMANCE BOND AUTHORIZED. The board may require an employee or a person with whom the pool manager contracts under Section 2205.204 to execute a bond in an amount determined by the board. The bond must be payable to the board and conditioned on the faithful performance of the employee's or other person's duties to the pool.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2205.206. IMMUNITY OF EMPLOYEES AND CONTRACTORS FROM CERTAIN LIABILITIES. An employee or a person with whom the pool manager contracts under Section 2205.204 is not liable with respect to a claim or judgment against a child-care facility covered by the pool.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2205.207. OFFICE; RECORDS. (a) The pool shall maintain the pool's principal office in Austin, Texas.

(b) Records and other information relating to the operation of the pool must be maintained in the pool's principal office.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2205.208. ANNUAL AUDIT. The board shall require an annual audit of the pool's capital, surplus, and reserves. The audit must be conducted by an actuary who is a member of the American Academy of Actuaries or a similar national organization of actuaries recognized by the board.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER F. TEXAS CHILD-CARE FACILITY LIABILITY FUND

Sec. 2205.251. FUND CREATION; MANAGEMENT. (a) The Texas child-care facility liability fund is established on the creation of the pool.

(b) The fund is composed of:

- (1) premiums paid by child-care facilities for coverage provided by the pool;
- (2) contributions and other money received by the pool to cover the initial expenses of the fund;
- (3) investments of the fund and money earned from those investments; and
- (4) any other money received by the pool.

(c) The pool manager, under the general supervision of the board, shall manage and invest the money in the fund in the manner provided by the plan of operation.

(d) Money earned by the investment of money in the fund must be deposited in the fund or reinvested for the fund.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2205.252. CONTRIBUTIONS. The board shall determine the amount of contributions necessary to meet the initial expenses of the pool. The board shall make this determination based on the information provided by the plan of operation.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2205.253. USES OF FUND. (a) Administrative expenses of the pool may be paid from the fund. Payments for administrative expenses during a fiscal year may not exceed 10 percent of the total amount of the money in the fund during that fiscal year.

(b) Money in the fund may not be used to pay:

(1) punitive damages; or

(2) a fine or penalty imposed for a violation of:

(A) a statute;

(B) a rule of a state agency; or

(C) an ordinance or order of a local government.

(c) A claim or judgment may be paid from the fund under excess liability insurance coverage only if all benefits payable under any other underlying liability insurance policy covering that claim or judgment are exhausted.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2205.254. DEPOSITORY BANK. (a) The board may select one or more banks to serve as a depository for the fund.

(b) A depository bank must provide security before money in the fund may be deposited in the bank in an amount that exceeds the maximum amount secured by the Federal Deposit Insurance Corporation. The security must be in an amount sufficient to secure the excess amount of the deposit.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER G. POOL COVERAGE

Sec. 2205.301. SCOPE OF COVERAGE. (a) The pool shall insure a child-care facility and the facility's officers and employees against liability for acts and omissions under the laws of this state by the officers and employees in their official or employment capacities.

(b) The pool shall provide to a child-care facility that qualifies under this chapter and the plan of operation:

(1) primary liability insurance coverage in an amount not to exceed \$300,000; and

(2) excess liability insurance coverage in an amount that the board determines is actuarially sound.

(c) The pool may participate in evaluating, settling, and defending a claim against a child-care facility insured by the pool.

(d) The pool is liable in an amount not to exceed the limit of coverage provided to a child-care facility on a claim made against the facility.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2205.302. BASIS OF COVERAGE. The pool may provide liability insurance coverage on a claims-made basis or an occurrence basis.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2205.303. RATES AND LIMITS OF COVERAGE. (a) To ensure that the pool is actuarially sound, the board shall:

(1) set the premium rates charged; and

(2) determine the maximum limits of coverage provided.

(b) The pool manager, for the board's consideration, shall:

(1) collect and compile statistical information relating to the liability coverage provided by the pool, including relevant loss, expense, and premium information, and other necessary information;

(2) prepare the proposed premium rate schedules for the approval of the board; and

(3) prepare the maximum limits of coverage.

(c) The board shall periodically reexamine the rate schedules and the maximum limits of coverage.

(d) The pool manager shall make available to the public the information described by Subsection (b)(1).

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2205.304. COVERAGE PERIOD. A child-care facility that accepts coverage provided by the pool shall maintain that coverage for at least 24 consecutive months following the date the pool issued the coverage.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2205.305. NONRENEWAL OF COVERAGE. (a) Except as provided by Subsection (b), the pool may refuse to renew the coverage of a child-care facility that fails to comply with the pool's underwriting standards.

(b) The pool may not refuse to renew the coverage of a child-care facility during the first 24 months following the date the facility is first provided coverage by the pool if the facility maintains the underwriting standards established by the plan of operation.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2205.306. SUBSEQUENT COVERAGE. A child-care facility that voluntarily discontinues coverage provided by the pool is not eligible to subsequently obtain coverage from the pool for at least 12 months following the date the coverage is discontinued.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2205.307. PAYMENT OF CLAIMS AND JUDGMENTS. (a) If money in the fund would be exhausted by the payment of all final and

settled claims and final judgments during a fiscal year, the pool shall prorate the amount paid to each person having the claim or judgment.

(b) If the amount paid by the pool is prorated under this section, each person described by Subsection (a) shall receive an amount equal to the percentage that the amount owed to that person by the pool bears to the total amount owed, outstanding, and payable by the pool.

(c) The pool shall pay in the next fiscal year the remaining amount that is due and unpaid to a person who receives a prorated payment under this section.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

CHAPTER 2206. RISK MANAGEMENT POOLS FOR CERTAIN EDUCATIONAL ENTITIES
SUBCHAPTER A. GENERAL PROVISIONS

Sec. 2206.001. DEFINITIONS. In this chapter:

- (1) "Board" means the board of trustees of a pool.
- (2) "Fund" means a risk management fund.
- (3) "Junior college district" means a junior college district created under the laws of this state.
- (4) "Pool" means a risk management pool created under this chapter.
- (5) "School district" means a public school district created under the laws of this state.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2206.002. APPLICABILITY OF OTHER LAWS. (a) Except as provided by Subsection (b), a pool is not considered insurance under this code or other laws of this state, and the department does not have jurisdiction over the pool.

(b) The pool is subject to Chapter 541 and Section 543.001.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 42 (S.B. 784), Sec. 2.02, eff. September 1, 2015.

SUBCHAPTER B. SCHOOL DISTRICT RISK MANAGEMENT POOL

Sec. 2206.051. CREATION OF SCHOOL DISTRICT RISK MANAGEMENT POOL. (a) The boards of trustees of five or more school districts may create the school district risk management pool by adopting a resolution to create the pool.

(b) The school district risk management pool insures each school district that purchases coverage in the pool against liability under law for the district's acts and omissions.

(c) Not more than one school district risk management pool may be created under this subchapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2206.052. PARTICIPATION IN POOL. (a) A school district that meets the criteria established by the school district risk management pool in the pool's plan of operation may:

- (1) purchase coverage from the pool; and
- (2) use district money to pay the fees, contributions, or premiums required to participate in the pool and obtain the coverage.

(b) A junior college district may not participate in the school district risk management pool.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2206.053. ORGANIZATIONAL MEETING; SELECTION OF TEMPORARY BOARD. (a) On authorization to create the school district risk management pool as provided by Section 2206.051, the board of trustees of each school district adopting a resolution to create the pool shall select one representative to meet with representatives of the other school districts adopting the resolution.

(b) At the meeting, the representatives shall:

- (1) adopt guidelines for developing an organizational plan for the pool; and

(2) select nine individuals to serve as a temporary board for the pool.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER C. JUNIOR COLLEGE DISTRICT RISK MANAGEMENT POOL

Sec. 2206.101. CREATION OF JUNIOR COLLEGE DISTRICT RISK MANAGEMENT POOL. (a) The board of trustees of five or more junior college districts may create the junior college district risk management pool by adopting a resolution to create the pool.

(b) The junior college district risk management pool insures each junior college district that purchases coverage in the pool against liability under law for the district's acts and omissions.

(c) Not more than one junior college district risk management pool may be created under this subchapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2206.102. PARTICIPATION IN POOL. (a) A junior college district that meets the criteria established by the junior college district risk management pool in the pool's plan of operation may:

(1) purchase coverage from the pool; and

(2) use district money to pay the fees, contributions, or premiums required to participate in the pool and obtain the coverage.

(b) A school district may not participate in the junior college district risk management pool.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2206.103. ORGANIZATIONAL MEETING; SELECTION OF TEMPORARY BOARD. (a) On authorization to create the junior college district risk management pool as provided by Section 2206.101, the board of trustees of each junior college district adopting a resolution to create the pool shall select one representative to meet with representatives of the other junior college districts adopting the

resolution.

(b) At the meeting, the representatives shall:

- (1) adopt guidelines for developing an organizational plan for the pool; and
- (2) select nine individuals to serve as a temporary board for the pool.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER D. PLAN OF OPERATION

Sec. 2206.151. TIME FOR CREATION OF PLAN OF OPERATION. (a) Not later than the 30th day after the date the temporary board of a pool is selected, the temporary board shall meet and begin preparing a detailed plan of operation for the pool.

(b) The temporary board shall complete the plan of operation not later than the 90th day after the date the temporary board is selected.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2206.152. CONTENTS OF PLAN OF OPERATION. (a) Subject to the requirements of this chapter, a pool's plan of operation must include:

- (1) the organizational structure of the pool, including:
 - (A) the number of regular board members;
 - (B) the method of selecting the board members;
 - (C) the board's method of procedure and operation; and
 - (D) a summary of the method for managing and operating the pool;
- (2) a description of the fees, contributions, or financial arrangements necessary to cover the initial expenses of the pool and estimates, supported by statistical data, of the amounts of those fees, contributions, or other financial arrangements;
- (3) underwriting guidelines and procedures for evaluating risks;
- (4) procedures for purchasing reinsurance;
- (5) methods, procedures, and guidelines for establishing:

- (A) premium rates for pool coverage; and
- (B) pool coverage limits;
- (6) procedures for processing and paying claims;
- (7) methods and procedures for defraying losses and expenses of the pool;
- (8) methods, procedures, and guidelines for managing and investing the money in the fund created for the pool;
- (9) minimum capital and surplus to be maintained by the pool; and
- (10) minimum standards for reserve requirements for the pool.

(b) The plan of operation may include any matter relating to the organization and operation of the pool and the pool's finances.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER E. BOARD OF TRUSTEES

Sec. 2206.201. BOARD OF TRUSTEES. (a) A pool is governed by a board of trustees as provided by the plan of operation.

(b) Not later than the 15th day after the date the temporary board of a pool completes the plan of operation, the initial regular board must be selected and take office as provided by the plan.

(c) An individual serving on the board who is an officer or employee of a school district or junior college district covered by the pool performs duties on the board as additional duties required of the individual's original office or employment.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2206.202. GENERAL AUTHORITY OF BOARD; RULES. (a) A board is responsible for the general administration and operation of the pool and the pool's fund.

(b) The board may:

- (1) exercise powers and enter into contracts necessary to implement this chapter and the plan of operation; and
- (2) adopt rules to implement this chapter and the plan of operation.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2206.203. PERSONNEL; CONTRACTS FOR SERVICES. (a) A board may employ a fund manager and other persons necessary to implement this chapter and the plan of operation.

(b) The board may employ or contract with a person or insurer for underwriting, accounting, claims, and other services.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2206.204. PERFORMANCE BOND REQUIRED. (a) Each board member and each board employee who has authority over money in the fund or money collected or invested by the pool shall execute a bond in an amount determined by the board. The bond must be payable to the pool and conditioned on the faithful performance of the person's duties.

(b) The pool shall pay the cost of a bond executed under Subsection (a).

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2206.205. IMMUNITY FROM CERTAIN LIABILITIES. A board member or board employee is not liable:

(1) with respect to a claim or judgment for which coverage is provided by the pool; or

(2) for a claim or judgment made against a school district or junior college district covered by the pool.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER F. RISK MANAGEMENT FUND

Sec. 2206.251. FUND CREATION; MANAGEMENT. (a) Immediately after taking office, an initial regular board shall create a risk

management fund. The fund must include:

- (1) fees, contributions, and premiums collected by the pool;
- (2) investments of money in the fund;
- (3) interest earned on investments made by the pool; and
- (4) all other income received by the pool.

(b) The board shall manage and invest the money in the fund in the manner provided by the plan of operation.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2206.252. USES OF FUND. (a) The money in a pool's fund:

(1) shall be used to pay liability claims and judgments against school districts or junior college districts that participate in the pool, not to exceed the limits of the coverage provided by the pool; and

(2) may be used to pay the administrative and management costs of the pool and the fund, not to exceed the limits provided in the plan of operation.

(b) On the board's approval, a pool may pay commissions from the fund.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER G. PREMIUM RATES AND COVERAGE; REINSURANCE

Sec. 2206.301. PREMIUM RATES AND COVERAGE LIMITS. A pool's board shall determine the premium rates charged by the pool and pool coverage limits to ensure that the pool and the fund are actuarially sound.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2206.302. GUARANTEED ISSUANCE OF INITIAL COVERAGE; RISK MANAGEMENT. (a) Subject to Subsection (b), a school district or junior college district that applies for initial coverage through a

pool is entitled to that coverage for a period of not less than one year, regardless of loss history. The board may approve a longer period for the initial coverage.

(b) For a school district or junior college district to obtain initial coverage, the board may require that the district participate in a risk management appraisal and comply with the recommendations resulting from the appraisal.

(c) If complying with the recommended risk management techniques resulting from the appraisal does not reduce the school district's or junior college district's losses during the initial coverage period sufficiently to meet the pool's underwriting standards, the board may deny the district subsequent coverage through the pool.

(d) The pool may assess a surcharge to a school district or junior college district covered during the initial coverage period if the district does not meet the basic underwriting guidelines for the pool.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2206.303. REINSURANCE. A board may purchase reinsurance for a risk covered through the pool.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

CHAPTER 2207. EXCESS LIABILITY POOLS FOR COUNTIES AND CERTAIN EDUCATIONAL ENTITIES

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 2207.001. DEFINITIONS. In this chapter:

- (1) "Board" means the board of trustees of a pool.
- (2) "County" means a county in this state.
- (3) "Fund" means an excess liability fund.
- (4) "Junior college district" means a junior college district created under the laws of this state.
- (5) "Pool" means an excess liability pool created under this chapter.
- (6) "School district" means a public school district

created under the laws of this state.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2207.002. POOL NOT ENGAGED IN BUSINESS OF INSURANCE. (a) Except as provided by Subsection (b), a pool is not engaged in the business of insurance under this code or other laws of this state, and the department does not have jurisdiction over a pool.

(b) A pool is subject to Chapter 541 and Section 543.001.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 42 (S.B. 784), Sec. 2.03, eff. September 1, 2015.

SUBCHAPTER B. COUNTY EXCESS LIABILITY POOL

Sec. 2207.051. CREATION OF COUNTY EXCESS LIABILITY POOL. (a) The county judges of five or more counties may, on written agreement, create a county excess liability pool.

(b) The county excess liability pool provides excess liability insurance coverage as provided by this chapter and the pool's plan of operation.

(c) Not more than one county excess liability pool may be created under this subchapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2207.052. PARTICIPATION IN OTHER POOLS NOT PERMITTED. A county may participate only in a pool created for counties.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2207.053. SELECTION OF TEMPORARY BOARD. At the time a

written agreement is executed under Section 2207.051, the county judges of each county executing the agreement to create the pool shall select nine individuals to:

- (1) serve as a temporary board; and
- (2) draft the plan of operation for the pool.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER C. SCHOOL DISTRICT EXCESS LIABILITY POOL

Sec. 2207.101. CREATION OF SCHOOL DISTRICT EXCESS LIABILITY POOL. (a) Acting on behalf of their boards, the presidents of the boards of trustees of five or more school districts may, on written agreement, create a school district excess liability pool.

(b) The school district excess liability pool provides excess liability insurance coverage as provided by this chapter and the pool's plan of operation.

(c) Not more than one school district excess liability pool may be created under this subchapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2207.102. PARTICIPATION IN OTHER POOLS NOT PERMITTED. A school district may participate only in a pool created for school districts.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2207.103. SELECTION OF TEMPORARY BOARD. At the time a written agreement is executed under Section 2207.101, the presidents of the boards of trustees of each school district executing the agreement to create the pool shall select nine individuals to:

- (1) serve as a temporary board; and
- (2) draft the plan of operation for the pool.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April

1, 2007.

SUBCHAPTER D. JUNIOR COLLEGE DISTRICT EXCESS LIABILITY POOL

Sec. 2207.151. CREATION OF JUNIOR COLLEGE DISTRICT EXCESS LIABILITY POOL. (a) Acting on behalf of their boards, the presiding officers of the boards of trustees of five or more junior college districts may, on written agreement, create a junior college district excess liability pool.

(b) The junior college district excess liability pool provides excess liability insurance coverage as provided by this chapter and the pool's plan of operation.

(c) Not more than one junior college district excess liability pool may be created under this subchapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2207.152. PARTICIPATION IN OTHER POOLS NOT PERMITTED. A junior college district may participate only in a pool created for junior college districts.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2207.153. SELECTION OF TEMPORARY BOARD. At the time a written agreement is executed under Section 2207.151, the presiding officers of the boards of trustees of each junior college district executing the agreement to create the pool shall select nine individuals to:

- (1) serve as a temporary board; and
- (2) draft the plan of operation for the pool.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER E. PLAN OF OPERATION

Sec. 2207.201. TIME FOR CREATION OF PLAN OF OPERATION. (a)

Not later than the 30th day after the date the temporary board of a pool is selected, the temporary board shall meet to prepare a detailed plan of operation for the pool.

(b) The temporary board shall complete and adopt the plan of operation not later than the 90th day after the date the temporary board is selected.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2207.202. CONTENTS OF PLAN OF OPERATION. (a) Subject to the requirements of this chapter, a pool's plan of operation must include:

- (1) the organizational structure of the pool, including:
 - (A) the method of selecting the board;
 - (B) the board's method of procedure and operation; and
 - (C) a summary of the method for managing and operating the pool;
- (2) a description of the contributions and other financial arrangements necessary to cover the initial expenses of the pool and estimates, supported by statistical data, of the amounts of those contributions or other financial arrangements;
- (3) underwriting standards and procedures for evaluating risks;
- (4) procedures for purchasing reinsurance;
- (5) methods, procedures, and guidelines for:
 - (A) establishing the premium rates for and maximum limits of excess liability insurance coverage available from the pool; and
 - (B) managing and investing money in the fund created for the pool;
- (6) procedures for processing and paying claims;
- (7) methods and procedures for defraying losses and expenses of the pool;
- (8) guidelines for nonrenewal of coverage;
- (9) minimum capital and surplus to be maintained by the pool; and
- (10) minimum standards for reserve requirements for the pool.

(b) The plan of operation may include any matter relating to the organization and operation of the pool or to the pool's finances.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER F. BOARD OF TRUSTEES

Sec. 2207.251. BOARD OF TRUSTEES. (a) A pool is governed by a board of trustees composed of nine members selected as provided by the plan of operation.

(b) Not later than the 15th day after the date the temporary board of a pool adopts the plan of operation, the initial regular board must be selected as provided by the plan. The members of the initial regular board shall take office not later than the 30th day after the date the plan of operation is adopted.

(c) An individual serving on the board who is an officer or employee of a county, school district, or junior college district covered by the pool performs duties on the board as additional duties required of the individual's original office or employment.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2207.252. TERMS; VACANCY. (a) Board members serve two-year terms that expire at the time provided by the plan of operation.

(b) A vacancy on the board shall be filled as provided by the plan of operation.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2207.253. PERFORMANCE BOND REQUIRED. (a) Each board member shall execute a bond in the amount required by the plan of operation. The bond must be payable to the pool and conditioned on the faithful performance of the member's duties.

(b) The pool shall pay the cost of the bond executed under this section.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2207.254. COMPENSATION. A board member is not entitled to compensation for the member's service on the board.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2207.255. OFFICERS; MEETINGS. (a) The board shall select from the board members a presiding officer, an assistant presiding officer, and a secretary who serve one-year terms that expire as provided by the plan of operation.

(b) The board shall hold meetings at the call of the presiding officer and at times established by the board's rules.

(c) A majority of the board members constitutes a quorum.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2207.256. GENERAL POWERS AND DUTIES OF BOARD. (a) In addition to other duties provided by the plan of operation, the board shall:

(1) approve contracts other than excess liability insurance contracts issued by the pool to a county, school district, or junior college district, as applicable;

(2) adopt premium rate schedules and policy forms for the pool; and

(3) receive service of summons on behalf of the pool.

(b) The board may:

(1) adopt necessary rules, including rules to implement this chapter;

(2) delegate specific responsibilities to the pool manager; and

(3) amend the plan of operation to ensure the orderly management and operation of the pool.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April

1, 2007.

Sec. 2207.257. ANNUAL AUDIT; REPORT. (a) Each year as provided by the plan of operation, the board shall have an actuary audit the capital, surplus, and reserves of the pool and prepare a formal report for the pool and the members of the pool.

(b) The actuary must be a member of the American Academy of Actuaries.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2207.258. IMMUNITY OF BOARD MEMBERS FROM CERTAIN LIABILITIES. A board member is not liable:

(1) with respect to a claim or judgment for which coverage is provided by the pool; or

(2) for a claim or judgment against a county, school district, or junior college district covered by the applicable pool.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER G. OPERATION OF POOL

Sec. 2207.301. GENERAL POWERS AND DUTIES OF POOL. (a) A pool shall:

(1) issue excess liability insurance coverage to each county, school district, or junior college district entitled to coverage under this chapter;

(2) collect premiums for coverage issued or renewed by the pool;

(3) process and pay valid claims; and

(4) maintain detailed data regarding the pool.

(b) The pool may:

(1) enter into contracts;

(2) purchase reinsurance;

(3) cancel or refuse to renew coverage; and

(4) perform any other act necessary to implement this chapter, the plan of operation, or a rule adopted by the board.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2207.302. POOL MANAGER; PERFORMANCE BOND REQUIRED. (a) The board shall appoint a pool manager who serves at the pleasure of the board, and the board shall supervise the pool manager's activities.

(b) The pool manager is entitled to receive the compensation authorized by the board.

(c) The pool manager shall execute a bond in the amount determined by the board. The bond must be payable to the pool and conditioned on the faithful performance of the pool manager's duties.

(d) The pool shall pay the cost of the bond executed under this section.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2207.303. GENERAL POWERS AND DUTIES OF POOL MANAGER. (a) The pool manager shall manage and conduct the affairs of the pool under the general supervision of the board and shall perform any other duties as directed by the board.

(b) In addition to any other duties provided by the board, the pool manager shall:

(1) receive and pass on applications for excess liability insurance coverage from the pool;

(2) negotiate contracts for the pool; and

(3) prepare and submit to the board for approval proposed policy forms for coverage from the pool.

(c) The pool manager may refuse to renew the coverage of a county, school district, or junior college district insured by the pool based on the guidelines included in the plan of operation.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2207.304. PERSONNEL. (a) The pool manager shall employ or contract with persons necessary to assist the board and the pool

manager in implementing the powers and duties of the pool.

(b) The board must approve:

- (1) the compensation paid to a pool employee; and
- (2) a contract made with a person under this section.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2207.305. PERFORMANCE BOND AUTHORIZED. The board may require an employee or a person with whom the pool manager contracts under Section 2207.304 to execute a bond in an amount determined by the board. The bond must be payable to the board and conditioned on the faithful performance of the employee's or other person's duties to the pool.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2207.306. IMMUNITY OF EMPLOYEES AND CONTRACTORS FROM CERTAIN LIABILITIES. An employee or a person with whom the pool manager contracts under Section 2207.304 is not liable:

- (1) with respect to a claim or judgment for which coverage is provided by the pool; or
- (2) for a claim or judgment against a county, school district, or junior college district covered by the applicable pool.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2207.307. OFFICE; RECORDS. (a) A pool shall maintain the pool's principal office in Austin, Texas.

(b) Records, files, and other documents and information relating to the pool must be maintained in the pool's principal office.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER H. EXCESS LIABILITY FUND

Sec. 2207.351. FUND CREATION; MANAGEMENT. (a) On creation of a pool, the initial regular board shall create an excess liability fund.

(b) The fund is composed of:

(1) premiums paid by counties, school districts, or junior college districts, as applicable, for coverage provided by the pool;

(2) contributions and other money received by the pool to cover the initial expenses of the fund;

(3) investments of the fund and money earned from those investments; and

(4) any other money received by the pool.

(c) The pool manager shall manage the fund under the general supervision of the board. The fund manager, under the general supervision of the board, shall manage and invest the money in the fund in the manner provided by the plan of operation.

(d) Money earned by the investment of money in the fund must be deposited in the fund or reinvested for the fund.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2207.352. CONTRIBUTIONS. The board shall determine the amount of any contributions necessary to meet the initial expenses of the pool. The board shall make this determination based on the data provided by the plan of operation.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2207.353. USES OF FUND. (a) Administrative expenses of the pool may be paid from the fund. Payments for administrative expenses during a fiscal year of the pool may not exceed the amount established by the board.

(b) The pool may pay commissions from the fund on approval of the board.

(c) Money in the fund may not be used to pay:

(1) punitive damages; or

(2) a fine or penalty imposed for a violation of:

- (A) a statute;
- (B) an administrative rule or regulation; or
- (C) an order, rule, or ordinance.

(d) Money for a claim may not be paid from the fund under excess liability insurance coverage until all benefits payable under any other underlying liability insurance policy covering the claim or judgment are exhausted.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2207.354. DEPOSITORY BANK. (a) The board may select one or more banks to serve as a depository for money in the fund.

(b) A depository bank must execute a bond or provide other security before the pool manager may deposit fund money in the bank in an amount that exceeds the maximum amount secured by the Federal Deposit Insurance Corporation. The bond or other security must be in an amount sufficient to secure the excess amount of the deposit.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER I. POOL COVERAGE

Sec. 2207.401. ENTITLEMENT TO COVERAGE. A county, school district, or junior college district is entitled to coverage from the pool if the county, school district, or junior college district:

- (1) submits a complete application;
- (2) provides other information required by the pool;
- (3) meets the underwriting standards established by the pool; and
- (4) pays the premiums required for the coverage.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2207.402. SCOPE OF COVERAGE. (a) A pool shall insure a county, school district, or junior college district and the entity's officers and employees against liability for acts and omissions under

the laws governing that county, school district, or junior college district and the entity's officers and employees in their official or employment capacities.

(b) Except as provided by Subsection (c), under the excess liability insurance coverage, a pool shall pay any portion of a claim against a county, school district, or junior college district, as applicable, and the entity's officers and employees that:

(1) exceeds \$500,000; and

(2) is finally determined or settled or is included in a final judgment of a court.

(c) The amount paid by a pool under this section may not exceed the amount the board determines is actuarially sound for the pool.

(d) A pool may participate in evaluating, settling, or defending a claim made under the excess liability insurance coverage.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2207.403. BASIS OF COVERAGE. The pool may provide excess liability insurance coverage on a claims-made basis or an occurrence basis.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2207.404. RATES AND LIMITS OF COVERAGE. (a) To ensure that the pool is actuarially sound, the board shall:

(1) set the premium rates charged; and

(2) determine the maximum limits of coverage provided.

(b) The pool manager, for the board's consideration, shall:

(1) collect and compile statistical data relating to the excess liability insurance coverage provided by the pool, including relevant loss, expense, and premium data, and other information;

(2) prepare the proposed premium rate schedules for the approval of the board; and

(3) prepare the maximum limits of coverage.

(c) The board shall periodically reexamine the rate schedules and the maximum limits of coverage as conditions change.

(d) The pool manager shall make available to the public the

information described by Subsection (b)(1).

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2207.405. USE OF ENTITY MONEY FOR POOL COVERAGE AUTHORIZED. A county, school district, or junior college district may use its money to pay any contributions or premiums required by the applicable pool to purchase excess liability insurance coverage from the pool.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2207.406. COVERAGE PERIOD. A county, school district, or junior college district that accepts coverage provided by the applicable pool shall maintain that coverage for at least 36 calendar months following the month in which the pool issued the coverage.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2207.407. NONRENEWAL OF COVERAGE. (a) Except as provided by Subsection (b), the applicable pool may refuse to renew the coverage of a county, school district, or junior college district that fails to comply with the pool's underwriting standards.

(b) The applicable pool may not refuse to renew the coverage of a county, school district, or junior college district during the first 36 calendar months following the month in which the entity is first provided coverage by the pool.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2207.408. SUBSEQUENT COVERAGE. (a) A county, school district, or junior college district that voluntarily discontinues coverage provided by the applicable pool may not subsequently obtain

coverage from the pool for at least 36 calendar months following the month in which the entity discontinues the coverage.

(b) A county, school district, or junior college district whose coverage is not renewed under Section 2207.407 is not eligible to subsequently apply for coverage during the 12 calendar months following the month in which the applicable pool gives written notice of nonrenewal.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2207.409. PAYMENT OF CLAIMS AND JUDGMENTS. (a) If money in the fund would be exhausted by the payment of all final and settled claims and final judgments during a fiscal year, the pool shall prorate the amount paid to each person having the claim or judgment.

(b) If the amount paid by the pool is prorated under this section, each person described by Subsection (a) shall receive an amount equal to the percentage that the amount owed to that person by the pool bears to the total amount owed, outstanding, and payable by the pool.

(c) The pool shall pay in the next fiscal year the remaining amount that is due and unpaid to a person who receives a prorated payment under this section.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

CHAPTER 2208. TEXAS PUBLIC ENTITY EXCESS INSURANCE POOL
SUBCHAPTER A. GENERAL PROVISIONS

Sec. 2208.001. DEFINITIONS. In this chapter:

- (1) "Board" means the board of trustees of the pool.
- (2) "Fund" means the Texas public entity excess insurance fund.
- (3) "Insurance" means liability insurance or workers' compensation insurance.
- (4) "Pool" means the Texas public entity excess insurance pool.
- (5) "Public entity" means one or more municipalities that

have formed an insurance pool under Chapter 791, Government Code.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2208.002. POOL NOT ENGAGED IN BUSINESS OF INSURANCE. (a) Except as provided by Subsection (b), the pool is not engaged in the business of insurance under this code or other laws of this state, and the department has no jurisdiction over the pool.

(b) The pool is subject to Chapter 541.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 42 (S.B. 784), Sec. 2.04, eff. September 1, 2015.

SUBCHAPTER B. CREATION OF POOL

Sec. 2208.051. CREATION OF POOL. (a) The Texas Public Entity Excess Insurance Pool is created on the written agreement of the presiding officers of 25 or more public entities in this state.

(b) The pool provides excess liability and workers' compensation insurance coverage to a public entity and the entity's officers and employees as provided by this chapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2208.052. PARTICIPATION IN POOL. A public entity is entitled to coverage from the pool if the entity:

- (1) submits a complete application;
- (2) provides other relevant information required by the pool;
- (3) meets the underwriting guidelines established by the pool; and
- (4) pays the premiums required for the coverage.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April

1, 2007.

SUBCHAPTER C. BOARD OF TRUSTEES

Sec. 2208.101. ADMINISTRATION OF POOL; BOARD MEMBERSHIP. (a) A board of trustees shall administer the pool.

(b) The board is composed of the members of the governing board of an association that:

(1) on September 2, 1987, had been providing pooled self-insurance in this state for more than five years; and

(2) has as the association's members the public entities that entered into the written agreement under Section 2208.051.

(c) Board members shall represent members of the pool.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2208.102. COMPENSATION. A board member is not entitled to compensation for the member's service on the board.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2208.103. OFFICERS; MEETINGS. (a) Each individual who serves as an officer of the governing board of the association described by Section 2208.101(b) serves as an officer of the board.

(b) The board shall hold meetings at the call of the presiding officer and at times established by the board's rules.

(c) A majority of the board members constitutes a quorum.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2208.104. GENERAL POWERS AND DUTIES OF BOARD. (a) In addition to other duties provided by the plan of operation, the board shall:

(1) approve contracts other than excess insurance contracts issued to public entities by the pool;

- (2) adopt premium rate schedules and policy forms for the pool; and
- (3) receive service of summons on behalf of the pool.
- (b) The board may:
 - (1) adopt necessary rules, including rules to implement this chapter;
 - (2) delegate specific responsibilities to the pool manager; and
 - (3) amend the plan of operation to ensure the orderly management and operation of the pool.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2208.105. IMMUNITY OF BOARD MEMBERS FROM CERTAIN LIABILITIES. A board member is not liable:

- (1) with respect to a claim or judgment for which coverage is provided by the pool; or
- (2) for a claim or judgment against a public entity covered by the pool.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER D. PLAN OF OPERATION

Sec. 2208.151. TIME FOR CREATION OF PLAN OF OPERATION. Not later than the 30th day after the date the pool is created, the board shall meet to prepare a detailed plan of operation for the pool.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2208.152. CONTENTS OF PLAN OF OPERATION. (a) Subject to the requirements of this chapter, the plan of operation must include:

- (1) the organizational structure of the pool, the board's method of procedure and operation, and a summary of the method for managing and operating the pool;
- (2) a description of the financial arrangements necessary

to cover the initial expenses of the pool and estimates, supported by statistical data, of the amounts of those contributions or other financial arrangements;

(3) underwriting guidelines and procedures for evaluating risks;

(4) procedures for purchasing reinsurance;

(5) methods, procedures, and guidelines for:

(A) establishing premium rates for and maximum limits of excess coverage available from the pool; and

(B) managing and investing the fund;

(6) procedures for processing and paying claims;

(7) methods and procedures for defraying losses and expenses of the pool; and

(8) guidelines for nonrenewal of coverage.

(b) The plan of operation may include any matter relating to the organization and operation of the pool or to the pool's finances.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER E. OPERATION OF POOL

Sec. 2208.201. GENERAL POWERS AND DUTIES OF POOL. (a) The pool shall:

(1) issue insurance coverage to each public entity entitled to coverage under this chapter;

(2) collect premiums for coverage issued or renewed by the pool;

(3) process and pay valid claims; and

(4) maintain detailed data regarding the pool.

(b) The pool may:

(1) enter into contracts;

(2) purchase reinsurance;

(3) cancel or refuse to renew coverage; and

(4) perform any other act necessary to implement this chapter, the plan of operation, or a rule adopted by the board.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2208.202. POOL MANAGER. (a) The board shall appoint a pool manager who serves at the pleasure of the board, and the board shall supervise the pool manager's activities.

(b) The pool manager is entitled to receive compensation as authorized by the board.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2208.203. GENERAL POWERS AND DUTIES OF POOL MANAGER. (a) The pool manager shall manage and conduct the affairs of the pool under the general supervision of the board and shall perform any other duties as directed by the board.

(b) In addition to any other duties provided by the board, the pool manager shall:

(1) receive and pass on applications for insurance coverage from the pool;

(2) negotiate contracts for the pool; and

(3) prepare, and submit to the board for approval, proposed policy forms for coverage from the pool.

(c) The pool manager may refuse to renew the coverage of a public entity insured by the pool based on the guidelines included in the plan of operation.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2208.204. PERSONNEL. (a) The pool manager shall employ or contract with persons necessary to assist the board and the pool manager in implementing the powers and duties of the pool.

(b) The board must approve:

(1) the compensation paid to a pool employee; and

(2) a contract made with a person under this section.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2208.205. PERFORMANCE BOND AUTHORIZED. The board may

require an employee or a person with whom the pool manager contracts under Section 2208.204 to execute a bond in an amount determined by the board. The bond must be payable to the board and conditioned on the faithful performance of the employee's or other person's duties to the pool.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2208.206. IMMUNITY OF EMPLOYEES AND CONTRACTORS FROM CERTAIN LIABILITIES. An employee or a person with whom the pool manager contracts under Section 2208.204 is not liable:

- (1) with respect to a claim or judgment for which coverage is provided by the pool; or
- (2) for a claim or judgment against a public entity covered by the pool.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2208.207. OFFICE; RECORDS. (a) The pool shall maintain the pool's principal office in Austin, Texas.

(b) Records, files, and other documents and information relating to the pool must be maintained in the pool's principal office.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER F. TEXAS PUBLIC ENTITY EXCESS INSURANCE FUND

Sec. 2208.251. FUND CREATION; MANAGEMENT. (a) On creation of the pool, the board shall create the Texas public entity excess insurance fund.

(b) The fund is composed of:

- (1) premiums paid by public entities for coverage provided by the pool;
- (2) proceeds from bonds and other money received by the pool to cover the expenses of the fund;

(3) investments of the fund and money earned from those investments; and

(4) any other money received by the pool.

(c) The pool manager shall manage the fund under the general supervision of the board. The fund manager, under the general supervision of the board, shall manage and invest the money in the fund in the manner provided by the plan of operation.

(d) Money earned by the investment of money in the fund must be deposited in the fund or reinvested for the fund.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2208.252. USES OF FUND. (a) Administrative expenses of the pool may be paid from the fund.

(b) Money in the fund may not be used to pay:

(1) punitive damages;

(2) a fine or penalty imposed for a violation of:

(A) a statute;

(B) an administrative rule or regulation; or

(C) an order or ordinance of a public entity; or

(3) a claim under excess insurance coverage until all benefits payable under any other underlying policy or self-insurance covering the claim or judgment are exhausted.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2208.253. DEPOSITORY. (a) The board may select one or more banks to serve as depository for money in the fund.

(b) A depository bank must execute a bond or provide other security before the pool manager may deposit fund money in the bank in an amount that exceeds the maximum amount secured by the Federal Deposit Insurance Corporation. The bond or other security must be in an amount sufficient to secure the excess amount of the deposit.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER G. POOL COVERAGE

Sec. 2208.301. SCOPE OF COVERAGE. (a) Except as provided by Subsection (b), under the excess insurance coverage, the pool shall pay any portion of a claim against a public entity and the entity's officers and employees that:

- (1) exceeds \$1 million; and
- (2) is finally determined or settled or is included in a final judgment of a court.

(b) The amount paid by the pool under this section may not exceed the amount the board determines is actuarially sound for the pool.

(c) The pool may participate in evaluating or defending a claim made under the insurance coverage.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2208.302. BASIS OF COVERAGE. The pool may provide excess insurance coverage on a claims-made basis or an occurrence basis.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2208.303. PUNITIVE DAMAGES NOT COVERED. Excess insurance coverage provided by the pool may not include coverage for punitive damages.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2208.304. RATES AND LIMITS OF COVERAGE. (a) To ensure that the pool is actuarially sound, the board shall:

- (1) set the premium rates charged; and
- (2) determine the maximum limits of insurance coverage provided.

(b) The pool manager, for the board's consideration, shall:
(1) collect and compile statistical data relating to the insurance coverage provided by the pool, including relevant loss,

expense, and premium data and other information;

(2) prepare the proposed premium rate schedules for the approval of the board; and

(3) prepare the maximum limits of insurance coverage.

(c) The board shall periodically reexamine the rate schedules and the maximum limits of insurance coverage as conditions change.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2208.305. USE OF PUBLIC MONEY FOR POOL COVERAGE AUTHORIZED. A public entity may use the entity's money to pay any contributions or premiums required by the pool to purchase excess insurance coverage from the pool.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2208.306. COVERAGE PERIOD. A public entity that accepts coverage provided by the pool shall maintain that coverage for at least 35 calendar months following the month in which the pool issued the coverage.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2208.307. NONRENEWAL OF COVERAGE. The pool may refuse to renew the insurance coverage of a public entity that fails to comply with the pool's underwriting or risk management guidelines.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2208.308. SUBSEQUENT COVERAGE. (a) A public entity that voluntarily discontinues insurance coverage provided by the pool may not subsequently obtain coverage from the pool for at least 36 calendar months following the month in which the entity discontinues

the coverage.

(b) A public entity whose insurance coverage is not renewed by the pool is not eligible to subsequently apply for coverage during the 11 calendar months following the month in which the pool gives written notice of nonrenewal.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2208.309. PAYMENT OF CLAIMS AND JUDGMENTS. (a) If money in the fund would be exhausted by the payment of all final and settled claims and final judgments during a fiscal year, the pool shall prorate the amount paid to each person having the claim or judgment.

(b) If the amount paid by the pool is prorated under this section, each person described by Subsection (a) shall receive an amount equal to the percentage that the amount owed to that person by the pool bears to the total amount owed, outstanding, and payable by the pool.

(c) The public entity incurring the original liability shall pay the remaining amount that is due and unpaid to a person who receives a prorated payment under this section.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

CHAPTER 2209. TEXAS NONPROFIT ORGANIZATIONS LIABILITY POOL

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 2209.001. DEFINITIONS. In this chapter:

(1) "Board" means the board of trustees of the pool.

(2) "Fund" means the Texas nonprofit organizations liability fund.

(3) "Nonprofit organization" means an organization that is exempt from federal income taxation under Section 501(a), Internal Revenue Code of 1986, by being described as an exempt organization by Section 501(c)(3) or (4), Internal Revenue Code of 1986.

(4) "Pool" means the Texas Nonprofit Organizations Liability Pool.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2209.002. POOL NOT ENGAGED IN BUSINESS OF INSURANCE. (a) Except as provided by this section and Section 2209.003(b), the pool is not engaged in the business of insurance under this code or other laws of this state, and this code, including Chapter 462, and other insurance laws of this state do not apply to the pool.

(b) The pool is subject to:

(1) this chapter;

(2) the requirements of this code or the commissioner relating to reporting liability claims data; and

(3) the requirements of Chapter 2251 and Article 5.13-2 relating to making, filing, and approving rates.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2209.003. DEPARTMENT AND COMMISSIONER SUPERVISION. (a) The pool is subject to the department's continuing supervision relating to the pool's solvency.

(b) The commissioner may set certain minimum requirements to ensure the capability of the pool to satisfy the pool's obligations.

(c) The department shall charge the pool reasonable fees for services performed by the department under this chapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER B. CREATION OF POOL

Sec. 2209.051. CREATION OF POOL. (a) The Texas Nonprofit Organizations Liability Pool is created on the written agreement of the chief executive officers of 15 or more nonprofit organizations.

(b) The pool provides primary and excess liability insurance coverage as provided by this chapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2209.052. PARTICIPATION IN POOL. A nonprofit organization is entitled to coverage from the pool if the organization:

- (1) submits a complete application;
- (2) provides other information required by the pool;
- (3) meets the underwriting standards established by the pool; and
- (4) pays the premiums required for the coverage.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2209.053. SELECTION OF TEMPORARY BOARD. At the time the chief executive officers of the nonprofit organizations enter into the written agreement under Section 2209.051, the officers shall select nine individuals to:

- (1) serve as the temporary board; and
- (2) draft the plan of operation for the pool.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER C. PLAN OF OPERATION

Sec. 2209.101. TIME FOR CREATION OF PLAN OF OPERATION. (a) Not later than the 30th day after the date the temporary board is selected, the temporary board shall meet to prepare a detailed plan of operation for the pool.

(b) The temporary board shall complete and adopt the plan of operation not later than the 90th day after the date the temporary board is selected.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2209.102. CONTENTS OF PLAN OF OPERATION. (a) Subject to the requirements of this chapter, the plan of operation must include:

- (1) the organizational structure of the pool, including:

(A) the method of selecting the board;
 (B) the board's method of procedure and operation; and
 (C) a summary of the method for managing and operating the pool;

(2) a description of the contributions and other financial arrangements necessary to cover the initial expenses of the pool and estimates, supported by statistical data, of the amounts of those contributions or other financial arrangements;

(3) underwriting standards and procedures for evaluating risks, including a requirement that all participants in the pool receive ongoing training in the methods of controlling liability losses;

(4) procedures for purchasing reinsurance;

(5) methods, procedures, and guidelines for:

(A) establishing premium rates for and maximum limits of excess coverage available from the pool;

(B) negotiating and paying settlements, defending claims, and paying judgments; and

(C) managing and investing the fund;

(6) procedures for processing and paying claims;

(7) methods and procedures for defraying losses and expenses of the pool; and

(8) guidelines for nonrenewal of coverage.

(b) The plan of operation may include any matter relating to the organization and operation of the pool or to the pool's finances.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2209.103. APPROVAL OF PLAN. (a) On completion of the plan of operation, the temporary board shall submit the plan to the department for examination, suggested changes, and final approval.

(b) The department shall approve the plan of operation only if the department is satisfied that the pool is able and will continue to be able to pay valid claims made against the pool.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER D. BOARD OF TRUSTEES

Sec. 2209.151. GOVERNANCE OF POOL; BOARD MEMBERSHIP. (a) The pool is governed by a board of trustees composed of nine members selected as provided by the plan of operation.

(b) Not later than the 15th day after the date the department approves the plan of operation, the initial regular board must be selected as provided by the plan of operation. The members of the initial regular board shall take office not later than the 30th day after the date the plan of operation is adopted.

(c) Four board members must be representatives of the public. A public representative may not:

(1) be an officer, director, or employee of an insurer, insurance agency, agent, broker, solicitor, adjuster, or other business entity regulated by the department;

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

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

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2209.152. TERMS; VACANCY. (a) Board members serve staggered two-year terms. The terms of four members expire in odd-numbered years as provided by the plan of operation.

(b) A vacancy on the board shall be filled as provided by the plan of operation.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2209.153. PERFORMANCE BOND REQUIRED. (a) Each board member shall execute a bond in the amount required by the plan of operation. The bond must be payable to the pool and conditioned on the faithful performance of the member's duties.

(b) The pool shall pay the cost of the bond executed under this section.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April

1, 2007.

Sec. 2209.154. COMPENSATION. A board member is not entitled to compensation for the member's service on the board.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2209.155. OFFICERS; MEETINGS. (a) The board shall select from the board members a presiding officer, an assistant presiding officer, and a secretary, who serve one-year terms that expire as provided by the plan of operation.

(b) The board shall hold meetings at the call of the presiding officer and at times established by the board's rules.

(c) A majority of the board members constitutes a quorum.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2209.156. GENERAL POWERS AND DUTIES OF BOARD. (a) In addition to other duties provided by the plan of operation, the board shall:

(1) approve contracts other than insurance contracts issued by the pool to nonprofit organizations;

(2) adopt premium rate schedules and policy forms for the pool; and

(3) receive service of summons on behalf of the pool.

(b) The board may:

(1) adopt necessary rules, including rules to implement this chapter;

(2) delegate specific responsibilities to the pool manager; and

(3) with the department's approval, amend the plan of operation to ensure the orderly management and operation of the pool.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2209.157. IMMUNITY OF BOARD MEMBERS FROM CERTAIN LIABILITIES. A board member is not liable:

- (1) with respect to a claim or judgment for which coverage is provided by the pool; or
- (2) for a claim or judgment against a nonprofit organization covered by the pool.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER E. OPERATION OF POOL

Sec. 2209.201. GENERAL POWERS AND DUTIES OF POOL. (a) The pool shall:

- (1) issue primary and excess liability coverage to each nonprofit organization entitled to coverage under this chapter;
- (2) collect premiums for coverage issued or renewed by the pool;
- (3) process and pay valid claims;
- (4) maintain detailed data regarding the pool; and
- (5) establish a plan to conduct loss control training or contract with an outside organization or individual to establish ongoing training and facilities inspection programs designed to reduce the potential liability losses of pool participants.

(b) The pool may:

- (1) enter into contracts;
- (2) purchase reinsurance;
- (3) cancel or refuse to renew coverage; and
- (4) perform any other act necessary to carry out this chapter, the plan of operation, or a rule adopted by the board.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2209.202. POOL MANAGER; PERFORMANCE BOND REQUIRED. (a) The board shall appoint a pool manager who serves at the pleasure of the board, and the board shall supervise the pool manager's activities.

(b) The pool manager is entitled to receive compensation as authorized by the board.

(c) The pool manager shall execute a bond in the amount determined by the board. The bond must be payable to the pool and conditioned on the faithful performance of the pool manager's duties.

(d) The pool shall pay the cost of the bond executed under this section.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2209.203. GENERAL POWERS AND DUTIES OF POOL MANAGER. (a) The pool manager shall manage and conduct the affairs of the pool under the general supervision of the board and shall perform any other duties as directed by the board.

(b) In addition to any other duties provided by the board, the pool manager shall:

(1) receive and pass on applications for liability coverage from the pool;

(2) negotiate contracts for the pool; and

(3) prepare, and submit to the board for approval, proposed policy forms for coverage from the pool.

(c) The pool manager may refuse to renew the coverage of a nonprofit organization insured by the pool based on the guidelines included in the plan of operation.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2209.204. PERSONNEL. (a) The pool manager shall employ or contract with persons necessary to assist the board and the pool manager in carrying out the powers and duties of the pool.

(b) The board must approve:

(1) the compensation paid to a pool employee; and

(2) a contract made with a person under this section.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2209.205. PERFORMANCE BOND AUTHORIZED. The board may

require an employee or a person with whom the pool manager contracts under Section 2209.204 to execute a bond in an amount determined by the board. The bond must be payable to the board and conditioned on the faithful performance of the employee's or other person's duties to the pool.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2209.206. IMMUNITY OF EMPLOYEES AND CONTRACTORS FROM CERTAIN LIABILITIES. An employee or a person with whom the pool manager contracts under Section 2209.204 is not liable:

- (1) with respect to a claim or judgment for which coverage is provided by the pool; or
- (2) for a claim or judgment against a nonprofit organization covered by the pool.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2209.207. RECORDS. Records, files, and other documents and information relating to the pool must be maintained in the pool's principal office.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER F. TEXAS NONPROFIT ORGANIZATIONS LIABILITY FUND

Sec. 2209.251. FUND CREATION; MANAGEMENT. (a) On creation of the pool, the initial regular board shall create the Texas nonprofit organizations liability fund.

(b) The fund is composed of:

- (1) premiums paid by nonprofit organizations for coverage provided by the pool;
- (2) contributions and other money received by the pool to cover the initial expenses of the fund;
- (3) investments of the fund and money earned from those investments; and

(4) any other money received by the pool.

(c) The pool manager shall manage the fund under the general supervision of the board. The fund manager, under the general supervision of the board, shall manage and invest the money in the fund in the manner provided by the plan of operation.

(d) Money earned by the investment of money in the fund must be deposited in the fund or reinvested for the fund.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2209.252. CONTRIBUTIONS. The board shall determine the amount of any contributions necessary to meet the initial expenses of the pool. The board shall make this determination based on the data provided by the plan of operation.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2209.253. USES OF FUND. (a) Administrative expenses of the pool may be paid from the fund. Payments for administrative expenses during a fiscal year of the pool may not exceed 10 percent of the total amount of the money in the fund during that fiscal year.

(b) Money in the fund may not be used to pay:

(1) punitive damages; or

(2) a fine or penalty imposed for a violation of:

(A) a statute;

(B) an administrative rule of a state agency; or

(C) an ordinance or order of a local government.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2209.254. DEPOSITORY BANK. (a) The board may select one or more banks to serve as a depository for money in the fund.

(b) A depository bank must execute a bond or provide other security before the pool manager may deposit fund money in the bank in an amount that exceeds the maximum amount secured by the Federal

Deposit Insurance Corporation. The bond or other security must be in an amount sufficient to secure the excess amount of the deposit.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER G. POOL COVERAGE

Sec. 2209.301. SCOPE OF COVERAGE. (a) The pool shall insure a nonprofit organization and the organization's officers and employees against liability for acts and omissions under the laws of this state.

(b) The pool shall provide to a nonprofit organization that qualifies under this chapter and the plan of operation:

(1) primary liability insurance coverage in an amount not to exceed \$250,000; and

(2) excess liability insurance coverage in an amount that the board finds is actuarially sound.

(c) The pool may participate in evaluating, settling, and defending a claim against a nonprofit organization insured by the pool if the claim is covered by pool coverage.

(d) The pool is liable in an amount not to exceed the limit of coverage provided to a nonprofit organization on a claim made against the organization.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2209.302. COVERAGE ON CLAIMS-MADE BASIS. The pool may provide liability insurance coverage on a claims-made basis on forms approved by the department.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2209.303. PUNITIVE DAMAGES NOT COVERED. Liability insurance coverage provided by the pool may not include coverage for punitive damages.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2209.304. RATES AND LIMITS OF COVERAGE. (a) To ensure that the pool is actuarially sound, the board shall:

- (1) set the premium rates charged; and
- (2) determine the maximum limits of coverage provided.

(b) The pool manager, for the board's consideration, shall:

(1) collect and compile statistical data relating to the liability insurance coverage provided by the pool, including relevant loss, expense, and premium data, and other information;

(2) prepare the proposed premium rate schedules for the approval of the board; and

(3) prepare the maximum limits of coverage.

(c) The board shall periodically reexamine the rate schedules and the maximum limits of coverage as conditions change.

(d) The pool manager shall make available to the public the information described by Subsection (b)(1).

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2209.305. COVERAGE PERIOD. A nonprofit organization that accepts coverage provided by the pool shall maintain that coverage for at least 24 calendar months following the month in which the pool issued the coverage.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2209.306. NONRENEWAL OF COVERAGE. (a) Except as provided by Subsection (b), the pool may refuse to renew the coverage of a nonprofit organization that fails to comply with the pool's underwriting standards.

(b) The pool may not refuse to renew the coverage of a nonprofit organization during the first 24 calendar months following the month in which the nonprofit organization is first provided coverage by the pool if the organization maintains the underwriting

standards established by the plan of operation.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2209.307. SUBSEQUENT COVERAGE. (a) A nonprofit organization that voluntarily discontinues coverage provided by the pool may not subsequently obtain coverage from the pool for at least 12 calendar months following the month in which the organization discontinues the coverage.

(b) A nonprofit organization whose coverage is not renewed under Section 2209.306 is not eligible to subsequently apply for coverage during the 12 calendar months following the month in which the pool gives written notice of nonrenewal.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2209.308. PAYMENT OF CLAIMS AND JUDGMENTS. (a) If money in the fund would be exhausted by the payment of all final and settled claims and final judgments during a fiscal year, the pool shall prorate the amount paid to each person having the claim or judgment.

(b) If the amount paid by the pool is prorated under this section, each person described by Subsection (a) shall receive an amount equal to the percentage that the amount owed to that person by the pool bears to the total amount owed, outstanding, and payable by the pool.

(c) The pool shall pay in the next fiscal year the remaining amount that is due and unpaid to a person who receives a prorated payment under this section.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

CHAPTER 2210. TEXAS WINDSTORM INSURANCE ASSOCIATION

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 2210.001. PURPOSE. The primary purpose of the Texas

Windstorm Insurance Association is the provision of an adequate market for windstorm and hail insurance in the seacoast territory of this state. The legislature finds that the provision of adequate windstorm and hail insurance is necessary to the economic welfare of this state, and without that insurance, the orderly growth and development of this state would be severely impeded. This chapter provides a method by which adequate windstorm and hail insurance may be obtained in certain designated portions of the seacoast territory of this state. The association is intended to serve as a residual insurer of last resort for windstorm and hail insurance in the seacoast territory. The association shall:

- (1) function in such a manner as to not be a direct competitor in the private market; and
- (2) provide windstorm and hail insurance coverage to those who are unable to obtain that coverage in the private market.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. [2017](#)), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1408 (H.B. [4409](#)), Sec. 5, eff. June 19, 2009.

Sec. 2210.002. SHORT TITLE; SUNSET PROVISION. (a) This chapter may be cited as the Texas Windstorm Insurance Association Act.

(b) The association is subject to review under Chapter 325, Government Code (Texas Sunset Act), but is not abolished under that chapter. The association shall be reviewed during the period in which state agencies abolished in 2031 are reviewed. The association shall pay the costs incurred by the Sunset Advisory Commission in performing the review of the association under this subsection. The Sunset Advisory Commission shall determine the costs of the review performed under this subsection, and the association shall pay the amount of those costs promptly on receipt of a statement from the Sunset Advisory Commission regarding those costs. This subsection expires September 1, 2031.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. [2017](#)), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1408 (H.B. 4409), Sec. 6, eff. June 19, 2009.

Acts 2011, 82nd Leg., R.S., Ch. 1232 (S.B. 652), Sec. 1.04, eff. June 17, 2011.

Acts 2011, 82nd Leg., 1st C.S., Ch. 2 (H.B. 3), Sec. 3, eff. September 28, 2011.

Acts 2013, 83rd Leg., R.S., Ch. 1279 (H.B. 1675), Sec. 3.06, eff. June 14, 2013.

Acts 2019, 86th Leg., R.S., Ch. 525 (S.B. 615), Sec. 1, eff. September 1, 2019.

Sec. 2210.0025. BIENNIAL REPORT TO LEGISLATURE. On or before December 31 of each even-numbered year, the board of directors shall submit to the commissioner, the appropriate committees of each house of the legislature, and the Sunset Advisory Commission a written report relating to the operations of the association during the preceding biennium. The report must include:

(1) any proposed changes in the laws relating to regulation of the association and a statement of the reasons for the changes; and

(2) any information regarding association operations or procedures that is requested by the department to be addressed in the report.

Added by Acts 2009, 81st Leg., R.S., Ch. 1408 (H.B. 4409), Sec. 7, eff. June 19, 2009.

Sec. 2210.003. GENERAL DEFINITIONS. In this chapter, unless the context clearly indicates otherwise:

(1) "Administrator" means an entity contractually retained to manage the association and administer the plan of operation under Section 2210.062.

(1-a) "Association" means the Texas Windstorm Insurance Association.

(2) "Board of directors" means the board of directors of the association.

(3) "Catastrophe area" means a municipality, a part of a municipality, a county, or a part of a county designated by the

commissioner under Section 2210.005.

(3-a) "Catastrophe reserve trust fund" means the trust fund established under Subchapter J.

(3-b) "Catastrophe year" means a calendar year in which an occurrence or a series of occurrences results in insured losses, regardless of when the insured losses are ultimately paid.

(4) "First tier coastal county" means:

- (A) Aransas County;
- (B) Brazoria County;
- (C) Calhoun County;
- (D) Cameron County;
- (E) Chambers County;
- (F) Galveston County;
- (G) Jefferson County;
- (H) Kenedy County;
- (I) Kleberg County;
- (J) Matagorda County;
- (K) Nueces County;
- (L) Refugio County;
- (M) San Patricio County; or
- (N) Willacy County.

(5) Repealed by Acts 2009, 81st Leg., R.S., Ch. 1408, Sec. 44(1), eff. June 19, 2009.

(6) "Insurance" means Texas windstorm and hail insurance.

(7) "Net direct premium" means gross direct written premium less return premium on each canceled contract, regardless of assumed or ceded reinsurance, that is written on property in this state, as defined by the board of directors.

(8) "New building code" means a building standard, specification, or guideline adopted by the commissioner after May 1, 1997, that must be satisfied before new residential construction qualifies for a certificate of compliance that constitutes evidence of insurability of the structure by the association.

(9) "Plan of operation" means the plan adopted under this chapter for the operation of the association.

(10) "Seacoast territory" means the territory of this state composed of the first tier coastal counties and the second tier coastal counties.

(11) "Second tier coastal county" means:

- (A) Bee County;

- (B) Brooks County;
- (C) Fort Bend County;
- (D) Goliad County;
- (E) Hardin County;
- (F) Harris County;
- (G) Hidalgo County;
- (H) Jackson County;
- (I) Jim Wells County;
- (J) Liberty County;
- (K) Live Oak County;
- (L) Orange County;
- (M) Victoria County; or
- (N) Wharton County.

(12) Repealed by Acts 2009, 81st Leg., R.S., Ch. 1408, Sec. 44(1), eff. June 19, 2009.

(13) "Texas windstorm and hail insurance" means deductible insurance against:

- (A) direct loss to insurable property incurred as a result of windstorm or hail, as those terms are defined and limited in policies and forms approved by the department; and
- (B) indirect losses resulting from the direct loss.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1408 (H.B. 4409), Sec. 8, eff. June 19, 2009.

Acts 2009, 81st Leg., R.S., Ch. 1408 (H.B. 4409), Sec. 44(1), eff. June 19, 2009.

Acts 2011, 82nd Leg., 1st C.S., Ch. 2 (H.B. 3), Sec. 4, eff. September 28, 2011.

Acts 2015, 84th Leg., R.S., Ch. 615 (S.B. 900), Sec. 1, eff. September 1, 2015.

Sec. 2210.004. DEFINITION OF INSURABLE PROPERTY. (a) Except as provided by Subsection (h), for purposes of this chapter and subject to this section, "insurable property" means immovable property at a fixed location in a catastrophe area or corporeal movable property located in that immovable property, as designated in

the plan of operation, that is determined by the association according to the criteria specified in the plan of operation to be in an insurable condition against windstorm and hail, as determined by normal underwriting standards. The term includes property described by Section 2210.209.

(b) A structure located in a catastrophe area, construction of which began on or after the 30th day after the date of publication of the plan of operation, that is not built in compliance with building specifications set forth in the plan of operation or continued in compliance with those specifications, does not constitute an insurable risk for purposes of windstorm and hail insurance except as otherwise provided by this chapter.

(c) A structure, or an addition to a structure, that is constructed in conformity with plans and specifications that comply with the specifications set forth in the plan of operation at the time construction begins may not be declared ineligible for windstorm and hail insurance as a result of subsequent changes in the building specifications set forth in the plan of operation.

(d) Except as otherwise provided by this section, if repair of damage to a structure involves replacement of items covered in the building specifications set forth in the plan of operation, the repairs must be completed in a manner that complies with those specifications for the structure to continue to be insurable property for windstorm and hail insurance.

(e) If repair to a structure, other than a roof repair that exceeds 100 square feet, is less than five percent of the total amount of property coverage on the structure, the repairs may be completed in a manner that returns the structure to the structure's condition immediately before the loss without affecting the eligibility of the structure to qualify as insurable property.

(f) This chapter does not preclude special rating of individual risks as may be provided in the plan of operation.

(g) For purposes of this chapter, a residential structure is insurable property if:

(1) the residential structure is not:

(A) a condominium, apartment, duplex, or other multifamily residence; or

(B) a hotel or resort facility;

(2) the residential structure is located within an area designated as a unit under the Coastal Barrier Resources Act (Pub. L.

No. 97-348); and

(3) a building permit or plat for the residential structure was filed with the municipality, the county, or the United States Army Corps of Engineers before June 11, 2003.

(h) For purposes of this chapter, a structure is not insurable property if the commissioner of the General Land Office notifies the association of a determination that the structure is located on the public beach under procedures established under Section 61.011, Natural Resources Code, and that the structure:

(1) constitutes an imminent hazard to safety, health, or public welfare; or

(2) substantially interferes with the free and unrestricted right of the public to enter or leave the public beach or traverse any part of the public beach.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.061(a), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.061(a), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 1256 (H.B. 2819), Sec. 21, eff. September 1, 2007.

Acts 2009, 81st Leg., R.S., Ch. 1408 (H.B. 4409), Sec. 9, eff. June 19, 2009.

Sec. 2210.005. DESIGNATION AS CATASTROPHE AREA; REVOCATION OF DESIGNATION. (a) After at least 10 days' notice and a hearing, the commissioner may designate an area of the seacoast territory of this state as a catastrophe area if the commissioner determines, unless such a determination results in an adverse impact to the exposure of the association, that windstorm and hail insurance is not reasonably available to a substantial number of the owners of insurable property located in that territory because the territory is subject to unusually frequent and severe damage resulting from windstorms or hailstorms.

(b) The commissioner shall revoke a designation made under Subsection (a) if the commissioner determines, after at least 10

days' notice and a hearing, that the applicable insurance coverage is no longer reasonably unavailable to a substantial number of owners of insurable property within the designated territory.

(c) If the association determines that windstorm and hail insurance is no longer reasonably unavailable to a substantial number of owners of insurable property in a territory designated as a catastrophe area, the association may request in writing that the commissioner revoke the designation. After at least 10 days' notice and a hearing, but not later than the 30th day after the date of the hearing, the commissioner shall:

- (1) approve the request and revoke the designation; or
- (2) reject the request.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1408 (H.B. 4409), Sec. 10, eff. June 19, 2009.

Sec. 2210.006. APPLICABILITY OF CHAPTER TO CERTAIN INSURERS.

(a) Except as provided by Subsection (b), this chapter applies to each insurer authorized to engage in the business of property insurance in this state, including a county mutual insurance company, a Lloyd's plan, and a reciprocal or interinsurance exchange.

(b) This chapter does not apply to:

(1) a farm mutual insurance company operating under Chapter 911, unless the company is acting as a fronting insurer, as defined by Section 221.001(c);

(2) a nonaffiliated county mutual fire insurance company described by Section 912.310 that is writing exclusively industrial fire insurance policies as described by Section 912.310(a)(2); or

(3) a mutual insurance company or a statewide mutual assessment company engaged in business under Chapter 12 or 13, Title 78, Revised Statutes, respectively, before those chapters' repeal by Section 18, Chapter 40, Acts of the 41st Legislature, 1st Called Session, 1929, as amended by Section 1, Chapter 60, General Laws, Acts of the 41st Legislature, 2nd Called Session, 1929, that retains the rights and privileges under the repealed law to the extent provided by those sections.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.063(a), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.063(a), eff. September 1, 2007.

Acts 2017, 85th Leg., R.S., Ch. 1083 (H.B. 3496), Sec. 4, eff. September 1, 2017.

Sec. 2210.007. IMMUNITY FROM LIABILITY IN GENERAL. (a) This section applies to:

- (1) the association and a director, agent, or association staff;
 - (2) the commissioner, the department, and department staff;
- and
- (3) a participating insurer and the insurer's agents and staff.

(b) A person described by Subsection (a) is not liable, and a cause of action does not arise against the person, for:

- (1) an inspection made under the plan of operation; or
- (2) any statement made in good faith by the person:
 - (A) in a report or communication concerning risks submitted to the association; or
 - (B) at any administrative hearing conducted under this chapter in connection with the inspection or statement.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2210.008. DEPARTMENT ORDERS; GENERAL RULEMAKING AUTHORITY.

(a) The commissioner may issue any orders that the commissioner considers necessary to implement this chapter.

(b) The commissioner may adopt rules in the manner prescribed by Subchapter A, Chapter 36, as reasonable and necessary to implement this chapter.

(c) In rules adopted under this chapter, the commissioner shall define the meaning of "alter" and "alteration" for purposes of this

chapter, specifically as used in Subchapters E and F.

(d) The association may propose a rule for adoption by the commissioner. Except as provided by this section, the association's proposal is governed by Subchapter B, Chapter 2001, Government Code. The association is an interested person under that subchapter for purposes of a proceeding initiated under this section.

(e) Notwithstanding Section 2001.021(c), Government Code, not later than the 30th day after the date the commissioner receives a proposed rule from the association, the commissioner shall initiate a rulemaking proceeding under Subchapter B, Chapter 2001, Government Code.

(f) The association may request a public hearing under Section 2001.029, Government Code, in connection with a rule proposed under this section.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1408 (H.B. 4409), Sec. 11, eff. June 19, 2009.

Acts 2019, 86th Leg., R.S., Ch. 525 (S.B. 615), Sec. 2, eff. September 1, 2019.

Sec. 2210.0081. CERTAIN ACTIONS BROUGHT AGAINST ASSOCIATION BY COMMISSIONER. In an action brought by the commissioner against the association under Chapter 441:

(1) the association's inability to satisfy obligations under Subchapter M related to the issuance of public securities under this chapter constitutes a condition that makes the association's continuation in business hazardous to the public or to the association's policyholders for the purposes of Section 441.052;

(2) the time for the association to comply with the requirements of supervision or for the conservator to complete the conservator's duties, as applicable, is limited to three years from the date the commissioner commences the action against the association; and

(3) unless the commissioner takes further action against the association under Chapter 441, as a condition of release from supervision, the association must demonstrate to the satisfaction of

the commissioner that the association is able to satisfy obligations under Subchapter M related to the issuance of public securities under this chapter.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 2 (H.B. 3), Sec. 5, eff. September 28, 2011.

Sec. 2210.009. LIST OF PRIVATE INSURERS; INCENTIVE PLAN. (a) The department shall maintain a list of all insurers that engage in the business of property and casualty insurance in the voluntary market in the seacoast territory.

(b) The department shall develop incentive programs in the manner described by Section 2210.053(b) to encourage authorized insurers to write insurance on a voluntary basis and to minimize the use of the association as a means to obtain insurance.

Added by Acts 2009, 81st Leg., R.S., Ch. 1408 (H.B. 4409), Sec. 12, eff. June 19, 2009.

Sec. 2210.010. CERTAIN CONDUCT IN DISPUTE RESOLUTION PROHIBITED. (a) For purposes of this section, "presiding officer" includes a judge, mediator, arbitrator, appraiser, or panel member.

(b) If a person insured under this chapter is assigned to act as presiding officer to preside over or resolve a dispute involving the association and another person insured under this chapter, the presiding officer shall, not later than the seventh day after the date of assignment, give written notice to the association and to each other party to the dispute, or the association's or other party's attorney, that the presiding officer is insured under this chapter.

(c) In a proceeding with respect to which the commissioner has authority to designate the presiding officer, the association or other party that receives notice under Subsection (b) may file with the commissioner a written objection to the assignment of the presiding officer to the dispute. The written objection must contain the factual basis on which the association or other party objects to the assignment.

(d) The commissioner shall assign a different presiding officer to the dispute if, after reviewing the objection filed under

Subsection (c), the commissioner determines that the presiding officer originally assigned to the dispute has a direct financial or personal interest in the outcome of the dispute.

(e) The association or another party must file an objection under Subsection (c) not later than the earlier of:

(1) the seventh day after the date the association or other party receives actual notice that the presiding officer is insured under this chapter; or

(2) the seventh day before the date of the first proceeding concerning the dispute.

(f) The commissioner may, on a showing of good cause, extend the deadline to file an objection under Subsection (e).

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 2 (H.B. 3), Sec. 5, eff. September 28, 2011.

Sec. 2210.012. STANDARDS OF CONDUCT: BOARD OF DIRECTORS AND EMPLOYEES; REPORT OF CERTAIN FRAUDULENT CONDUCT. (a) A member of the board of directors or an employee of the association may not:

(1) accept or solicit any gift, favor, or service that might reasonably tend to influence the member or employee in the discharge of duties related to the operation or business of the association or that the member or employee knows or should know is being offered with the intent to influence the member's or employee's conduct related to the operation or business of the association;

(2) accept other employment or engage in a business or professional activity that the member or employee might reasonably expect would require or induce the member or employee to disclose confidential information acquired by reason of the member's or employee's position with the association;

(3) accept other employment or compensation that could reasonably be expected to impair the member's or employee's independence of judgment in the performance of the member's or employee's duties related to the operation or business of the association;

(4) make personal investments that could reasonably be expected to create a substantial conflict between the member's or employee's private interest and the interest of the association; or

(5) intentionally or knowingly solicit, accept, or agree to

accept any benefit for having exercised the member's or employee's powers related to the operation or business of the association or having performed, in favor of another, the member's or employee's duties related to the operation or business of the association.

(b) An association employee who violates Subsection (a) or a code of conduct established under Section 2210.107(a)(4) is subject to an employment-related sanction, including termination of the employee's employment with the association.

(c) A member of the board of directors or an association employee who violates Subsection (a) is subject to any applicable civil or criminal penalty if the violation also constitutes a violation of another statute or rule.

(d) A board member or employee of the association who reasonably suspects that a fraudulent insurance act has been or is about to be committed by any board member or employee of the association shall, not later than the 30th day after discovering the conduct, report the conduct and identity of the person engaging in the conduct to the department and may report the conduct and the identity of the person engaging in the conduct to another authorized governmental agency. The department shall forward a report received under this subsection to the authorized governmental agency in accordance with Chapter 701.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 2 (H.B. 3), Sec. 5, eff. September 28, 2011.

Sec. 2210.013. CERTAIN EMPLOYMENT AND CONTRACTS PROHIBITED. A member of the board of directors or an employee of the association may not appoint or employ, or contract with, the following individuals for the provision of goods or services in connection with the operation or business of the association, if the individual to be appointed or employed, or with whom a contract is to be entered into, is to be directly or indirectly compensated from funds of the association:

(1) an individual related to the member or employee within a degree of relationship described by Section 573.002, Government Code; or

(2) an individual related to any member of the board of directors or employee of the association within a degree of

relationship described by Section 573.002, Government Code.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 2 (H.B. 3), Sec. 5, eff. September 28, 2011.

Sec. 2210.014. APPLICABILITY OF CERTAIN OTHER LAW. (a) A person may not bring a private action against the association, including a claim against an agent or representative of the association, under Chapter 541 or 542. Notwithstanding any other provision of this code or this chapter, a class action under Subchapter F, Chapter 541, or under Rule 42, Texas Rules of Civil Procedure, may only be brought against the association by the attorney general at the request of the department.

(b) Chapter 542 does not apply to the association or to an agent or representative of the association.

(c) An administrator contracted under Section 2210.062, if applicable, is an agent of the association for purposes of managing the association and administering the plan of operation under this chapter.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 2 (H.B. 3), Sec. 5, eff. September 28, 2011.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 615 (S.B. 900), Sec. 2, eff. September 1, 2015.

Sec. 2210.015. STUDY OF MARKET INCENTIVES; BIENNIAL REPORTING.

(a) Each biennium, the department shall conduct a study of market incentives to promote participation in the voluntary windstorm and hail insurance market in the seacoast territory of this state. The study must address as possible incentives the mandatory or voluntary issuance of windstorm and hail insurance in conjunction with the issuance of a homeowners policy in the seacoast territory.

(b) The department shall include the results of the study conducted under this section in the report submitted under Section 32.022.

Added by Acts 2015, 84th Leg., R.S., Ch. 615 (S.B. 900), Sec. 3, eff. September 1, 2015.

Sec. 2210.016. AGENT REQUIREMENTS. (a) The association may establish requirements that an agent must comply with to offer or sell a Texas windstorm and hail insurance policy under this chapter.

(b) The association may audit an agent who offers or sells Texas windstorm and hail insurance policies under this chapter to determine the agent's compliance with requirements established under Subsection (a). If the association finds that an agent is not in compliance with association requirements, the association may take appropriate action to limit or prohibit the agent from offering or selling a Texas windstorm and hail insurance policy under this chapter until the agent complies with those requirements.

(c) An agent who offers or sells Texas windstorm and hail insurance policies under this chapter is not an agent of the association.

Added by Acts 2023, 88th Leg., R.S., Ch. 39 (S.B. [2232](#)), Sec. 1, eff. September 1, 2023.

SUBCHAPTER B. ADMINISTRATION OF ASSOCIATION

Sec. 2210.051. COMPOSITION OF ASSOCIATION; REQUIRED MEMBERSHIP.

(a) The association is composed of all property insurers authorized to engage in the business of property insurance in this state, other than insurers prevented by law from writing on a statewide basis coverages available through the association.

(b) As a condition of the insurer's authority to engage in the business of insurance in this state, each insurer subject to Subsection (a) must be a member of the association and must remain a member for the duration of the association's existence. An insurer that ceases to be a member of the association remains liable on insurance contracts entered into during the insurer's membership in the association to the same extent and effect as if the insurer's membership in the association had not been terminated.

(c) An insurer that becomes authorized to write and is engaged in writing insurance that requires the insurer to be a member of the association shall become a member of the association on the January 1 following the effective date of that authorization. The determination of the insurer's participation in the association is

made as of the date of the insurer's membership in the manner used to determine participation for all other members of the association.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2210.052. MEMBER PARTICIPATION IN ASSOCIATION. (a) Each member of the association shall participate in insured losses and operating expenses of the association, in excess of premium and other revenue of the association, in the proportion that the net direct premiums of that member during the preceding calendar year bears to the aggregate net direct premiums by all members of the association, as determined using the information provided under Subsection (b).

(b) The department shall review annual statements, other reports, and other statistics that the department considers necessary to obtain the information required under Subsection (a) and shall provide that information to the association. The department is entitled to obtain the annual statements, other reports, and other statistics from any member of the association.

(c) Each member's participation in the association shall be determined annually in the manner provided by the plan of operation. For purposes of determining participation in the association, two or more members that are subject to common ownership or that operate in this state under common management or control shall be treated as a single member. The determination shall also include the net direct premiums of an affiliate that is under that common management or control, including an affiliate that is not authorized to engage in the business of property insurance in this state.

(d) Notwithstanding Subsection (a), a member, in accordance with the plan of operation, is entitled to receive credit for similar insurance voluntarily written in areas designated by the commissioner. The member's participation in the insured losses and operating expenses of the association in excess of premium and other revenue of the association shall be reduced in accordance with the plan of operation.

(e) Notwithstanding Subsections (a)-(d), an insurer that becomes a member of the association and that has not previously been a member of the association is not subject to participation in any insured losses and operating expenses of the association in excess of

premium and other revenue of the association until the second anniversary of the date on which the insurer first becomes a member of the association.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1408 (H.B. 4409), Sec. 13, eff. June 19, 2009.

Sec. 2210.053. OPERATION OF ASSOCIATION. (a) In accordance with this chapter and the plan of operation, and with respect to insurance on insurable property, the association, on behalf of the association's members, may:

(1) cause issuance of insurance policies to applicants for insurance coverage;

(2) assume reinsurance from the members;

(3) cede reinsurance to the members; and

(4) purchase reinsurance on behalf of the members.

(b) The department may develop programs to improve the efficient operation of the association, including a program for approving policy forms under Section 2301.010 and a program designed to create incentives for insurers to write windstorm and hail insurance voluntarily to cover property located in a catastrophe area, especially property located on the barrier islands of this state.

(c) The association may not be considered a debtor authorized to file a petition or seek relief in bankruptcy under Title 11, United States Code.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2011, 82nd Leg., 1st C.S., Ch. 2 (H.B. 3), Sec. 6, eff. September 28, 2011.

Sec. 2210.054. ANNUAL STATEMENT. (a) The association shall file annually with the department and the state auditor's office a statement covering periods designated by the department that

summarizes the transactions, conditions, operations, and affairs of the association during the preceding year.

(b) The statement must:

- (1) be filed at times designated by the department;
- (2) contain the information prescribed by the department;

and

- (3) be in the form prescribed by the department.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2011, 82nd Leg., 1st C.S., Ch. 2 (H.B. 3), Sec. 7, eff. September 28, 2011.

Sec. 2210.055. LEGAL COUNSEL. (a) The association shall establish a plan in the plan of operation under which the association's legal representation before the department and the legislature is without conflict of interest or the appearance of a conflict of interest as defined by the Texas Disciplinary Rules of Professional Conduct.

(b) The association shall adopt separate and distinct procedures for legal counsel in disputes involving policyholder claims against the association.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2210.056. USE OF ASSOCIATION ASSETS. (a) The association's net earnings may not inure, in whole or in part, to the benefit of a private shareholder or individual.

(b) The association's assets may not be used for or diverted to any purpose other than to:

- (1) satisfy, in whole or in part, the liability of the association on claims made on policies written by the association;
- (2) make investments authorized under applicable law;
- (3) pay reasonable and necessary administrative expenses incurred in connection with the operation of the association and the processing of claims against the association;
- (4) satisfy, in whole or in part, the obligations of the

association incurred in connection with Subchapters B-1, J, and M, including reinsurance, public securities, and financial instruments; or

(5) make remittance under the laws of this state to be used by this state to:

(A) pay claims made on policies written by the association;

(B) purchase reinsurance covering losses under those policies; or

(C) prepare for or mitigate the effects of catastrophic natural events.

(c) On dissolution of the association, all assets of the association, other than assets pledged for the repayment of public securities issued under this chapter, revert to this state.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1408 (H.B. 4409), Sec. 14, eff. June 19, 2009.

Acts 2011, 82nd Leg., 1st C.S., Ch. 2 (H.B. 3), Sec. 8, eff. September 28, 2011.

Sec. 2210.057. EXAMINATION OF ASSOCIATION. (a) The association is subject to Sections 401.051, 401.052, 401.054-401.062, 401.151, 401.152, 401.155, and 401.156 and Subchapter A, Chapter 86.

(b) A final examination report of the association resulting from an examination as provided by this section is a public record and is available to the public at the offices of the department in accordance with Chapter 552, Government Code.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2210.058. AUDIT OF ASSOCIATION. (a) The association is subject to audit by the state auditor and shall pay the costs incurred by the state auditor in performing an audit under this section.

(b) The association shall pay the costs described by Subsection

(a) promptly after receipt of a statement from the state auditor's office regarding the amount of those costs.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 2 (H.B. 3), Sec. 9, eff. September 28, 2011.

Sec. 2210.059. CLAIMS PRACTICES AUDIT. (a) The commissioner, in the manner and at the time the commissioner determines to be necessary, shall conduct a random audit of claim files concerning claims the bases of which are damage to insured property caused by a particular storm to:

- (1) determine whether the association is adequately and properly documenting claims decisions in each claim file; and
- (2) ensure that each claim is being handled appropriately, including being handled in accordance with the terms of the policy under which the claim is filed.

(b) The department shall conduct an audit required under this section as soon as possible to ensure the quality of the process with which the association is handling claims described by Subsection (a).

(c) If, following an audit conducted under this section, the commissioner determines that the association is not adequately and properly documenting claims decisions or that claims described by Subsection (a) are not otherwise being handled appropriately, the commissioner shall:

- (1) notify the board of directors of that determination; and
- (2) identify the manner in which the association should correct any deficiencies identified by the commissioner and issue an order to that effect.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 2 (H.B. 3), Sec. 9, eff. September 28, 2011.

Sec. 2210.060. INDEMNIFICATION BY ASSOCIATION. (a) Except as provided by Subsection (b), the association shall indemnify each director, officer, and employee of the association and each member of the association against all costs and expenses actually and necessarily incurred by the person or entity in connection with the defense of an action or proceeding in which the person or entity is

made a party because of the person's status as a director, officer, or employee of the association or the member's status as a member of the association.

(b) Subsection (a) does not apply to a matter in which the person or entity is determined in the action or proceeding to be liable because of misconduct in the performance of duties as a director, officer, or employee of the association or a member of the association.

(c) Subsection (a) does not authorize the association to indemnify a member of the association for participating in the assessments made by the association in the manner provided by this chapter.

(d) Indemnification under this section is not exclusive of other rights to which the member or officer may be entitled as a matter of law.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1408 (H.B. 4409), Sec. 15, eff. June 19, 2009.

Sec. 2210.061. CONTRACTORS AND MANAGERIAL EMPLOYEES: COMPENSATION AND BONUSES. The association shall post on the association's Internet website any compensation, monetary or otherwise, and any bonus that, when aggregated, exceed \$100,000 in a calendar year and that are paid or given by the association to:

- (1) a vendor or independent contractor with whom the association has a contract; or
- (2) an association employee.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 2 (H.B. 3), Sec. 9, eff. September 28, 2011.

Sec. 2210.062. ADMINISTRATION BY CONTRACTED ADMINISTRATOR AUTHORIZED. (a) Notwithstanding any other law, if determined by the commissioner to be in the best interest of the policyholders and the public, the commissioner may contract with an administrator to manage the association and administer the plan of operation.

(b) The commissioner shall adopt rules as necessary to implement this section if the commissioner determines management of the association and administration of the plan of operation by an administrator is in the best interest of the policyholders and the public.

(c) The administrator must hold either a managing general agent license issued under Chapter 4053 or a third-party administrator certificate of authority issued under Chapter 4151.

Added by Acts 2015, 84th Leg., R.S., Ch. 615 (S.B. 900), Sec. 4, eff. September 1, 2015.

SUBCHAPTER B-1. PAYMENT OF LOSSES

Sec. 2210.071. PAYMENT OF EXCESS LOSSES. (a) If, in a catastrophe year, an occurrence or series of occurrences in a catastrophe area results in insured losses and operating expenses of the association in excess of premium and other revenue of the association, the excess losses and operating expenses shall be paid as provided by this subchapter.

(b) The association may not pay insured losses and operating expenses resulting from an occurrence or series of occurrences in a catastrophe year with premium and other revenue earned in a subsequent year.

Added by Acts 2009, 81st Leg., R.S., Ch. 1408 (H.B. 4409), Sec. 16, eff. June 19, 2009.

Amended by:

Acts 2011, 82nd Leg., 1st C.S., Ch. 2 (H.B. 3), Sec. 10, eff. September 28, 2011.

Acts 2015, 84th Leg., R.S., Ch. 615 (S.B. 900), Sec. 5, eff. September 1, 2015.

Acts 2019, 86th Leg., R.S., Ch. 790 (H.B. 1900), Sec. 1, eff. June 10, 2019.

Sec. 2210.0715. PAYMENT FROM RESERVES AND TRUST FUND. (a) The association shall pay losses resulting from an occurrence or series of occurrences in a catastrophe year in excess of premium and other revenue of the association for that catastrophe year from reserves of the association available before or accrued during that catastrophe

year and amounts in the catastrophe reserve trust fund available before or accrued during that catastrophe year.

(b) Proceeds of public securities issued or assessments made before or as a result of any occurrence or series of occurrences in a catastrophe year that results in insured losses may not be included in reserves available for a subsequent catastrophe year for purposes of this section.

Added by Acts 2015, 84th Leg., R.S., Ch. 615 (S.B. 900), Sec. 5, eff. September 1, 2015.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 790 (H.B. 1900), Sec. 2, eff. June 10, 2019.

Sec. 2210.072. PAYMENT FROM CLASS 1 PUBLIC SECURITIES; FINANCIAL INSTRUMENTS. (a) Losses not paid under Section 2210.0715 shall be paid as provided by this section from the proceeds from Class 1 public securities issued in accordance with Subchapter M before, on, or after the date of any occurrence or series of occurrences that results in insured losses. Public securities described by this section must be paid within a period not to exceed 14 years, and may be paid sooner if the board of directors elects to do so and the commissioner approves.

(b) Public securities described by Subsection (a) that are issued before an occurrence or series of occurrences that results in incurred losses:

(1) may be issued on the request of the board of directors with the approval of the commissioner; and

(2) may not, in the aggregate, exceed \$500 million at any one time, regardless of the calendar year or years in which the outstanding public securities were issued.

(b-1) Public securities described by Subsection (a):

(1) shall be issued as necessary in a principal amount not to exceed \$500 million per catastrophe year, in the aggregate, for securities issued during that catastrophe year before the occurrence or series of occurrences that results in incurred losses in that year and securities issued on or after the date of that occurrence or series of occurrences, and regardless of whether for a single occurrence or a series of occurrences; and

(2) subject to the maximum described by Subdivision (1), may be issued, in one or more issuances or tranches, during the calendar year in which the occurrence or series of occurrences occurs or, if the public securities cannot reasonably be issued in that year, during the following calendar year.

(c) If public securities are issued as described by this section, the public securities shall be repaid in the manner prescribed by Subchapter M.

(d) The association may borrow from, or enter into other financing arrangements with, any market source, under which the market source makes interest-bearing loans or other financial instruments to the association to enable the association to pay losses under this section or to obtain public securities under this section. For purposes of this subsection, financial instruments includes commercial paper.

(e) The proceeds of any outstanding public securities described by Subsection (a) that are issued before an occurrence or series of occurrences, together with the proceeds of any outstanding Class 1 public securities issued on or before June 1, 2015, shall be depleted before the proceeds of any securities issued after an occurrence or series of occurrences may be used. This subsection does not prohibit the association from issuing securities after an occurrence or series of occurrences before the proceeds of outstanding public securities issued during a previous catastrophe year have been depleted.

(f) If, under Subsection (e), the proceeds of any outstanding public securities issued during a previous catastrophe year, together with the proceeds of any outstanding Class 1 public securities issued on or before June 1, 2015, must be depleted, those proceeds shall count against the limit on public securities described by this section in the catastrophe year in which the proceeds must be depleted.

Added by Acts 2009, 81st Leg., R.S., Ch. 1408 (H.B. 4409), Sec. 16, eff. June 19, 2009.

Amended by:

Acts 2011, 82nd Leg., 1st C.S., Ch. 2 (H.B. 3), Sec. 11, eff. September 28, 2011.

Acts 2015, 84th Leg., R.S., Ch. 615 (S.B. 900), Sec. 6, eff. September 1, 2015.

Sec. 2210.0725. PAYMENT FROM CLASS 1 ASSESSMENTS. (a) Losses in a catastrophe year not paid under Sections 2210.0715 and 2210.072 shall be paid as provided by this section from Class 1 member assessments not to exceed \$500 million for that catastrophe year.

(b) The association, with the approval of the commissioner, shall notify each member of the amount of the member's assessment under this section. The proportion of the losses allocable to each insurer under this section shall be determined in the manner used to determine each insurer's participation in the association for the year under Section 2210.052.

(c) A member of the association may not recoup an assessment paid under this section through a premium surcharge or tax credit.

Added by Acts 2015, 84th Leg., R.S., Ch. 615 (S.B. 900), Sec. 7, eff. September 1, 2015.

Sec. 2210.073. PAYMENT FROM CLASS 2 PUBLIC SECURITIES. (a) Losses not paid under Sections 2210.0715, 2210.072, and 2210.0725 shall be paid as provided by this section from the proceeds from Class 2 public securities authorized to be issued in accordance with Subchapter M on or after the date of any occurrence or series of occurrences that results in insured losses. Public securities issued under this section must be paid within a period not to exceed 10 years and may be paid sooner if the board of directors elects to do so and the commissioner approves.

(b) Public securities described by Subsection (a):

(1) shall be issued as necessary in a principal amount not to exceed \$250 million per catastrophe year, in the aggregate, whether for a single occurrence or a series of occurrences; and

(2) subject to the maximum described by Subdivision (1), may be issued, in one or more issuances or tranches, during the calendar year in which the occurrence or series of occurrences occurs or, if the public securities cannot reasonably be issued in that year, during the following calendar year.

(c) If the losses are paid with public securities described by this section, the public securities shall be paid in the manner prescribed by Subchapter M.

Added by Acts 2009, 81st Leg., R.S., Ch. 1408 (H.B. 4409), Sec. 16, eff. June 19, 2009.

Amended by:

Acts 2011, 82nd Leg., 1st C.S., Ch. 2 (H.B. 3), Sec. 12, eff. September 28, 2011.

Acts 2015, 84th Leg., R.S., Ch. 615 (S.B. 900), Sec. 8, eff. September 1, 2015.

Sec. 2210.074. PAYMENT THROUGH CLASS 2 ASSESSMENTS. (a) Losses in a catastrophe year not paid under Sections 2210.0715, 2210.072, 2210.0725, and 2210.073 shall be paid as provided by this section from Class 2 member assessments not to exceed \$250 million for that catastrophe year.

(b) The association, with the approval of the commissioner, shall notify each member of the amount of the member's assessment under this section. The proportion of the losses allocable to each insurer under this section shall be determined in the manner used to determine each insurer's participation in the association for the year under Section 2210.052.

(c) A member of the association may not recoup an assessment paid under this section through a premium surcharge or tax credit.

Added by Acts 2009, 81st Leg., R.S., Ch. 1408 (H.B. 4409), Sec. 16, eff. June 19, 2009.

Amended by:

Acts 2011, 82nd Leg., 1st C.S., Ch. 2 (H.B. 3), Sec. 13, eff. September 28, 2011.

Acts 2015, 84th Leg., R.S., Ch. 615 (S.B. 900), Sec. 9, eff. September 1, 2015.

Sec. 2210.0741. PAYMENT THROUGH CLASS 3 PUBLIC SECURITIES. (a) Losses not paid under Sections 2210.0715, 2210.072, 2210.0725, 2210.073, and 2210.074 shall be paid as provided by this section from the proceeds from Class 3 public securities authorized to be issued in accordance with Subchapter M on or after the date of any occurrence or series of occurrences that results in insured losses. Public securities issued under this section must be paid within a period not to exceed 10 years, and may be paid sooner if the board of directors elects to do so and the commissioner approves.

(b) Public securities described by Subsection (a):

(1) shall be issued as necessary in a principal amount not to exceed \$250 million per catastrophe year, in the aggregate, whether for a single occurrence or a series of occurrences; and

(2) subject to the maximum described by Subdivision (1), may be issued, in one or more issuances or tranches, during the calendar year in which the occurrence or series of occurrences occurs or, if the public securities cannot reasonably be issued in that year, during the following calendar year.

(c) If the losses are paid with public securities described by this section, the public securities shall be paid in the manner prescribed by Subchapter M.

Added by Acts 2015, 84th Leg., R.S., Ch. 615 (S.B. 900), Sec. 10, eff. September 1, 2015.

Sec. 2210.0742. PAYMENT FROM CLASS 3 ASSESSMENTS. (a) Losses in a catastrophe year not paid under Sections 2210.0715, 2210.072, 2210.0725, 2210.073, 2210.074, and 2210.0741 shall be paid as provided by this section from Class 3 member assessments not to exceed \$250 million for that catastrophe year.

(b) The association, with the approval of the commissioner, shall notify each member of the amount of the member's assessment under this section. The proportion of the losses allocable to each insurer under this section shall be determined in the manner used to determine each insurer's participation in the association for the year under Section 2210.052.

(c) A member of the association may not recoup an assessment paid under this section through a premium surcharge or tax credit.

Added by Acts 2015, 84th Leg., R.S., Ch. 615 (S.B. 900), Sec. 10, eff. September 1, 2015.

Sec. 2210.075. REINSURANCE. (a) Before any occurrence or series of occurrences, an insurer may elect to purchase reinsurance to cover an assessment for which the insurer would otherwise be liable under this subchapter.

(b) An insurer must notify the board of directors, in the manner prescribed by the association whether the insurer will be purchasing reinsurance. If the insurer does not elect to purchase

reinsurance under this section, the insurer remains liable for any assessment imposed under this subchapter.

Added by Acts 2009, 81st Leg., R.S., Ch. 1408 (H.B. 4409), Sec. 16, eff. June 19, 2009.

Amended by:

Acts 2011, 82nd Leg., 1st C.S., Ch. 2 (H.B. 3), Sec. 14, eff. September 28, 2011.

Acts 2015, 84th Leg., R.S., Ch. 615 (S.B. 900), Sec. 11, eff. September 1, 2015.

**SUBCHAPTER C. ASSOCIATION BOARD OF DIRECTORS; GENERAL
POWERS AND DUTIES OF BOARD OF DIRECTORS**

Sec. 2210.101. ACCOUNTABLE TO COMMISSIONER. The board of directors is responsible and accountable to the commissioner.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2210.102. COMPOSITION. (a) The board of directors is composed of nine members appointed by the commissioner in accordance with this section.

(b) Three members must be representatives of the insurance industry who actively write and renew windstorm and hail insurance in the first tier coastal counties.

(c) Three members must, as of the date of the appointment, reside in the first tier coastal counties. Each of the following regions must be represented by a member residing in the region and appointed under this subsection:

(1) the region consisting of Cameron, Kenedy, Kleberg, and Willacy Counties;

(2) the region consisting of Aransas, Calhoun, Nueces, Refugio, and San Patricio Counties; and

(3) the region consisting of Brazoria, Chambers, Galveston, Jefferson, and Matagorda Counties and any part of Harris County designated as a catastrophe area under Section 2210.005.

(c-1) One of the members appointed under Subsection (c) must be a property and casualty agent who is licensed under this code and is not a captive agent.

(d) Three members must reside in an area of this state that is located more than 100 miles from the Texas coastline.

(e) All members must have demonstrated experience in insurance, general business, or actuarial principles and the member's area of expertise, if any, sufficient to make the success of the association probable.

(f) Repealed by Acts 2023, 88th Leg., R.S., Ch. 530 (H.B. 3311), Sec. 1, eff. September 1, 2023.

(g) Members appointed to the board of directors under Subsections (c) and (d), other than the member appointed under Subsection (c-1), must represent the general public in the regions described by those subsections. A person may not be appointed to represent the general public under Subsection (c) or (d) if the person or the person's spouse:

(1) is employed by or participates in the management of a business entity or other organization:

(A) operating in the property and casualty insurance industry in this state;

(B) receiving money from the association, other than insurance claim payments; or

(C) receiving money from association policyholders with respect to the policyholders' claims;

(2) owns or controls, directly or indirectly, more than a 10 percent interest in a business entity or other organization:

(A) operating in the property and casualty insurance industry in this state;

(B) receiving money from the association, other than insurance claim payments; or

(C) receiving money from association policyholders with respect to the policyholders' claims; or

(3) uses or receives a substantial amount of tangible goods, services, or money from the association, other than:

(A) insurance claim payments; or

(B) compensation or reimbursement authorized by law for the board members' membership, attendance, or expenses.

(h) Repealed by Acts 2015, 84th Leg., R.S., Ch. 615, Sec. 31(1), eff. September 1, 2015.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 548 (S.B. 1263), Sec. 2.14, eff. September 1, 2007.

Acts 2009, 81st Leg., R.S., Ch. 1408 (H.B. 4409), Sec. 18, eff. June 19, 2009.

Acts 2011, 82nd Leg., 1st C.S., Ch. 2 (H.B. 3), Sec. 15, eff. September 28, 2011.

Acts 2015, 84th Leg., R.S., Ch. 615 (S.B. 900), Sec. 12, eff. September 1, 2015.

Acts 2015, 84th Leg., R.S., Ch. 615 (S.B. 900), Sec. 31(1), eff. September 1, 2015.

Acts 2019, 86th Leg., R.S., Ch. 525 (S.B. 615), Sec. 3, eff. September 1, 2019.

Acts 2023, 88th Leg., R.S., Ch. 530 (H.B. 3311), Sec. 1, eff. September 1, 2023.

Sec. 2210.103. TERMS. (a) Members of the board of directors serve three-year staggered terms, with the terms of three members expiring on the third Tuesday of March of each year.

(b) A person may serve on the board of directors for not more than three consecutive full terms, not to exceed nine years.

(c) A member of the board of directors may be removed by the commissioner with cause stated in writing and posted on the association's website. The commissioner shall appoint a replacement in accordance with Section 2210.102 for a member who leaves or is removed from the board of directors.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1408 (H.B. 4409), Sec. 19, eff. June 19, 2009.

Acts 2015, 84th Leg., R.S., Ch. 615 (S.B. 900), Sec. 13, eff. September 1, 2015.

Sec. 2210.1031. TRAINING. (a) A person who is appointed to and qualifies for office as a member of the board of directors may not vote, deliberate, or be counted as a member in attendance at a

meeting of the board of directors until the person completes a training program that complies with this section.

(b) The training program must provide the person with information regarding:

- (1) the law governing the operation of the association;
- (2) the programs, functions, rules, and budget of the association;
- (3) the scope of and limitations on the rulemaking authority of the board of directors;
- (4) the results of the most recent formal audit of the association;
- (5) the requirements of:
 - (A) laws relating to open meetings, public information, administrative procedure, and conflict of interest disclosure; and
 - (B) other laws applicable to the board of directors in performing the board's duties; and
- (6) any applicable ethics policies adopted by the association or the Texas Ethics Commission.

(c) The general manager of the association shall create a training manual that includes the information required by Subsection (b). The general manager shall distribute a copy of the training manual annually to each member of the board of directors. Each member of the board of directors shall sign and submit to the general manager a statement acknowledging that the member received and has reviewed the training manual.

Added by Acts 2019, 86th Leg., R.S., Ch. 525 (S.B. 615), Sec. 4, eff. September 1, 2019.

Sec. 2210.104. OFFICERS. The board of directors shall elect from the board's membership an executive committee consisting of a presiding officer, assistant presiding officer, and secretary-treasurer.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1408 (H.B. 4409), Sec. 20, eff. June 19, 2009.

Sec. 2210.105. MEETINGS. (a) Except for an emergency meeting, the association shall:

(1) notify the department not later than the 11th day before the date of a meeting of the board of directors or of the members of the association; and

(2) not later than the seventh day before the date of a meeting of the board of directors, post notice of the meeting on the association's Internet website and the department's Internet website.

(b) Except for a closed meeting authorized by Subchapter D, Chapter 551, Government Code, a meeting of the board of directors or of the members of the association is open to the public.

(b-1) The commissioner or the commissioner's designated representative may attend a meeting of the board of directors or the members of the association, including a closed meeting authorized by Subchapter D, Chapter 551, Government Code, except for those portions of a closed meeting that involve the rendition of legal advice to the board concerning a regulatory matter or that would constitute an ex parte communication with the commissioner.

(c) Notice of a meeting of the board of directors or the association must be given as provided by Chapter 551, Government Code.

(d) Except for an emergency meeting, a meeting of the board of directors shall be held at a location as determined by the board of directors.

(e) The association shall:

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

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

(f) A recording of a meeting must be maintained in the archive required under Subsection (e) through and including the second anniversary of the meeting.

(g) The presence of the commissioner or the commissioner's designated representative at a closed meeting does not waive or impair any privilege, including attorney-client privilege, that exists in statute or at common law.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1408 (H.B. 4409), Sec. 21, eff. June 19, 2009.

Acts 2011, 82nd Leg., 1st C.S., Ch. 2 (H.B. 3), Sec. 16, eff. September 28, 2011.

Sec. 2210.1051. MEETINGS OF BOARD OF DIRECTORS. (a) Notwithstanding Chapter 551, Government Code, or any other law, members of the board of directors may meet by telephone conference call, videoconference, or other similar telecommunication method. The board may use telephone conference call, videoconference, or other similar telecommunication method for purposes of establishing a quorum or voting or for any other meeting purpose in accordance with this subsection and Subsection (b). This subsection applies without regard to the subject matter discussed or considered by the members of the board at the meeting.

(b) A meeting held by telephone conference call, videoconference, or other similar telecommunication method:

(1) is subject to the notice requirements applicable to other meetings of the board of directors;

(2) may not be held unless notice of the meeting specifies the location of the meeting and a recording of the meeting is posted on the association's website;

(3) must be audible to the public at the location specified in the notice under Subdivision (2); and

(4) must provide two-way audio communication between all members of the board attending the meeting during the entire meeting, and if the two-way audio communication link with members attending the meeting is disrupted so that a quorum of the board is no longer participating in the meeting, the meeting may not continue until the two-way audio communication link is reestablished.

Added by Acts 2009, 81st Leg., R.S., Ch. 1408 (H.B. 4409), Sec. 22, eff. June 19, 2009.

Sec. 2210.1052. EMERGENCY MEETING. If the ultimate loss estimate for an occurrence or series of occurrences made by the chief financial officer or chief actuary of the association indicates

member insurers may be subject to an assessment under Subchapter B-1, the board of directors shall call an emergency meeting to notify the member insurers about the assessment.

Added by Acts 2019, 86th Leg., R.S., Ch. 790 (H.B. 1900), Sec. 3, eff. June 10, 2019.

Sec. 2210.106. IMMUNITY OF DIRECTOR OR OFFICER FROM LIABILITY.

(a) A director or officer of the association is not individually liable for an act or failure to act in the performance of official duties in connection with the association.

(b) Subsection (a) does not apply to:

- (1) an act or failure to act of the association or an employee of the association;
- (2) an act or omission involving a motor vehicle; or
- (3) an act or failure to act that constitutes bad faith, intentional misconduct, or gross negligence.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2210.107. PRIMARY BOARD OBJECTIVES; REPORT. (a) The primary objectives of the board of directors are to ensure that the board and the association:

- (1) operate in accordance with this chapter, the plan of operation, and commissioner rules;
- (2) comply with sound insurance principles;
- (3) meet all standards imposed under this chapter;
- (4) establish a code of conduct and performance standards for association employees and persons with which the association contracts; and
- (5) establish, and adhere to terms of, an annual evaluation of association management necessary to achieve the statutory purpose, board objectives, and any performance or enterprise risk management objectives established by the board.

(b) Repealed by Acts 2019, 86th Leg., R.S., Ch. 525 (S.B. 615), Sec. 17, eff. September 1, 2019.

(c) Not later than June 1 of each year, the association shall submit to the commissioner, the legislative oversight board

established under Subchapter N, the governor, the lieutenant governor, and the speaker of the house of representatives a report evaluating the extent to which the board met the objectives described by Subsection (a) in the 12-month period immediately preceding the date of the report.

Added by Acts 2009, 81st Leg., R.S., Ch. 1408 (H.B. 4409), Sec. 23, eff. June 19, 2009.

Amended by:

Acts 2011, 82nd Leg., 1st C.S., Ch. 2 (H.B. 3), Sec. 17, eff. September 28, 2011.

Acts 2019, 86th Leg., R.S., Ch. 525 (S.B. 615), Sec. 17, eff. September 1, 2019.

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

(b) A settlement agreement to which the association is a party:

(1) is public information and is not exempted from required disclosure under Chapter 552, Government Code; and

(2) if applicable, must contain the name of any attorney or adjuster representing a claimant or the association in connection with the claim that is the basis of the settlement.

(c) Subsection (b) may not be construed to limit or otherwise restrict the categories of information that are public information under Section 552.022, Government Code.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 2 (H.B. 3), Sec. 18, eff. September 28, 2011.

Sec. 2210.109. DISCLOSURE OF CONFLICTS. (a) A member of the board of directors, or a member of a subcommittee of the board of directors that relates to underwriting and actuarial matters, shall disclose any potential conflict of interest of the member known by the member with respect to a matter for discussion or vote by the board or subcommittee, as applicable, before the discussion or vote. A potential conflict of interest is an interest that may reasonably be expected to diminish the member's independent judgment with respect to the matter for discussion or vote. Potential conflicts of

interest required to be disclosed under this section include:

(1) a financial or personal interest in an entity that may financially benefit from the outcome of the discussion or vote; and

(2) holding an insurance policy issued by the association that may be affected by the discussion or vote.

(b) A disclosure under this section must be made available to the public. A board or subcommittee member satisfies this requirement if:

(1) with respect to an open meeting or meeting broadcast live on the association's Internet website, the member publicly discloses the conflict of interest in the meeting or during the broadcast; or

(2) with respect to a meeting that is not an open meeting or broadcast live on the association's Internet website, the member discloses the conflict of interest in the agenda of the meeting and makes the agenda publicly available on the association's Internet website before the meeting.

Added by Acts 2019, 86th Leg., R.S., Ch. 525 (S.B. 615), Sec. 5, eff. September 1, 2019.

SUBCHAPTER D. PLAN OF OPERATION

Sec. 2210.151. ADOPTION OF PLAN OF OPERATION. With the advice of the board of directors, the commissioner by rule shall adopt the plan of operation to provide Texas windstorm and hail insurance in a catastrophe area.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1408 (H.B. 4409), Sec. 24, eff. June 19, 2009.

Sec. 2210.152. CONTENTS OF PLAN OF OPERATION. (a) The plan of operation must:

(1) provide for the efficient, economical, fair, and nondiscriminatory administration of the association; and

(2) include:

(A) a plan for the equitable assessment of the members

of the association to defray losses and expenses;

(B) underwriting standards;

(C) procedures for accepting and ceding reinsurance;

(D) procedures for obtaining and repaying amounts under any financial instruments authorized under this chapter;

(E) procedures for determining the amount of insurance to be provided to specific risks;

(F) time limits and procedures for processing applications for insurance;

(G) a requirement that a nonresident agent licensed under Section 4056.052 may not offer or sell a Texas windstorm and hail insurance policy under this chapter unless the nonresident agent's state of residence authorizes a resident agent licensed in this state to act in the nonresident agent's state as an agent for that state's residual insurer of last resort for windstorm and hail insurance; and

(H) other provisions as considered necessary by the department to implement the purposes of this chapter.

(b) The plan of operation may provide for liability limits for an insured structure and for the corporeal movable property located in the structure.

(c) The plan of operation shall require the association to use the claim settlement guidelines published by the commissioner under Section 2210.578(f) in evaluating the extent to which a loss to insured property is incurred as a result of wind, waves, tidal surges, or rising waters not caused by waves or surges.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1408 (H.B. 4409), Sec. 25, eff. June 19, 2009.

Acts 2011, 82nd Leg., 1st C.S., Ch. 2 (H.B. 3), Sec. 19, eff. September 28, 2011.

Acts 2017, 85th Leg., R.S., Ch. 878 (H.B. 3018), Sec. 1, eff. January 1, 2018.

Sec. 2210.153. AMENDMENTS TO PLAN OF OPERATION. (a) The association may present a recommendation for a change in the plan of

operation to the department at:

(1) periodic hearings conducted by the department for that purpose; or

(2) hearings relating to property and casualty insurance rates.

(b) The association must present a proposed change to the department in writing in the manner prescribed by the commissioner. A proposed change does not take effect unless adopted by the commissioner by rule.

(c) An interested person may, in accordance with Chapter 2001, Government Code, petition the commissioner to modify the plan of operation.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER E. INSURANCE COVERAGE

Sec. 2210.201. DEFINITION OF INSURABLE INTEREST. In this subchapter, "insurable interest" includes any lawful and substantial economic interest in the safety or preservation of property from loss, destruction, or pecuniary damage.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2210.202. APPLICATION FOR COVERAGE; DECLINATION REQUIREMENT. (a) A person who has an insurable interest in insurable property may apply to the association for insurance coverage provided under the plan of operation and an inspection of the property, subject to any rules established by the board of directors and approved by the commissioner. The association shall make insurance available to each applicant in the catastrophe area whose property is insurable property but who, after diligent efforts, is unable to obtain property insurance through the voluntary market, as evidenced by one declination from an insurer authorized to engage in the business of, and writing, property insurance providing windstorm and hail coverage in the first tier coastal counties. For purposes of this section, "declination" has the meaning assigned by the plan of operation and shall include a refusal to offer coverage

for the perils of windstorm and hail and the inability to obtain substantially equivalent insurance coverage for the perils of windstorm and hail. Notwithstanding Section 2210.203(c), evidence of one declination every three calendar years is required before renewal of an association policy.

(b) A property and casualty agent must submit an application for initial insurance coverage on behalf of the applicant on forms prescribed by the association. An application for initial coverage must contain:

(1) a statement as to whether the applicant has submitted or will submit the required premium payment 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) and proof of flood insurance coverage or unavailability of that coverage as described by Section 2210.203(a-1).

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 548 (S.B. 1263), Sec. 2.15, eff. September 1, 2007.

Acts 2009, 81st Leg., R.S., Ch. 1408 (H.B. 4409), Sec. 26, eff. June 19, 2009.

Acts 2011, 82nd Leg., 1st C.S., Ch. 2 (H.B. 3), Sec. 20, eff. September 28, 2011.

Acts 2019, 86th Leg., R.S., Ch. 525 (S.B. 615), Sec. 6, eff. September 1, 2019.

Sec. 2210.203. ISSUANCE OF COVERAGE; TERM; RENEWAL. (a) If the association determines that the property for which an application for initial insurance coverage is made is insurable property, the association, on payment of the premium in full or in part as authorized under Section 2210.2032, shall direct the issuance of an insurance policy as provided by the plan of operation.

(a-1) This subsection applies only to a structure constructed, altered, remodeled, or enlarged on or after September 1, 2009, and only for insurable property located in areas designated by the commissioner. Notwithstanding Subsection (a), if all or any part of

the property to which this subsection applies is located in Zone V or another similar zone with an additional hazard associated with storm waves, as defined by the National Flood Insurance Program, and if flood insurance under that federal program is available, the association may not issue an insurance policy for initial or renewal coverage unless evidence that the property is covered by a flood insurance policy is submitted to the association. An agent offering or selling a Texas windstorm and hail insurance policy in any area designated by the commissioner under this subsection shall offer flood insurance coverage to the prospective insured, if that coverage is available.

(b) A policy issued under this section is for a one-year term.

(c) A policy may be renewed annually as long as the property continues to be insurable property.

(c-1) With the advice of the association, the commissioner shall adopt rules establishing a grace period of not more than 10 days after the due date for the receipt of payment of premium for the renewal of a policy.

(d) The commissioner, after receiving a recommendation from the board of directors, shall approve a commission structure for payment of an agent who submits an application for coverage to the association on behalf of a person who has an insurable interest in insurable property. The commission structure adopted by the commissioner must be fair and reasonable, taking into consideration the amount of work performed by an agent in submitting an application to the association and the prevailing commission structure in the private windstorm market.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1408 (H.B. 4409), Sec. 27, eff. June 19, 2009.

Acts 2011, 82nd Leg., 1st C.S., Ch. 2 (H.B. 3), Sec. 21, eff. September 28, 2011.

Acts 2019, 86th Leg., R.S., Ch. 525 (S.B. 615), Sec. 7, eff. September 1, 2019.

Acts 2021, 87th Leg., R.S., Ch. 353 (H.B. 2920), Sec. 1, eff. September 1, 2021.

Sec. 2210.2031. AUTOMATIC RENEWAL. (a) The association shall establish a process for automatic renewal of a residential property policy in accordance with this section.

(b) The process established under Subsection (a) must:

(1) provide for the association to verify:

(A) the declination required by Section 2210.202;

(B) flood insurance coverage required by Section 2210.203; and

(C) any other information related to insurability of a property, including changes to the condition or value of the property that would affect the availability of coverage or premium cost to insure the property; and

(2) provide an opportunity for the policyholder to elect to cancel the policy before the policy automatically renews.

Added by Acts 2019, 86th Leg., R.S., Ch. 525 (S.B. 615), Sec. 8, eff. September 1, 2019.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 40 (S.B. 2233), Sec. 1, eff. September 1, 2023.

Sec. 2210.2032. PREMIUM PAYMENT METHODS. (a) The association shall accept payment of premium by credit card. The association may impose a fee on a policyholder for the use of a credit card to pay premium. The fee may not exceed the amount necessary to recoup the cost incurred by the association in connection with the policyholder's use of a credit card.

(b) The association shall provide to policyholders the option to pay premium in installments. A policyholder that pays premium in accordance with an installment payment plan established by the association and remains current on the payments satisfies the obligation for payment of premium under this chapter.

Added by Acts 2019, 86th Leg., R.S., Ch. 525 (S.B. 615), Sec. 8, eff. September 1, 2019.

Sec. 2210.204. CANCELLATION OF CERTAIN COVERAGE. (a) Subsections (b) and (c) apply if:

(1) an agent or another person, firm, or corporation

finances the payment of all or a portion of the premium for insurance coverage;

(2) there is an outstanding balance for the financing of the premium; and

(3) that balance, or an installment of that balance, is not paid before the expiration of the 10th day after the due date.

(b) The agent or other person, firm, or corporation to whom the balance described by Subsection (a) is due may request cancellation of the insurance coverage by:

(1) returning the policy, with proof that the insured was notified of the return; or

(2) requesting the association to cancel the insurance coverage by a notice mailed to the insured and to any others shown in the policy as having an insurable interest in the property.

(c) On completion of cancellation under Subsection (b), the association shall refund the unearned premium, less any minimum retained premium set forth in the plan of operation, to the person, firm, or corporation to whom the unpaid balance is due.

(d) If an insured requests cancellation of the insurance coverage, the association shall refund the unearned premium only if the cancellation was for one of the following reasons:

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

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

(3) total loss of the insured property; or

(4) a determination by the association that the insured property is no longer insurable under the association's rules and procedures.

(d-1) The property and casualty agent who received a commission as the result of the issuance of an association policy providing the coverage canceled under Subsection (d) shall refund the agent's commission on any unearned premium in the same manner.

(d-2) An insured must provide proof in the form and manner prescribed by the association of a cancellation reason described by Subsection (d)(1), (2), or (3) to be eligible for a refund under that subsection.

(d-3) If an insured requests cancellation for a reason other than a reason described by Subsection (d) or fails to provide proof under Subsection (d-2), the insured's premium is considered earned and is not refundable.

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

- (1) the purchase of similar coverage in the voluntary market;
- (2) sale of the property to an unrelated party;
- (3) death of the policyholder; or
- (4) total loss of the property.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 548 (S.B. 1263), Sec. 2.16, eff. September 1, 2007.

Acts 2009, 81st Leg., R.S., Ch. 1408 (H.B. 4409), Sec. 28, eff. June 19, 2009.

Acts 2011, 82nd Leg., 1st C.S., Ch. 2 (H.B. 3), Sec. 22, eff. September 28, 2011.

Acts 2023, 88th Leg., R.S., Ch. 526 (H.B. 3208), Sec. 1, eff. September 1, 2023.

Sec. 2210.2041. NONREFUNDABLE SURCHARGE. A nonrefundable surcharge established under this chapter is not refundable under this code for any reason or purpose.

Added by Acts 2009, 81st Leg., R.S., Ch. 1408 (H.B. 4409), Sec. 29, eff. June 19, 2009.

Sec. 2210.205. REQUIRED POLICY PROVISIONS: DEADLINE FOR FILING CLAIM; NOTICE CONCERNING RESOLUTION OF CERTAIN DISPUTES. (a) A windstorm and hail insurance policy issued by the association must:

- (1) require an insured to file a claim under the policy not later than the first anniversary of the date on which the damage to property that is the basis of the claim occurs;
- (2) contain, in boldface type, a conspicuous notice concerning the resolution of disputes under the policy, including:

(A) the processes and deadlines for appraisal under Section 2210.574 and alternative dispute resolution under Section 2210.575;

(B) the binding effect of appraisal under Section 2210.574; and

(C) the necessity of complying with the requirements of Subchapter L-1 to seek relief, including judicial relief; and

(3) contain a conspicuous notice concerning the availability of supplemental payments under the policy, including:

(A) a description of the process for requesting a supplemental payment; and

(B) notice of applicable deadlines related to supplemental payments.

(b) The commissioner, on a showing of good cause by a person insured under this chapter, may extend the one-year period described by Subsection (a)(1) for a period not to exceed 180 days.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 2 (H.B. 3), Sec. 23, eff. September 28, 2011.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 525 (S.B. 615), Sec. 9, eff. September 1, 2019.

Sec. 2210.207. WINDSTORM AND HAIL INSURANCE: REPLACEMENT COST COVERAGE. (a) In this section, "roof covering" means:

(1) the roofing material exposed to the weather;

(2) the underlayments applied for moisture protection; and

(3) all flashings required in the replacement of a roof covering.

(b) Subject to any applicable deductibles and the limits for the coverage purchased by the insured, a windstorm and hail insurance policy issued by the association may include replacement cost coverage for one- and two-family dwellings, including outbuildings, as provided under the dwelling extension coverage in the policy.

(c) If, on the effective date of an association policy, the total amount of insurance applicable to a dwelling is equal to 80 percent or more of the full replacement cost of the dwelling or equal to the maximum amount of insurance otherwise available through the association, coverage applicable to the dwelling under the policy is

extended to include the full cost of repair or replacement, without a deduction for depreciation.

(d) If, on the effective date of an association policy, the total amount of insurance applicable to a dwelling is equal to less than 80 percent of the full replacement cost of the dwelling and less than the maximum amount of insurance available through the association, liability for loss under the policy may not exceed the replacement cost of the part of the dwelling that is damaged or destroyed, less depreciation.

(e) Notwithstanding this chapter or any other law, the commissioner, after notice and hearing, may adopt rules to:

(1) authorize the association to provide actual cash value coverage instead of replacement cost coverage on the roof covering of a building insured by the association; and

(2) establish:

(A) the conditions under which the association may provide that actual cash value coverage;

(B) the appropriate premium reductions when coverage for the roof covering is provided on an actual cash value basis; and

(C) the disclosure that must be provided to the policyholder, prominently displayed on the face of the windstorm and hail insurance policy.

(f) Notwithstanding Chapter 40, a hearing under Subsection (e) shall be held before the commissioner or the commissioner's designee.

(g) The commissioner may adopt rules as necessary to implement this section.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 525 (S.B. 615), Sec. 10, eff. September 1, 2019.

Acts 2019, 86th Leg., R.S., Ch. 790 (H.B. 1900), Sec. 4, eff. June 10, 2019.

Sec. 2210.208. WINDSTORM AND HAIL INSURANCE: COVERAGE FOR CERTAIN INDIRECT LOSSES. (a) Except as provided by Subsections (e) and (f), a windstorm and hail insurance policy issued by the association for a dwelling, as that term is defined by the department

or a successor to the department, must include coverage for:

- (1) wind-driven rain damage, regardless of whether an opening is made by the wind;
- (2) loss of use; and
- (3) consequential losses.

(b) A windstorm and hail insurance policy issued by the association for tenant contents of a dwelling or other residential building must include coverage for loss of use and consequential losses.

(c) The coverage required under Subsection (a) or (b) must be made:

- (1) according to forms approved by the commissioner; and
- (2) for a premium paid by the insured based on rates established by commissioner rule.

(d) The association shall provide coverage under this section as directed by commissioner rule.

(e) The association is not required to offer coverage for indirect losses as provided by Subsection (a) or (b) unless that coverage was excluded from a companion policy in the voluntary market.

(f) The association is not required to provide coverage for:

- (1) loss of use, if the loss is loss of rent or loss of rental value; or
- (2) additional living expenses, if the insured property is a secondary or a nonprimary residence.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2210.209. WINDSTORM AND HAIL INSURANCE: COVERAGE FOR CERTAIN PROPERTY LOCATED OVER WATER. (a) A windstorm and hail insurance policy issued by the association may include coverage for:

- (1) a building or other structure located in the seacoast territory that is built wholly or partially over water; and
- (2) the corporeal movable property contained in a building or structure described by Subdivision (1).

(b) The association may impose appropriate limits of coverage and deductibles for coverage described by Subsection (a).

(c) The board of directors of the association shall submit any

proposed changes to the plan of operation necessary to implement Subsections (a) and (b) to the commissioner in the manner provided by Section 2210.153.

(d) The commissioner shall adopt rules as necessary to implement this section, including any rules necessary to implement changes in the plan of operation proposed under Subsection (c).

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.062(a), eff. September 1, 2007.

Added by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.062(a), eff. September 1, 2007.

Sec. 2210.210. COVERAGE OF CERTAIN STRUCTURES PROHIBITED. The association may not issue coverage for a wind turbine regardless of whether the turbine could otherwise be considered insurable property under this chapter.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 2 (H.B. 3), Sec. 23, eff. September 28, 2011.

SUBCHAPTER F. PROPERTY INSPECTIONS FOR WINDSTORM AND HAIL INSURANCE

Sec. 2210.251. PLAN OF OPERATION COMPLIANCE REQUIREMENTS. (a) Except as provided by this section, to be considered insurable property eligible for windstorm and hail insurance coverage from the association, a structure that is constructed, altered, remodeled, enlarged, or repaired or to which additions are made on or after January 1, 1988, must comply with the plan of operation.

(b) After January 1, 2004, for geographic areas specified by the commissioner, the commissioner by rule shall adopt the 2003 International Residential Code for one- and two-family dwellings published by the International Code Council. For those geographic areas, the commissioner by rule may adopt a subsequent edition of that code and may adopt any supplements published by the International Code Council and amendments to that code.

(c) Repealed by Acts 2015, 84th Leg., R.S., Ch. 1073 (H.B. 2439), Sec. 9(1), eff. September 1, 2015.

(d) A structure constructed, altered, remodeled, enlarged, or repaired or to which additions were made before January 1, 1988, that is located in an area that was governed at the time of the

construction, alteration, remodeling, enlargement, repair, or addition by a building code recognized by the association is insurable property eligible for windstorm and hail insurance coverage from the association without compliance with the inspection or approval requirements of this section or the plan of operation.

(e) A structure constructed, altered, remodeled, enlarged, or repaired or to which additions were made before January 1, 1988, that is located in an area not governed by a building code recognized by the association is insurable property eligible for windstorm and hail insurance coverage from the association without compliance with the inspection or approval requirements of this section or the plan of operation if the structure was previously insured by an insurer authorized to engage in the business of insurance in this state and the structure is in essentially the same condition as when previously insured, except for normal wear and tear, and is without any structural change other than a change made according to code. For purposes of this subsection, evidence of previous insurance coverage must reflect coverage for the perils of windstorm and hail for the property within the 12-month period immediately preceding the date of the application for coverage through the association and includes:

- (1) a copy of a previous insurance policy;
- (2) copies of canceled checks or agent's records that show payments for previous policies; and
- (3) a copy of the title to the structure or mortgage company records that show previous policies.

(f) Notwithstanding any other provision of this subchapter, insurance coverage for a residential structure may be issued or renewed through the association subject to the inspection requirements imposed under Section 2210.258, if applicable.

(g) A certificate of compliance issued by the department under Section 2210.2515 demonstrates compliance with the applicable building code under the plan of operation. The certificate is evidence of insurability of the structure by the association.

(h) Repealed by Acts 2015, 84th Leg., R.S., Ch. 1073 (H.B. [2439](#)), Sec. 9(1), eff. September 1, 2015.

(i) Repealed by Acts 2015, 84th Leg., R.S., Ch. 1073 (H.B. [2439](#)), Sec. 9(1), eff. September 1, 2015.

(j) Repealed by Acts 2015, 84th Leg., R.S., Ch. 1073 (H.B. [2439](#)), Sec. 9(1), eff. September 1, 2015.

(k) Repealed by Acts 2015, 84th Leg., R.S., Ch. 1073 (H.B. [2439](#))

), Sec. 9(1), eff. September 1, 2015.

(l) Repealed by Acts 2015, 84th Leg., R.S., Ch. 1073 (H.B. 2439), Sec. 9(1), eff. September 1, 2015.

(m) Repealed by Acts 2015, 84th Leg., R.S., Ch. 1073 (H.B. 2439), Sec. 9(1), eff. September 1, 2015.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1408 (H.B. 4409), Sec. 30, eff. September 1, 2009.

Acts 2011, 82nd Leg., 1st C.S., Ch. 2 (H.B. 3), Sec. 24, eff. September 28, 2011.

Acts 2013, 83rd Leg., R.S., Ch. 1228 (S.B. 1702), Sec. 1, eff. June 14, 2013.

Acts 2015, 84th Leg., R.S., Ch. 188 (S.B. 498), Sec. 1, eff. May 28, 2015.

Acts 2015, 84th Leg., R.S., Ch. 1073 (H.B. 2439), Sec. 1, eff. September 1, 2015.

Acts 2015, 84th Leg., R.S., Ch. 1073 (H.B. 2439), Sec. 2, eff. September 1, 2015.

Acts 2015, 84th Leg., R.S., Ch. 1073 (H.B. 2439), Sec. 9(1), eff. September 1, 2015.

Acts 2017, 85th Leg., R.S., Ch. 324 (S.B. 1488), Sec. 10.003, eff. September 1, 2017.

Acts 2019, 86th Leg., R.S., Ch. 525 (S.B. 615), Sec. 11, eff. September 1, 2019.

Acts 2019, 86th Leg., R.S., Ch. 790 (H.B. 1900), Sec. 5, eff. June 10, 2019.

Sec. 2210.2515. ISSUANCE OF CERTIFICATES OF COMPLIANCE. (a) In this section:

(1) "Completed improvement" means:

(A) an improvement in which the original transfer of title from the builder to the initial owner of the improvement has occurred; or

(B) if a transfer under Paragraph (A) is not contemplated, an improvement that is substantially completed.

(2) "Improvement" means the construction of or repair,

alteration, remodeling, or enlargement of a structure to which the plan of operation applies.

(3) "Ongoing improvement" means:

(A) an improvement in which the original transfer of title from the builder to the initial owner of the improvement has not occurred; or

(B) if a transfer under Paragraph (A) is not contemplated, an improvement that is not substantially completed.

(b) A person shall provide written notice on a form prescribed by and submitted to the department of the person's intent to construct, repair, alter, remodel, or enlarge a structure for which the person is seeking coverage under this chapter before the person begins to construct, repair, alter, remodel, or enlarge the structure.

(c) A person may apply to the department on a form prescribed by the department for a certificate of compliance for a completed improvement. The department shall issue a certificate of compliance for a completed improvement if a professional engineer licensed by the Texas Board of Professional Engineers and Land Surveyors:

(1) has designed the improvement, has affixed the engineer's seal on the design, and submits to the department on a form prescribed by the department an affirmation that the design complies with the applicable building code under the plan of operation and that the improvement was constructed in accordance with the design; or

(2) completes and submits to the department a sealed post-construction evaluation report that:

(A) confirms the improvement's compliance with the applicable building code under the plan of operation; and

(B) includes documentation supporting the engineer's post-construction evaluation report on a form prescribed by the department on which the engineer has affixed the engineer's seal.

(c-1) The department may deny an application for a certificate of compliance under Subsection (c) if the evaluation report or the form prescribed by the department under Subsection (c)(1) is not fully documented as required under Subsection (c).

(c-2) A form prescribed by the department under Subsection (c) may not require a professional engineer to assume liability for the construction of an improvement.

(d) A person may apply to the department on a form prescribed

by the department for a certificate of compliance for an ongoing improvement. Except as provided by Subsection (e), the department shall issue a certificate of compliance for an ongoing improvement if a qualified inspector under Section 2210.254 inspects the ongoing improvement in accordance with commissioner rule and affirms that the improvement:

(1) conforms to a design of the improvement that has a seal affixed by a professional engineer licensed by the Texas Board of Professional Engineers and Land Surveyors and complies with the applicable building code under the plan of operation; or

(2) complies with the applicable building code under the plan of operation.

(e) Except as otherwise provided by this subchapter, the department may not issue a certificate of compliance under Subsection (d) if within six months after the date of the final inspection of the structure that is the subject of the application, the department has not received:

(1) fully completed forms prescribed by the department demonstrating that the improvement satisfies the requirements under Subsection (d)(1) or (2); and

(2) payment in full of all inspection fees, including fees for prior department inspections, owed to the department.

(f) Repealed by Acts 2019, 86th Leg., R.S., Ch. 790 (H.B. 1900), Sec. 12, eff. June 10, 2019.

(g) The department may enter into contracts as necessary to implement this section.

(h) The department may charge a reasonable fee to cover the cost of making building requirements and inspection standards available to the public. The department shall charge a reasonable fee for each inspection of each structure under this section in an amount set by the commissioner.

(i) The department is authorized to submit a formal complaint under Chapter 1001, Occupations Code, to the Texas Board of Professional Engineers and Land Surveyors related to the engineering work of a professional engineer as reflected in the sealed post-construction evaluation report or other materials submitted by an engineer under Subsection (c).

(j) If the department finds that a person acting as a qualified inspector under Section 2210.254 has failed to provide complete and accurate information in connection with an inspection for a

certificate of compliance under this section, the department may impose a reasonable penalty on the inspector, including by prohibiting the inspector from applying for certificates of compliance under this section. The commissioner may adopt rules as necessary to implement this subsection.

(k) The department may not rescind a certificate of compliance after issuing the certificate under this section.

Added by Acts 2015, 84th Leg., R.S., Ch. 1073 (H.B. 2439), Sec. 3, eff. September 1, 2015.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 525 (S.B. 615), Sec. 12, eff. September 1, 2019.

Acts 2019, 86th Leg., R.S., Ch. 790 (H.B. 1900), Sec. 6, eff. June 10, 2019.

Acts 2019, 86th Leg., R.S., Ch. 790 (H.B. 1900), Sec. 12, eff. June 10, 2019.

Acts 2019, 86th Leg., R.S., Ch. 1232 (H.B. 1523), Sec. 2.10, eff. September 1, 2019.

Acts 2021, 87th Leg., R.S., Ch. 494 (H.B. 3564), Sec. 1, eff. June 14, 2021.

Acts 2021, 87th Leg., R.S., Ch. 915 (H.B. 3607), Sec. 12.001, eff. September 1, 2021.

Sec. 2210.252. INTERNATIONAL RESIDENTIAL CODE BUILDING SPECIFICATIONS. (a) After January 1, 2004, for geographic areas specified by the commissioner, the commissioner by rule may supplement the plan of operation building specifications with the structural provisions of the International Residential Code for one- and two-family dwellings, as published by the International Code Council or an analogous entity recognized by the department.

(b) For a geographic area specified under Subsection (a), the commissioner by rule may adopt a subsequent edition of the International Residential Code for one- and two-family dwellings and may adopt a supplement published by the International Code Council or an amendment to that code.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2210.253. INSURER ASSESSMENT: FIRST TIER COASTAL COUNTY.

(a) In this section, "property insurance" means a commercial or residential insurance policy prescribed or approved by the department that provides coverage for windstorm and hail damage, including a Texas windstorm and hail insurance policy.

(b) The department shall assess each insurer that provides property insurance in a first tier coastal county in accordance with this section.

(c) The total assessment under this section in a state fiscal year must be in the amount estimated by the department as necessary to cover the administrative costs of the windstorm inspection program under Section 2210.251 to be incurred in the first tier coastal counties in that fiscal year.

(d) The assessment must be based on each insurer's proportionate share of the total extended coverage and other allied lines premium received by all insurers for property insurance in the first tier coastal counties in the calendar year preceding the year in which the assessment is made.

(e) The commissioner shall adopt rules to implement the assessment of insurers under this section.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2210.254. QUALIFIED INSPECTORS. (a) For purposes of this chapter, a "qualified inspector" includes:

(1) a person determined by the department to be qualified because of training or experience to perform building inspections;

(2) a licensed professional engineer; and

(3) an inspector who:

(A) is certified by the International Code Council, the Building Officials and Code Administrators International, Inc., the International Conference of Building Officials, or the Southern Building Code Congress International, Inc.;

(B) has certifications as a buildings inspector and coastal construction inspector; and

(C) complies with other requirements specified by commissioner rule.

(b) A windstorm inspection may be performed only by a qualified

inspector.

(c) Before performing building inspections, a qualified inspector must be approved and appointed or employed by the department.

(d) The department may charge a reasonable fee for the filing of applications by and determining the qualifications of persons for appointment as qualified inspectors.

(e) The department may establish an annual renewal period for persons appointed as qualified inspectors.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2011, 82nd Leg., 1st C.S., Ch. 2 (H.B. 3), Sec. 25, eff. September 28, 2011.

Acts 2015, 84th Leg., R.S., Ch. 1073 (H.B. 2439), Sec. 4, eff. September 1, 2015.

Sec. 2210.2551. ENFORCEMENT AUTHORITY; RULES. (a) The department has exclusive authority over all matters relating to the appointment and oversight of qualified inspectors for purposes of this chapter and to the physical inspection of structures for the purposes of determining whether to issue a certificate of compliance under Section 2210.2515(d), including the submission of documents to the department or association regarding the physical inspection of structures.

(b) The commissioner by rule shall establish criteria to ensure that a person seeking appointment as a qualified inspector under this subchapter possesses the knowledge, understanding, and professional competence to perform windstorm inspections for the issuance of a certificate of compliance under Section 2210.2515(d) and to comply with other requirements of this chapter.

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

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

(d) Repealed by Acts 2015, 84th Leg., R.S., Ch. 1073 , Sec. 9(3), eff. September 1, 2015.

(e) Repealed by Acts 2015, 84th Leg., R.S., Ch. 1073 , Sec. 9(3), eff. September 1, 2015.

(f) The commissioner may not adopt or enforce a rule that requires an engineer to affix the engineer's seal to an inspection form submitted under this subchapter.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 2 (H.B. 3), Sec. 27, eff. September 28, 2011.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1073 (H.B. 2439), Sec. 5, eff. September 1, 2015.

Acts 2015, 84th Leg., R.S., Ch. 1073 (H.B. 2439), Sec. 9(3), eff. September 1, 2015.

Sec. 2210.256. DISCIPLINARY PROCEEDINGS REGARDING APPOINTED INSPECTORS AND CERTAIN OTHER PERSONS. (a) After notice and hearing, the department may revoke an appointment made under Section 2210.254 if the appointee is found to be in violation of this subchapter or a rule of the commissioner adopted under this subchapter.

(a-1) In addition to any other action authorized under this section, the commissioner ex parte may enter an emergency cease and desist order under Chapter 83 against a qualified inspector, or a person acting as a qualified inspector, if:

(1) the commissioner believes that:

(A) the qualified inspector has:

(i) through submitting or failing to submit to the department substantiating information, failed to demonstrate that a structure or a portion of a structure subject to inspection is built to a design that conforms to the requirements described by Section 2210.2515(d); or

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

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

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

(b) The commissioner, instead of revocation, may impose one or more of the following sanctions if the commissioner determines from the facts that the sanction would be fair, reasonable, or equitable:

(1) suspension of the appointment for a specific period, not to exceed one year;

(2) issuance of an order directing the appointee to cease and desist from the specified activity or failure to act determined to be in violation of this subchapter or rules of the commissioner adopted under this subchapter; or

(3) if the commissioner finds that the appointee knowingly, wilfully, fraudulently, or with gross negligence signed or caused to be prepared an inspection report that contains a false or fraudulent statement, issuance of an order directing the appointee to pay within a specified time, not to exceed 60 days, a fine not to exceed \$5,000 for the violation.

(c) A fine paid as a result of an order issued under Subsection (b)(3) shall be deposited in the general revenue fund.

(d) If it is found after a hearing that an appointee has failed to comply with an order issued under Subsection (b), the department shall, unless the order is stayed, revoke the appointment of the person.

(e) The department may informally dispose of any matter under Subsection (a) or (b) by consent order or default.

(f) Repealed by Acts 2015, 84th Leg., R.S., Ch. 1073 , Sec. 9(4), eff. September 1, 2015.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2011, 82nd Leg., 1st C.S., Ch. 2 (H.B. 3), Sec. 28, eff. September 28, 2011.

Acts 2011, 82nd Leg., 1st C.S., Ch. 2 (H.B. 3), Sec. 29, eff. September 28, 2011.

Acts 2015, 84th Leg., R.S., Ch. 1073 (H.B. 2439), Sec. 6, eff. September 1, 2015.

Acts 2015, 84th Leg., R.S., Ch. 1073 (H.B. 2439), Sec. 9(4), eff. September 1, 2015.

Sec. 2210.257. DEPOSIT OF FEES. All fees collected by the department under this subchapter shall be deposited to the credit of the Texas Department of Insurance operating account.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2210.258. COMPLIANCE WITH BUILDING CODES; ELIGIBILITY.

(a) Except as provided by Subsections (c) and (d) and notwithstanding any other provision of this chapter, to be eligible for insurance through the association, all construction, alteration, remodeling, enlargement, and repair of, or addition to, any structure located in the catastrophe area that is begun on or after the effective date of Sections 5 through 49, H.B. 4409, 81st Legislature, Regular Session, 2009, must be performed in compliance with the applicable building code standards, as set forth in the plan of operation.

(b) Except as provided by Subsections (c) and (d), the association may not insure a structure described by Subsection (a) until a certificate of compliance has been issued for the structure in accordance with Section 2210.2515.

(c) The association may insure a residential structure constructed, altered, remodeled, enlarged, repaired, or added to on or after June 19, 2009, that is not in compliance with the applicable building code standards, as set forth in the plan of operation, provided that:

(1) the structure had been insured on or after June 19, 2009, by an insurer in the private market that canceled or nonrenewed the insurance coverage of the structure;

(2) the applicant provides to the association proof that insurance coverage that was issued to the applicant or the previous insured for the structure was canceled or nonrenewed in the private market as described by Subdivision (1); and

(3) no construction, alteration, remodeling, enlargement, or repair of, or addition to, the structure occurred after cancellation or nonrenewal of the coverage and before submission of an application for coverage through the association.

(d) The association may insure a structure described by Subsection (a) for a policy term not to exceed 30 days if an inspection verification form or other inspection form adopted by the department has been issued for the structure for purposes of providing temporary coverage while an applicant seeks to secure a certificate of compliance for the structure if the structure is otherwise insurable property.

Added by Acts 2009, 81st Leg., R.S., Ch. 1408 (H.B. 4409), Sec. 31, eff. June 19, 2009.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 1228 (S.B. 1702), Sec. 2, eff. June 14, 2013.

Acts 2015, 84th Leg., R.S., Ch. 188 (S.B. 498), Sec. 2, eff. May 28, 2015.

Acts 2015, 84th Leg., R.S., Ch. 615 (S.B. 900), Sec. 14, eff. September 1, 2015.

Acts 2015, 84th Leg., R.S., Ch. 1073 (H.B. 2439), Sec. 7, eff. September 1, 2015.

Sec. 2210.259. SURCHARGE FOR CERTAIN NONCOMPLIANT STRUCTURES.

(a) Except as provided by Subsection (a-1), an insurance policy insuring a noncompliant residential structure under Section 2210.251(f) is subject to an annual premium surcharge in an amount equal to 15 percent of the premium for insurance coverage obtained through the association. The surcharge under this subsection applies to each policy issued or renewed by the association on or after the effective date of Sections 5 through 49, H.B. No. 4409, Acts of the 81st Legislature, Regular Session, 2009, and is due on the issuance or renewal of the policy.

(a-1) For a policy insuring a noncompliant residential structure eligible for coverage under Section 2210.258(c), the association shall charge:

(1) a premium based on the rate charged in the voluntary market for the portion of the canceled or nonrenewed policy that provides windstorm and hail insurance coverage for the applicable risk; and

(2) an annual premium surcharge in an amount equal to 10 percent of that premium.

(b) A premium surcharge collected under this section shall be deposited in the catastrophe reserve trust fund. A premium surcharge under this section is a separate nonrefundable charge in addition to the premiums collected and is not subject to premium tax or commissions. Failure to pay the surcharge by a policyholder constitutes failure to pay premium for purposes of policy cancellation.

(c) The commissioner by rule may provide for a discount of, or a credit against, a surcharge assessed under Subsection (a) in instances in which a policyholder demonstrates that the noncompliant structure was constructed with at least one structural building component that complies with the building code standards set forth in the plan of operation.

Added by Acts 2009, 81st Leg., R.S., Ch. 1408 (H.B. 4409), Sec. 31, eff. June 19, 2009.

Amended by:

Acts 2011, 82nd Leg., 1st C.S., Ch. 2 (H.B. 3), Sec. 30, eff. September 28, 2011.

Acts 2013, 83rd Leg., R.S., Ch. 1228 (S.B. 1702), Sec. 4, eff. June 14, 2013.

SUBCHAPTER H. RATES; DISCOUNTS AND CREDITS

Sec. 2210.351. ASSOCIATION FILINGS. (a) The association must file with the department each manual of classifications, rules, rates, including condition charges, and each rating plan, and each modification of those items that the association proposes to use.

(b) A filing under this section must indicate the character and the extent of the coverage contemplated and must be accompanied by the policy and endorsement forms proposed to be used. The forms may be designed specifically for use by the association without regard to other forms filed with, approved by, or prescribed by the department for use in this state.

(c) Except as provided by Subsection (d), as soon as reasonably possible after the filing has been made, the commissioner in writing shall approve or disapprove the filing. A filing is considered approved unless disapproved on or before the 30th day after the date of the filing. If the commissioner disapproves a filing, the commissioner shall state in writing the reasons for the disapproval

and the criteria the association is required to meet to obtain approval.

(d) The association may use a rate filed by the association without prior commissioner approval if:

(1) the filing is made not later than the 30th day before the date of any use or delivery for use of the rate;

(2) the filed rate does not exceed the rate in effect on the date on which the filing is made; and

(3) the commissioner has not disapproved the filing in writing, advising of the reasons for the disapproval and the criteria the association is required to meet to obtain approval.

(e) The department shall value the loss and loss adjustment expense data to be used for a filing not earlier than March 31 of the year before the year in which the filing is to be made.

(f) The association may not file a rate under this section that exceeds the rate in effect on the date on which the filing is made unless two-thirds of the board of directors votes to approve the rate.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1408 (H.B. 4409), Sec. 32, eff. June 19, 2009.

Acts 2021, 87th Leg., R.S., Ch. 147 (S.B. 1448), Sec. 1, eff. September 1, 2021.

Sec. 2210.3511. PUBLIC ACCESS TO RATE ADEQUACY ANALYSIS. (a) The association shall make the association's rate adequacy analysis publicly available on its Internet website for at least 14 days before the date the board of directors votes on the submission of a proposed rate filing based on the analysis to the department. The rate adequacy analysis must include:

(1) all user selected hurricane model input assumptions; and

(2) output data:

(A) with the same content and in the same format that is customarily provided to:

(i) the association by hurricane modelers; and

(ii) the department by the association; and

(B) in a searchable electronic format that allows for efficient analysis and is sufficiently detailed to allow the historical experience in this state to be compared to results produced by the model.

(b) The association shall accept public comment with respect to the association's rate adequacy analysis at a public meeting of the board of directors before the board of directors votes on the submission of a proposed rate filing to the department.

Added by Acts 2019, 86th Leg., R.S., Ch. 525 (S.B. 615), Sec. 13, eff. September 1, 2019.

Added by Acts 2019, 86th Leg., R.S., Ch. 790 (H.B. 1900), Sec. 7, eff. June 10, 2019.

Sec. 2210.3512. REQUIREMENT FOR VOTE ON RATE FILING. The board of directors may not vote on a proposed rate increase if:

- (1) there is a vacancy on the board; and
- (2) the vacancy has existed for at least 60 days at the time the vote is to be taken.

Added by Acts 2021, 87th Leg., R.S., Ch. 639 (H.B. 769), Sec. 1, eff. September 1, 2021.

Sec. 2210.352. MANUAL RATE FILINGS: ANNUAL FILING. (a) Not later than August 15 of each year, the association shall file with the department a proposed manual rate for all types and classes of risks written by the association.

(a-1) The association may use a rate filed by the association under this section without prior commissioner approval if:

- (1) the filing is made not later than the 30th day before the date of any use or delivery for use of the rate; and
- (2) the filed rate does not exceed the rate used by the association in effect on the date on which the filing is made.

(a-2) The association may not file to use a rate described by Subsection (a-1) more than once per year.

(a-3) The association may not file a rate under this section that exceeds the rate in effect on the date on which the filing is made unless two-thirds of the board of directors votes to approve the

rate.

(b) Except as provided by Subsection (a-1), before approving or disapproving a filing under this section, the commissioner shall provide all interested persons a reasonable opportunity to:

- (1) review the filing;
- (2) obtain copies of the filing on payment of any legally required copying cost; and
- (3) submit to the commissioner written comments or information related to the filing.

(c) Except as provided by Subsection (a-1), the commissioner shall approve or disapprove the filing in writing not later than October 15 of the year in which the filing was made. If the filing is not approved or disapproved on or before that date, the filing is considered approved.

(d) Except as provided by Subsection (a-1), if the commissioner disapproves a filing, the commissioner shall state in writing the reasons for the disapproval and the criteria the association is required to meet to obtain approval.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. [2017](#)), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1408 (H.B. [4409](#)), Sec. 33, eff. June 19, 2009.

Acts 2021, 87th Leg., R.S., Ch. 147 (S.B. [1448](#)), Sec. 2, eff. September 1, 2021.

Sec. 2210.353. MANUAL RATE FILINGS: AMENDED ANNUAL FILING.

(a) Not later than the 30th day after the date the association receives the commissioner's written disapproval under Section 2210.352(c), the association may file with the commissioner an amended annual filing that conforms to all criteria stated in that written disapproval.

(b) Not later than the 30th day after the date an amended filing made under Subsection (a) is received, the commissioner shall approve or disapprove the amended filing. If the filing is not disapproved on or before the 30th day after the date of receipt, the filing is considered approved. If the commissioner disapproves a filing, the commissioner shall state in writing the reasons for the

disapproval and the criteria the association is required to meet to obtain approval.

(c) Before approving or disapproving an amended annual filing under this section, the commissioner shall, in the manner provided by Section 2210.352(b), provide all interested persons a reasonable opportunity to:

- (1) review the amended annual filing;
- (2) obtain copies of the amended annual filing on payment of any legally required copying cost; and
- (3) submit to the commissioner written comments or information related to the amended annual filing.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1408 (H.B. 4409), Sec. 34, eff. June 19, 2009.

Sec. 2210.354. MANUAL RATE FILINGS: ADDITIONAL SUPPORTING INFORMATION. (a) In conjunction with the review of a filing under Section 2210.352, other than a filing made under Subsection (a-1) of that section:

- (1) the commissioner may request the association to provide additional supporting information relating to the filing; and
- (2) any interested person may file a written request with the commissioner, during a period specified by the commissioner by rule, for additional supporting information relating to the filing.

(b) A request under this section must be reasonable and must be directly related to the filing.

(c) The commissioner shall submit to the association all requests for additional supporting information made under this section for the commissioner's use and the use of any interested person not later than the 21st day after the date of receipt of the filing.

(d) Unless a different period is requested by the association and approved by the commissioner, the association shall provide the information to the commissioner not later than the fifth day after the date the written request for additional supporting information is delivered to the association.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1408 (H.B. 4409), Sec. 35, eff. June 19, 2009.

Sec. 2210.355. GENERAL RATE REQUIREMENTS; RATE STANDARDS. (a) Rates for coverage under this chapter must be made in accordance with this section.

(b) In adopting rates under this chapter, the following must be considered:

(1) the past and prospective loss experience within and outside this state of hazards for which insurance is made available through the plan of operation, if any;

(2) expenses of operation, including acquisition costs;

(3) a reasonable margin for profit and contingencies;

(4) payment of public security obligations issued under this chapter, including the additional amount of any debt service coverage determined by the association to be required for the issuance of marketable public securities; and

(5) all other relevant factors, within and outside this state.

(c) Rates must be reasonable, adequate, not unfairly discriminatory, and nonconfiscatory as to any class of insurer.

(d) For the establishment of rates and minimum premiums, the risks may be grouped by classification.

(e) Classification rates may be modified to produce rates for individual risks in accordance with rating plans that establish standards for measuring variations in those risks on the basis of any or all of the factors described by Subsection (b). The classification rates may include rules for classification of risks insured under this chapter and rate modifications to those classifications.

(f) Each provision regarding a rate, classification, standard, or premium must be made without prejudice to, or prohibition of, provision by the association for consent rates on individual risks if the rate and risk are acceptable to the association, and are analogous to the rate provided for under Article 5.26(a). This subsection applies regardless of whether such a risk would otherwise

be subject to or the subject of a rate classification provision or eligibility provision.

(g) A commission paid to an agent for a windstorm and hail insurance policy issued by the association must comply with the commission structure approved by the commissioner under Section 2210.203(d) and be reasonable, adequate, not unfairly discriminatory, and nonconfiscatory.

(h) In adopting rates under this chapter, recognized catastrophe models may be considered.

(i) The association may establish rating territories and may vary rates among the territories as provided by this subsection. A rating territory that subdivides a county may be used only if the rate for any subdivision in the county is not more than:

(A) five percent higher than the rate used by the association in 2009 in any other subdivision in the county;

(B) six percent higher than the rate used by the association in 2010 in any other subdivision in the county;

(C) seven percent higher than the rate used by the association in 2011 in any other subdivision in the county; and

(D) eight percent higher than the rate used by the association in 2012 in any other subdivision in the county.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1408 (H.B. 4409), Sec. 36, eff. June 19, 2009.

Acts 2011, 82nd Leg., 1st C.S., Ch. 2 (H.B. 3), Sec. 33, eff. September 28, 2011.

Acts 2015, 84th Leg., R.S., Ch. 615 (S.B. 900), Sec. 16, eff. September 1, 2015.

Sec. 2210.357. RATE CLASSIFICATIONS. All premiums written and losses paid under this chapter, as appropriate, must be included in applicable classifications for general ratemaking purposes.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2210.358. EXPERIENCE DATA. (a) Not later than June 1 of each year, the department shall provide to the association and other interested persons the experience data to be used in establishing the rates under this subchapter in that year.

(b) On request from the department, an insurer shall provide the data to the department or the department may obtain the data from a designated statistical agent, as defined by Section 38.201.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2210.359. LIMITATION ON CERTAIN RATE CHANGES. (a) Except as otherwise provided by this subsection, a rate approved by the commissioner under this subchapter may not reflect an average rate change that is more than 10 percent higher or lower than the rate for commercial windstorm and hail insurance or 10 percent higher or lower than the rate for noncommercial windstorm and hail insurance in effect on the date the filing is made. The rate may not reflect a rate change for an individual rating class that is 15 percent higher or lower than the rate for that individual rating class in effect on the date the filing is made. This subsection does not apply to a rate filed under Sections 2210.351(a)-(d).

(b) The commissioner may, after notice and hearing, suspend this section on a finding that a catastrophe loss or series of occurrences resulting in losses in the catastrophe area justify a need to ensure:

- (1) rate adequacy in the catastrophe area; and
- (2) availability of insurance outside the catastrophe area.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.0631, eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.0631, eff. September 1, 2007.

Sec. 2210.361. ASSOCIATION RECOMMENDATIONS REGARDING REDUCTIONS IN COVERAGES OR INCREASES IN DEDUCTIBLES. (a) The association may

make recommendations to the commissioner that would result in a reduction of coverages or an increase in an applicable deductible if the resultant reduction in coverages or increase in deductibles is accompanied by proposed rate credits.

(b) After notice and hearing, the commissioner may accept or reject a recommendation made by the association under this section.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1408 (H.B. 4409), Sec. 37, eff. June 19, 2009.

Sec. 2210.362. IMPLIED CONSENT BY APPLICANT FOR INSURANCE COVERAGE. For purposes of this chapter, an applicant for insurance coverage is considered to have consented to the appropriate rates and classifications authorized by this chapter regardless of any other rates or classifications.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2210.363. PREMIUM DISCOUNTS; SURCHARGE CREDITS. (a) The association may offer a person insured under this chapter an actuarially justified premium discount on a policy issued by the association, or an actuarially justified credit against a surcharge assessed against the person, other than a surcharge assessed under Subchapter M, if:

(1) the construction, alteration, remodeling, enlargement, or repair of, or an addition to, insurable property exceeds applicable building code standards set forth in the plan of operation; or

(2) the person elects to purchase a binding arbitration endorsement under Section 2210.554.

(b) A premium discount or a credit against a surcharge under Subsection (a)(2) may not exceed 10 percent of the premium for the policy, before the application of the discount.

(c) The commissioner shall adopt rules necessary to implement and enforce this section, including rules defining "actuarially

justified" for the purposes of this section.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 2 (H.B. 3), Sec. 34, eff. September 28, 2011.

**SUBCHAPTER J. CATASTROPHE RESERVE TRUST FUND; REINSURANCE AND
ALTERNATIVE RISK FINANCING**

Sec. 2210.451. DEFINITION. In this subchapter, "trust fund" means the catastrophe reserve trust fund.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2210.452. ESTABLISHMENT AND USE OF TRUST FUND. (a) The commissioner shall adopt rules under which the association makes payments to the catastrophe reserve trust fund. Except as otherwise specifically provided by this section, the trust fund may be used only for purposes directly related to funding the payment of insured losses, including:

(1) funding the obligations of the trust fund under Subchapter B-1; and

(2) purchasing reinsurance or using alternative risk financing mechanisms under Section 2210.453.

(b) All money, including investment income, deposited in the trust fund constitutes state funds until disbursed as provided by this chapter and commissioner rules. The comptroller shall hold the money outside the state treasury on behalf of, and with legal title in, the department. The department shall keep and maintain the trust fund in accordance with this chapter and commissioner rules. The comptroller, as custodian of the trust fund, shall administer the trust fund strictly and solely as provided by this chapter and commissioner rules.

(c) At the end of each calendar year or policy year, the association shall use the net gain from operations of the association, including all premium and other revenue of the association in excess of incurred losses, operating expenses, public security obligations, and public security administrative expenses, to make payments to the trust fund, procure reinsurance, or use alternative risk financing mechanisms, or to make payments to the

trust fund and procure reinsurance or use alternative risk financing mechanisms.

(d) The commissioner by rule shall establish the procedure relating to the disbursement of money from the trust fund to policyholders and for association administrative expenses directly related to funding the payment of insured losses in the event of an occurrence or series of occurrences within a catastrophe area that results in a disbursement under Subchapter B-1.

(e) The trust fund may be terminated only by law. On termination of the trust fund, all assets of the trust fund revert to the state to provide funding for the mitigation and preparedness plan established under Section 2210.454.

(f) The commissioner by rule shall establish the procedure relating to the disbursement of money from the trust fund to pay for operating expenses, including reinsurance or alternative risk financing mechanisms under Section 2210.453, if the association does not have sufficient premium and other revenue.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1408 (H.B. 4409), Sec. 38, eff. June 19, 2009.

Acts 2011, 82nd Leg., 1st C.S., Ch. 2 (H.B. 3), Sec. 35, eff. September 28, 2011.

Acts 2015, 84th Leg., R.S., Ch. 615 (S.B. 900), Sec. 18, eff. September 1, 2015.

Sec. 2210.4521. INVESTMENT OF TRUST FUND BALANCES. (a) The comptroller shall invest in accordance with the investment standard described by Section 404.024(j), Government Code, the portion of the trust fund balance that exceeds the amount of the sufficient balance determined under Subsection (b). The comptroller's investment of that portion of the balance is not subject to any other limitation or other requirement provided by Section 404.024, Government Code.

(b) At least once each 12-month period, the board of directors shall determine a balance for the trust fund that the board considers to be sufficient to meet the cash flow requirements of the fund in funding the payment of insured losses as provided by Section

2210.452(a). After determining that sufficient balance, the board shall provide notice of the sufficient balance to the comptroller.

(c) Not later than the 30th day after the date the board of directors provides notice of the sufficient balance determined under Subsection (b), the comptroller shall adjust the investment portfolio of trust fund money to ensure that only the portion of the fund that exceeds the sufficient balance is invested as required by Subsection (a).

(d) The comptroller shall include the fair market value of the investment portfolio of the trust fund in calculating the amount in the fund for purposes of this chapter.

Added by Acts 2015, 84th Leg., R.S., Ch. 615 (S.B. 900), Sec. 19, eff. September 1, 2015.

Sec. 2210.453. FUNDING LEVELS; REINSURANCE AND ALTERNATIVE RISK FINANCING MECHANISMS; REINSURANCE FROM CERTAIN INSURER OR BROKER PROHIBITED. (a) The association may purchase reinsurance or use alternative risk financing mechanisms or both as necessary.

(b) The association shall maintain total available loss funding in an amount not less than the probable maximum loss for the association for a catastrophe year with a probability of one in 100. If necessary, the required funding level shall be achieved through the purchase of reinsurance or the use of alternative financing mechanisms, or both, to operate in addition to or in concert with the trust fund, public securities, financial instruments, and assessments authorized by this chapter.

(c) The attachment point for reinsurance purchased under this section may not be less than the aggregate amount of all funding available to the association under Subchapter B-1.

(d) The cost of the reinsurance purchased or alternative financing mechanisms used under this section in excess of the minimum funding level required by Subsection (b) shall be paid by assessments as provided by this subsection. The association, with the approval of the commissioner, shall notify each member of the association of the amount of the member's assessment under this subsection. The proportion of the cost to each insurer under this subsection shall be determined in the manner used to determine each insurer's participation in the association for the year under Section 2210.052.

(e) A member of the association may not recoup an assessment paid under Subsection (d) through a premium surcharge or tax credit.

(f) The association may not purchase reinsurance under this section from an insurer or broker involved in the execution of a catastrophe model on which the association relies in:

(1) determining the probable maximum loss applicable for the period covered by the reinsurance; or

(2) adopting rates under Section 2210.355.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1408 (H.B. 4409), Sec. 39, eff. June 19, 2009.

Acts 2011, 82nd Leg., 1st C.S., Ch. 2 (H.B. 3), Sec. 36, eff. September 28, 2011.

Acts 2015, 84th Leg., R.S., Ch. 615 (S.B. 900), Sec. 20, eff. September 1, 2015.

Acts 2019, 86th Leg., R.S., Ch. 790 (H.B. 1900), Sec. 8, eff. June 10, 2019.

Acts 2021, 87th Leg., R.S., Ch. 639 (H.B. 769), Sec. 2, eff. September 1, 2021.

Acts 2021, 87th Leg., R.S., Ch. 639 (H.B. 769), Sec. 3, eff. September 1, 2021.

Sec. 2210.454. MITIGATION AND PREPAREDNESS PLAN. (a) The commissioner shall annually develop and implement a mitigation and preparedness plan.

(b) Each state fiscal year, the department may fund the mitigation and preparedness plan using available funds.

(c) The mitigation and preparedness plan must provide for actions to be taken in the seacoast territory by the commissioner, or by a local government, state agency, educational institution, or nonprofit organization designated by the commissioner in the plan, to implement programs to:

(1) improve preparedness for windstorm and hail catastrophes;

(2) reduce potential losses in the event of such a catastrophe; and

- (3) provide research into the means to:
- (A) reduce those losses;
 - (B) educate or inform the public in determining the appropriateness of particular upgrades to structures; or
 - (C) protect infrastructure from potential damage from those catastrophes.

(d) Money in excess of \$1 million may not be used under this section if the commissioner determines that an expenditure of investment income from the trust fund would jeopardize the actuarial soundness of the fund or materially impair the ability of the fund to serve the state purposes for which the fund was established.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1408 (H.B. 4409), Sec. 40, eff. June 19, 2009.

Sec. 2210.455. CATASTROPHE PLAN. (a) Not later than June 1 of each year, the board shall submit to the commissioner, the legislative oversight board established under Subchapter N, the governor, the lieutenant governor, and the speaker of the house of representatives a catastrophe plan covering the period beginning on the date the plan is submitted and ending on the following May 31.

(b) The catastrophe plan must:

(1) describe the manner in which the association will, during the period covered by the plan, evaluate losses and process claims after the following windstorms affecting an area of maximum exposure to the association:

(A) a windstorm with a four percent chance of occurring during the period covered by the plan;

(B) a windstorm with a two percent chance of occurring during the period covered by the plan; and

(C) a windstorm with a one percent chance of occurring during the period covered by the plan; and

(2) include, if the association does not purchase reinsurance under Section 2210.453 for the period covered by the plan, an actuarial plan for paying losses in the event of a catastrophe with estimated damages of \$2.5 billion or more.

(c) The catastrophe plan must include a description of how losses under association policies will be paid, and how claims under association policies will be administered and adjusted, during the period covered by the plan.

(d) The catastrophe plan submitted under this section is for informational purposes only and does not bind the association to a particular course of action.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 2 (H.B. 3), Sec. 37, eff. September 28, 2011.

SUBCHAPTER K. LIABILITY LIMITS

Sec. 2210.501. MAXIMUM LIABILITY LIMITS. (a) The board of directors shall propose the maximum liability limits under a windstorm and hail insurance policy issued by the association under this chapter. The maximum liability limits are considered approved by the commissioner unless the commissioner disapproves or modifies the liability limits by order issued not later than the 30th day after the date of receipt of a filing under Section 2210.503.

(b) Subject to Section 2210.502, the maximum liability limits for coverage on a single insurable property may not be less than:

(1) \$350,000 for:

(A) a dwelling, including an individually owned townhouse unit; and

(B) the corporeal movable property located in or about the dwelling and, as an extension of coverage, away from those premises, as provided under the policy;

(2) \$2,192,000 for a building, and the corporeal movable property located in the building, if the building is:

(A) owned by, and at least 75 percent of which is occupied by, a governmental entity; or

(B) not owned by, but is wholly and exclusively occupied by, a governmental entity;

(3) \$125,000 for individually owned corporeal movable property located in an apartment unit, residential condominium unit, or townhouse unit that is occupied by the owner of that property and, as an extension of coverage, away from those premises, as provided under the policy; and

(4) \$1,500,000 for:

(A) a structure other than a dwelling or a public building; and

(B) the corporeal movable property located in that structure and, as an extension of coverage, away from those premises, as provided under the policy.

(c) Maximum liability limits for insurable property not described by Subsection (b) are established by the plan of operation.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 307 (H.B. 1902), Sec. 1, eff. September 1, 2019.

Sec. 2210.502. ADJUSTMENTS TO MAXIMUM LIABILITY LIMITS. (a) Not later than September 30 of each year, the board of directors shall propose inflation adjustments to the maximum liability limits imposed under Section 2210.501 in increments of \$1,000, rounded to the nearest \$1,000, considering the limits imposed by Section 2210.501(b), at a rate that reflects any change in the BOECKH Index. If the BOECKH Index ceases to exist, the board of directors shall propose the adjustments in the same manner based on another index that the board of directors determines accurately reflects changes in the cost of construction or residential values in the catastrophe area.

(b) An adjustment to the maximum liability limits that is approved by the commissioner applies to each windstorm and hail insurance policy delivered, issued for delivery, or renewed on or after January 1 of the year following the date of the approval. The indexing of the limits shall adjust for changes occurring on and after January 1, 1997.

(c) The board of directors may propose additional increases in the maximum liability limits as the board determines necessary to implement the purposes of this chapter.

(d) Notwithstanding Section 2210.501(b), the maximum liability limit imposed under Section 2210.501(b)(2) is frozen, and the indexing and adjustments provided by this section do not apply to that limit, until the limit imposed on a structure subject to Section 2210.501(b)(4) and the corporeal property located in that structure

reaches or exceeds \$2,192,000, at which time the limit imposed under Section 2210.501(b)(2) shall be indexed and adjusted as provided for a risk under Section 2210.501(b)(4).

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2210.503. FILING OF PROPOSED ADJUSTMENTS WITH COMMISSIONER. Not later than the 10th day after the date a proposed adjustment to the maximum liability limits is determined under Section 2210.501(a) or (b) or Section 2210.502, the association shall file the proposed adjustments with the commissioner in writing. The filing must include:

- (1) a statement of the proposed adjusted limits;
- (2) a statement of the limits in effect immediately preceding the effective date of the proposed adjustment;
- (3) a brief summary of the changes to the BOECKH Index or other index on which the proposed adjustments are based; and
- (4) a brief summary of the computations used in determining the proposed adjustments.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2210.504. COMMISSIONER ACTION ON PROPOSED ADJUSTMENTS.

(a) Not later than the 30th day after the date the commissioner disapproves or modifies a filing under Section 2210.503, and after notice and hearing, the commissioner by order shall approve, disapprove, or modify the proposed adjustment to the maximum liability limits.

(b) Notwithstanding Subsection (a) and Sections 2210.501(c), 2210.502(a)-(c), and 2210.503, the commissioner may not approve adjustments of maximum liability limits to amounts lower than the amounts prescribed under Section 2210.501(b).

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 307 (H.B. 1902), Sec. 2, eff.

September 1, 2019.

Sec. 2210.505. REINSURED EXCESS LIMITS. (a) Notwithstanding any other law, the association may issue a windstorm and hail insurance policy that includes coverage for an amount in excess of a maximum liability limit established under Sections 2210.501-2210.504 if the association first obtains from a reinsurer approved by the commissioner reinsurance for the full amount of policy exposure above that limit.

(b) The premium charged by the association for the excess coverage must equal the amount of the reinsurance premium charged to the association by the reinsurer, plus any payment to the association that is approved by the commissioner.

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

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2210.506. EXCEPTION FROM CERTAIN ADMINISTRATIVE PROCEDURES. Chapter 40 does not apply to an action taken under this subchapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER L. CERTAIN APPEALS AND OTHER ACTIONS

Sec. 2210.551. APPEALS. (a) This section:

(1) does not apply to:

(A) a person who is required to resolve a dispute under Subchapter L-1; or

(B) a person insured under this chapter who has elected to purchase a binding arbitration endorsement offered by the association under Section 2210.554; and

(2) applies only to:

(A) a person not described by Subdivision (1) who is insured under this chapter or an authorized representative of the person; or

(B) an affected insurer.

(b) A person or entity described by Subsection (a)(2) who is aggrieved by an act, ruling, or decision of the association may appeal to the commissioner not later than the 30th day after the date of that act, ruling, or decision.

(c) If the association is aggrieved by the action of the commissioner with respect to a ruling, order, or determination of the commissioner, the association may, not later than the 30th day after the date of the action, make a written request to the commissioner for a hearing on the action.

(d) On 10 days' written notice of the time and place of the hearing, the commissioner shall conduct a hearing on the association's request or the appeal from an act, ruling, or decision of the association, not later than the 30th day after the date of receipt of the request or appeal.

(e) Repealed by Acts 2011, 82nd Leg., 1st C.S., Ch. 2, Sec. 57, eff. September 28, 2011.

(f) Not later than the 30th day after the date of the hearing, the commissioner shall affirm, reverse, or modify the commissioner's previous action or the act, ruling, or decision appealed to the commissioner. Pending the hearing and decision, the commissioner may suspend or postpone the effective date of the previous action or of the act, ruling, or decision appealed to the commissioner.

(g) The association, or the person or entity aggrieved by the order or decision of the commissioner, may appeal to a district court in the county in which the covered property is located or a district court in Travis County.

(h) An action brought under this section is subject to the procedures established under Subchapter D, Chapter 36.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2011, 82nd Leg., 1st C.S., Ch. 2 (H.B. 3), Sec. 39, eff. September 28, 2011.

Acts 2011, 82nd Leg., 1st C.S., Ch. 2 (H.B. 3), Sec. 57, eff. September 28, 2011.

Sec. 2210.554. VOLUNTARY ARBITRATION OF CERTAIN COVERAGE AND

CLAIM DISPUTES. (a) A person insured under this chapter may elect to purchase a binding arbitration endorsement in a form prescribed by the commissioner. A person who elects to purchase an endorsement under this section must arbitrate a dispute involving an act, ruling, or decision of the association relating to the payment of, the amount of, or the denial of the claim.

(b) An arbitration under this section shall be conducted in the manner and under rules and deadlines prescribed by the commissioner by rule.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 2 (H.B. 3), Sec. 40, eff. September 28, 2011.

SUBCHAPTER L-1. CLAIMS: SETTLEMENT AND DISPUTE RESOLUTION

Sec. 2210.571. DEFINITIONS. In this subchapter:

(1) "Association policy" means a windstorm and hail insurance policy issued by the association.

(2) "Claim" means a request for payment under an association policy. The term also includes any other claim against the association, or an agent or representative of the association, relating to an insured loss, under any theory or cause of action of any kind, regardless of the theory under which the claim is asserted, the cause of action brought, or the type of damages sought.

(3) "Claimant" means a person who makes a claim.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 2 (H.B. 3), Sec. 41, eff. September 28, 2011.

Sec. 2210.572. EXCLUSIVE REMEDIES AND LIMITATION ON AWARD. (a) This subchapter provides the exclusive remedies for a claim against the association, including an agent or representative of the association.

(b) Subject to Section 2210.576, the association may not be held liable for any amount other than covered losses payable under the terms of the association policy.

(c) The association, and an agent or representative of the association, may not be held liable for damages under Chapter 17, Business & Commerce Code, or, except as otherwise specifically provided by this chapter, under any provision of any law providing

for additional damages, punitive damages, or a penalty.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 2 (H.B. 3), Sec. 41, eff. September 28, 2011.

Sec. 2210.573. FILING OF CLAIM; CLAIM PROCESSING. (a) Subject to Section 2210.205(b), an insured must file a claim under an association policy not later than the first anniversary of the date on which the damage to property that is the basis of the claim occurs.

(b) The claimant may submit written materials, comments, documents, records, and other information to the association relating to the claim. If the claimant fails to submit information in the claimant's possession that is necessary for the association to determine whether to accept or reject a claim, the association may, not later than the 30th day after the date the claim is filed, request in writing the necessary information from the claimant.

(c) The association shall, on request, provide a claimant reasonable access to all information relevant to the determination of the association concerning the claim. The claimant may copy the information at the claimant's own cost or may request the association to provide a copy of all or part of the information to the claimant. The association may charge a claimant the actual cost incurred by the association in providing a copy of information under this section, excluding any amount for labor involved in making any information or copy of information available to a claimant.

(d) Unless the applicable 60-day period described by this subsection is extended by the commissioner under Section 2210.581, not later than the later of the 60th day after the date the association receives a claim or the 60th day after the date the association receives information requested under Subsection (b), the association shall provide the claimant, in writing, notification that:

- (1) the association has accepted coverage for the claim in full;
- (2) the association has accepted coverage for the claim in part and has denied coverage for the claim in part; or
- (3) the association has denied coverage for the claim in full.

(e) In a notice described by Subsection (d)(1), the association must inform the claimant of the amount of loss the association will pay and of the time limit to request appraisal under Section 2210.574.

(f) In a notice described by Subsection (d)(2) or (3), the association must inform the claimant of, as applicable:

(1) the portion of the loss for which the association accepts coverage and the amount of loss the association will pay;

(2) the portion of the loss for which the association denies coverage and a detailed summary of the manner in which the association determined not to accept coverage for that portion of the claim; and

(3) the time limit to:

(A) request appraisal under Section 2210.574 of the portion of the loss for which the association accepts coverage; and

(B) provide notice of intent to bring an action as required by Section 2210.575.

(f-1) In a notice described by Subsection (d)(1) or (2), the association must include additional information concerning the availability of supplemental payments under the policy, including:

(1) a description of the process for requesting a supplemental payment; and

(2) applicable deadlines related to supplemental payments.

(g) In addition to the notice required under Subsection (d)(2) or (3), the association shall provide a claimant with a form on which the claimant may provide the association notice of intent to bring an action as required by Section 2210.575.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 2 (H.B. 3), Sec. 41, eff. September 28, 2011.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 525 (S.B. 615), Sec. 14, eff. September 1, 2019.

Sec. 2210.5731. PAYMENT OF CLAIM. (a) Except as provided by Subsection (b), if the association notifies a claimant under Section 2210.573(d)(1) or (2) that the association has accepted coverage for a claim in full or has accepted coverage for a claim in part, the association shall pay the accepted claim or accepted portion of the

claim not later than the 10th day after the date notice is made.

(b) If payment of the accepted claim or accepted portion of the claim is conditioned on the performance of an act by the claimant, the association shall pay the claim not later than the 10th day after the date the act is performed.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 2 (H.B. 3), Sec. 41, eff. September 28, 2011.

Sec. 2210.5732. SUPPLEMENTAL PAYMENTS. (a) The association is authorized to provide for supplemental payments under a windstorm and hail insurance policy issued by the association.

(b) The commissioner shall adopt rules clarifying the deadlines related to supplemental payments. The commissioner shall solicit and consider comments from the association, association members, and policyholders in adopting rules under this section.

(c) The rules adopted under this section must ensure that a request for supplemental payment will not impair a policyholder's right to appraisal under Section 2210.574.

Added by Acts 2019, 86th Leg., R.S., Ch. 525 (S.B. 615), Sec. 15, eff. September 1, 2019.

Sec. 2210.574. DISPUTES CONCERNING AMOUNT OF ACCEPTED COVERAGE.

(a) If the association accepts coverage for a claim in full and a claimant disputes only the amount of loss the association will pay for the claim, or if the association accepts coverage for a claim in part and a claimant disputes the amount of loss the association will pay for the accepted portion of the claim, the claimant may request from the association a detailed summary of the manner in which the association determined the amount of loss the association will pay.

(b) If a claimant disputes the amount of loss the association will pay for a claim or a portion of a claim, the claimant, not later than the 60th day after the date the claimant receives the notice described by Section 2210.573(d)(1) or (2), may demand appraisal in accordance with the terms of the association policy.

(c) If a claimant, on a showing of good cause and not later than the 15th day after the expiration of the 60-day period described by Subsection (b), requests in writing that the 60-day period be

extended, the association may grant an additional 30-day period in which the claimant may demand appraisal.

(d) If a claimant demands appraisal under this section:

(1) the appraisal must be conducted as provided by the association policy;

(2) the claimant and the association are responsible in equal shares for paying any costs incurred or charged in connection with the appraisal, including a fee charged under Subsection (e); and

(3) the appraisal must be completed within the period established under Subsection (d-1).

(d-1) In consultation with the association, the commissioner shall adopt rules establishing the period in which an appraisal demanded under this section must be completed. In adopting the rules, the commissioner shall:

(1) allow flexibility for an adequate investigation of the claim that is the subject of the appraisal; and

(2) consider the time necessary to preserve the independence of the appraisers.

(e) If a claimant demands appraisal under this section and the appraiser retained by the claimant and the appraiser retained by the association are able to agree on an appraisal umpire to participate in the resolution of the dispute, the appraisal umpire is the umpire chosen by the two appraisers. If the appraiser retained by the claimant and the appraiser retained by the association are unable to agree on an appraisal umpire to participate in the resolution of the dispute, the commissioner shall select an appraisal umpire from a roster of qualified umpires maintained by the department. The department may:

(1) require appraisers to register with the department as a condition of being placed on the roster of umpires; and

(2) charge a reasonable registration fee to defray the cost incurred by the department in maintaining the roster and the commissioner in selecting an appraisal umpire under this subsection.

(f) Except as provided by Subsection (g), the appraisal decision is binding on the claimant and the association as to the amount of loss the association will pay for a fully accepted claim or the accepted portion of a partially accepted claim and is not appealable or otherwise reviewable. A claimant that does not demand appraisal before the expiration of the periods described by Subsections (b) and (c) waives the claimant's right to contest the

association's determination of the amount of loss the association will pay with reference to a fully accepted claim or the accepted portion of a partially accepted claim.

(g) A claimant or the association may, not later than the second anniversary of the date of an appraisal decision, file an action in a district court in the county in which the loss that is the subject of the appraisal occurred to vacate the appraisal decision and begin a new appraisal process if:

(1) the appraisal decision was obtained by corruption, fraud, or other undue means;

(2) the rights of the claimant or the association were prejudiced by:

(A) evident partiality by an appraisal umpire;

(B) corruption in an appraiser or appraisal umpire; or

(C) misconduct or wilful misbehavior of an appraiser or appraisal umpire; or

(3) an appraiser or appraisal umpire:

(A) exceeded the appraiser's or appraisal umpire's powers;

(B) refused to postpone the appraisal after a showing of sufficient cause for the postponement;

(C) refused to consider evidence material to the claim;

or

(D) conducted the appraisal in a manner that substantially prejudiced the rights of the claimant or the association.

(h) Except as provided by Subsection (g), a claimant may not bring an action against the association with reference to a claim for which the association has accepted coverage in full.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 2 (H.B. 3), Sec. 41, eff. September 28, 2011.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 600 (H.B. 3310), Sec. 1, eff. September 1, 2023.

Sec. 2210.5741. REPLACEMENT COST COVERAGE CLAIM PROCESSING.

(a) After the association accepts coverage for a claim in full or in part, a claimant whose association policy includes replacement cost

coverage for the claim may request the replacement cost payment by submitting to the association documentation of the cost and completion of the repairs related to the claim not later than the 545th day after the date the claimant receives a notification under Section 2210.573(d)(1) or (2).

(b) Not later than the 30th day after the date the association receives documentation under Subsection (a), the association shall provide the claimant, in writing, notification of:

(1) the amount of the replacement cost payment the association will make; and

(2) the deadline to request appraisal under this section.

(c) The association shall pay the amount described by Subsection (b)(1) not later than the 10th day after the date notification is provided under Subsection (b).

(d) If a claimant has not demanded appraisal with respect to a claim under Section 2210.574 and the claimant disputes the replacement cost amount the association will pay with respect to the claim, the claimant may demand appraisal of the replacement cost amount not later than the 30th day after the date the claimant receives the notification under Subsection (b). A claimant may demand appraisal under this section without regard to whether all repairs related to the claim are complete.

(e) Except with respect to the deadlines applicable to an appraisal under this section, the appraisal under this section shall be conducted in the same manner as an appraisal demanded under Section 2210.574.

(f) If a claimant's association policy includes replacement cost coverage, the written notification provided to the claimant under Section 2210.573(d)(1) or (2) must notify the claimant of the deadlines under this section for:

(1) completing repairs and submitting documentation under Subsection (a); and

(2) demanding appraisal under this section.

Added by Acts 2019, 86th Leg., R.S., Ch. 790 (H.B. 1900), Sec. 9, eff. June 10, 2019.

Sec. 2210.575. DISPUTES CONCERNING DENIED COVERAGE. (a) If the association denies coverage for a claim in part or in full and

the claimant disputes that determination, the claimant, not later than the expiration of the limitations period described by Section 2210.577(a), but after the date the claimant receives the notice described by Section 2210.573(d)(2) or (3), must provide the association with notice that the claimant intends to bring an action against the association concerning the partial or full denial of the claim.

(b) If a claimant provides notice of intent to bring an action under Subsection (a), the association may require the claimant, as a prerequisite to filing the action against the association, to submit the dispute to alternative dispute resolution by mediation or moderated settlement conference, as provided by Chapter 154, Civil Practice and Remedies Code. A claimant that does not provide notice of intent to bring an action before the expiration of the period described by Subsection (a) waives the claimant's right to contest the association's partial or full denial of coverage and is barred from bringing an action against the association concerning the denial of coverage.

(c) The association must request alternative dispute resolution of a dispute described by Subsection (b) not later than the 60th day after the date the association receives from the claimant notice of intent to bring an action.

(d) Alternative dispute resolution under this section must be completed not later than the 60th day after the date a request for alternative dispute resolution is made under Subsection (c). The 60-day period described by this subsection may be extended by the commissioner by rule in accordance with Section 2210.581 or by the association and a claimant by mutual consent.

(e) If the claimant is not satisfied after completion of alternative dispute resolution, or if alternative dispute resolution is not completed before the expiration of the 60-day period described by Subsection (d) or any extension under that subsection, the claimant may bring an action against the association in a district court in the county in which the loss that is the subject of the coverage denial occurred. An action brought under this subsection shall be presided over by a judge appointed by the judicial panel on multidistrict litigation designated under Section 74.161, Government Code. A judge appointed under this section must be an active judge, as defined by Section 74.041, Government Code, who is a resident of the county in which the loss that is the basis of the disputed denied

coverage occurred or of a first tier coastal county or a second tier coastal county adjacent to the county in which that loss occurred.

(f) If a claimant brings an action against the association concerning a partial or full denial of coverage, the court shall abate the action until the notice of intent to bring an action has been provided and, if requested by the association, the dispute has been submitted to alternative dispute resolution, in accordance with this section.

(g) A moderated settlement conference under this section may be conducted by a panel consisting of one or more impartial third parties.

(h) If the association requests mediation under this section, the claimant and the association are responsible in equal shares for paying any costs incurred or charged in connection with the mediation.

(i) If the association requests mediation under this section, and the claimant and the association are able to agree on a mediator, the mediator is the mediator agreed to by the claimant and the association. If the claimant and the association are unable to agree on a mediator, the commissioner shall select a mediator from a roster of qualified mediators maintained by the department. The department may:

(1) require mediators to register with the department as a condition of being placed on the roster; and

(2) charge a reasonable registration fee to defray the cost incurred by the department in maintaining the roster and the commissioner in selecting a mediator under this section.

(j) The commissioner shall establish rules to implement this section, including provisions for expediting alternative dispute resolution, facilitating the ability of a claimant to appear with or without counsel, establishing qualifications necessary for mediators to be placed on the roster maintained by the department under Subsection (i), and providing that formal rules of evidence shall not apply to the proceedings.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 2 (H.B. 3), Sec. 41, eff. September 28, 2011.

Sec. 2210.576. ISSUES BROUGHT TO SUIT; LIMITATIONS ON RECOVERY.

(a) The only issues a claimant may raise in an action brought against the association under Section 2210.575 are:

(1) whether the association's denial of coverage was proper; and

(2) the amount of the damages described by Subsection (b) to which the claimant is entitled, if any.

(b) Except as provided by Subsections (c) and (d), a claimant that brings an action against the association under Section 2210.575 may recover only:

(1) the covered loss payable under the terms of the association policy less, if applicable, the amount of loss already paid by the association for any portion of a covered loss for which the association accepted coverage;

(2) prejudgment interest from the first day after the date specified in Section 2210.5731 by which the association was or would have been required to pay an accepted claim or the accepted portion of a claim, at the prejudgment interest rate provided in Subchapter B, Chapter 304, Finance Code; and

(3) court costs and reasonable and necessary attorney's fees.

(c) Nothing in this chapter, including Subsection (b), may be construed to limit the consequential damages, or the amount of consequential damages, that a claimant may recover under common law in an action against the association.

(d) A claimant that brings an action against the association under Section 2210.575 may, in addition to the covered loss described by Subsection (b)(1) and any consequential damages recovered by the claimant under common law, recover damages in an amount not to exceed the aggregated amount of the covered loss described by Subsection (b)(1) and the consequential damages recovered under common law if the claimant proves by clear and convincing evidence that the association mishandled the claimant's claim to the claimant's detriment by intentionally:

(1) failing to meet the deadlines or timelines established under this subchapter without good cause, including the applicable deadline established under Section 2210.5731 for payment of an accepted claim or the accepted portion of a claim;

(2) disregarding applicable guidelines published by the commissioner under Section 2210.578(f);

(3) failing to provide the notice required under Section

2210.573(d);

(4) rejecting a claim without conducting a reasonable investigation with respect to the claim; or

(5) denying coverage for a claim in part or in full if the association's liability has become reasonably clear as a result of the association's investigation with respect to the portion of the claim that was denied.

(e) For purposes of Subsection (d), "intentionally" means actual awareness of the facts surrounding the act or practice listed in Subsection (d)(1), (2), (3), (4), or (5), coupled with the specific intent that the claimant suffer harm or damages as a result of the act or practice. Specific intent may be inferred from objective manifestations that the association acted intentionally or from facts that show that the association acted with flagrant disregard of the duty to avoid the acts or practices listed in Subsection (d)(1), (2), (3), (4), or (5).

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 2 (H.B. 3), Sec. 41, eff. September 28, 2011.

Sec. 2210.577. LIMITATIONS PERIOD. (a) Notwithstanding any other law, a claimant who brings an action against the association under Section 2210.575 must bring the action not later than the second anniversary of the date on which the person receives a notice described by Section 2210.573(d)(2) or (3).

(b) This section is a statute of repose and controls over any other applicable limitations period.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 2 (H.B. 3), Sec. 41, eff. September 28, 2011.

Sec. 2210.578. EXPERT PANEL. (a) The commissioner shall appoint a panel of experts to advise the association concerning the extent to which a loss to insurable property was incurred as a result of wind, waves, tidal surges, or rising waters not caused by waves or surges. The panel shall consist of a number of experts to be decided by the commissioner. The commissioner shall appoint one member of the panel to serve as the presiding officer of the panel.

(b) Members of the panel must have professional expertise in,

and be knowledgeable concerning, the geography and meteorology of the Texas seacoast territory, as well as the scientific basis for determining the extent to which damage to property is caused by wind, waves, tidal surges, or rising waters not caused by waves or surges.

(c) The panel shall meet at the request of the commissioner or the call of the presiding officer of the panel.

(d) The panel shall investigate, collect, and evaluate the information necessary to provide recommendations under Subsection (e). The cost and expense incurred by the panel associated with the work of the panel under this section shall be paid or reimbursed by the association.

(e) At the request of the commissioner, the panel shall recommend to the commissioner methods or models for determining the extent to which a loss to insurable property may be or was incurred as a result of wind, waves, tidal surges, or rising waters not caused by waves or surges for geographic areas or regions designated by the commissioner.

(f) After consideration of the recommendations made by the panel under Subsection (e), the commissioner shall publish guidelines that the association will use to settle claims.

(g) A member of the panel is not individually liable for an act or failure to act in the performance of the official duties in connection with the individual's work on the panel.

(h) In any review of a claim under this subchapter, and in any action brought against the association under Section 2210.575, the guidelines published by the commissioner under Subsection (f) govern the claim and are presumed to be accurate and correct, unless clear and convincing evidence supports a deviation from the guidelines.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 2 (H.B. 3), Sec. 41, eff. September 28, 2011.

Sec. 2210.579. CONSTRUCTION WITH OTHER LAW. (a) To the extent of any conflict between a provision of this subchapter and any other law, the provision of this subchapter prevails.

(b) Notwithstanding any other law, the association may not bring an action against a claimant, for declaratory or other relief, before the 180th day after the date an appraisal under Section 2210.574, or alternate dispute resolution under Section 2210.575, is

completed.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 2 (H.B. 3), Sec. 41, eff. September 28, 2011.

Sec. 2210.580. RULEMAKING. (a) The commissioner shall adopt rules regarding the provisions of this subchapter, including rules concerning:

(1) qualifications and selection of appraisers for the appraisal procedure, mediators for the mediation process, and members of the expert panel;

(2) procedures and deadlines for the payment and handling of claims by the association as well as the procedures and deadlines for a review of a claim by the association;

(3) notice of expert panel meetings and the transparency of deliberations of the panel; and

(4) any other matters regarding the handling of claims that are not inconsistent with this subchapter.

(b) All rules adopted by the commissioner under this section shall promote the fairness of the process, protect the rights of aggrieved policyholders, and ensure that policyholders may participate in the claims review process without the necessity of engaging legal counsel.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 2 (H.B. 3), Sec. 41, eff. September 28, 2011.

Sec. 2210.581. COMMISSIONER EXTENSION OF DEADLINES. (a) Subject to Subsection (b), the commissioner, on a showing of good cause, may by rule:

(1) extend any deadline established under this subchapter; and

(2) set the length of the extension.

(b) With reference to deadlines applicable to the association only, all deadline extensions related to claims arising from an occurrence may not exceed 120 days in the aggregate. This subsection does not affect the extension of a deadline applicable to a claimant or to both the association and a claimant.

(c) For the purposes of Subsection (a), "good cause" includes

military deployment.

(d) The commissioner shall adopt rules as necessary to implement this section. Section 2001.0045, Government Code, does not apply to rules adopted under this section.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 2 (H.B. 3), Sec. 41, eff. September 28, 2011.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 140 (H.B. 1944), Sec. 1, eff. September 1, 2019.

Acts 2019, 86th Leg., R.S., Ch. 790 (H.B. 1900), Sec. 10, eff. June 10, 2019.

Acts 2021, 87th Leg., R.S., Ch. 915 (H.B. 3607), Sec. 12.002, eff. September 1, 2021.

Acts 2021, 87th Leg., R.S., Ch. 915 (H.B. 3607), Sec. 12.003, eff. September 1, 2021.

Sec. 2210.582. OMBUDSMAN PROGRAM. (a) The department shall establish an ombudsman program to provide information and educational programs to assist persons insured under this chapter with the claim processes under this subchapter.

(b) Not later than March 1 of each year, the department shall prepare and submit to the commissioner a budget for the ombudsman program, including approval of all expenditures incurred in administering and operating the program. The commissioner shall adopt or modify and adopt the budget not later than April 1 of the year in which the budget is submitted.

(c) Not later than May 1 of each year, the association shall transfer to the ombudsman program money in an amount equal to the amount of the budget adopted under Subsection (b). The ombudsman program, not later than April 30 of each year, shall return to the association any unexpended funds that the program received from the association in the previous year.

(d) The department shall, not later than 60 days after the date of a catastrophic event, prepare and submit an amended budget to the commissioner for approval and report to the commissioner the approximate number of claimants eligible for ombudsman services. The commissioner shall adopt rules as necessary to implement an amended budget submitted under this section, including rules regarding the

transfer of additional money from the association to the program.

(e) The ombudsman program may provide to persons insured under this chapter information and educational programs through:

- (1) informational materials;
- (2) toll-free telephone numbers;
- (3) public meetings;
- (4) outreach centers;
- (5) the Internet; and
- (6) other reasonable means.

(f) The ombudsman program is administratively attached to the department. The department shall provide the staff, services, and facilities necessary for the ombudsman program to operate, including:

- (1) administrative assistance and service, including budget planning and purchasing;
- (2) personnel services;
- (3) office space; and
- (4) computer equipment and support.

(g) The ombudsman program shall prepare and make available to each person insured under this chapter information describing the functions of the ombudsman program.

(h) The association, in the manner prescribed by the commissioner by rule, shall notify each person insured under this chapter concerning the operation of the ombudsman program.

(i) The commissioner may adopt rules as necessary to implement this section.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 2 (H.B. 3), Sec. 41, eff. September 28, 2011.

SUBCHAPTER M. PUBLIC SECURITIES PROGRAM

Sec. 2210.601. PURPOSE. The legislature finds that authorizing the issuance of public securities to provide a method to raise funds to provide windstorm and hail insurance through the association in certain designated portions of the state is for the benefit of the public and in furtherance of a public purpose.

Added by Acts 2009, 81st Leg., R.S., Ch. 1408 (H.B. 4409), Sec. 41, eff. June 19, 2009.

Sec. 2210.602. DEFINITIONS. In this subchapter:

(1) "Authority" means the Texas Public Finance Authority.

(1-a) "Board" means the board of directors of the Texas Public Finance Authority.

(1-b) "Catastrophic event" means an occurrence or a series of occurrences that occurs in a catastrophe area during a calendar year and that results in insured losses and operating expenses of the association in excess of premium and other revenue of the association.

(2) "Class 1 public securities" means public securities authorized to be issued by Section 2210.072, including a commercial paper program authorized before the occurrence of a catastrophic event.

(2-a) "Class 1 public security trust fund" means the dedicated trust fund established by the board and held by the Texas Treasury Safekeeping Trust Company into which premium surcharges collected under Section 2210.612 for the purpose of paying Class 1 public securities are deposited.

(3) "Class 2 public securities" means public securities authorized to be issued on or after the occurrence of a catastrophic event by Section 2210.073.

(3-a) "Class 2 public security trust fund" means the dedicated trust fund established by the board and held by the Texas Treasury Safekeeping Trust Company into which premium surcharges collected under Section 2210.613 for the purpose of paying Class 2 public securities are deposited.

(4) "Class 3 public securities" means public securities authorized to be issued on or after the occurrence of a catastrophic event by Section 2210.0741.

(4-a) "Class 3 public security trust fund" means the dedicated trust fund established by the board and held by the Texas Treasury Safekeeping Trust Company into which premium surcharges collected under Section 2210.6131 for the purpose of paying Class 3 public securities are deposited.

(5) "Credit agreement" has the meaning assigned by Chapter 1371, Government Code.

(5-a) Repealed by Acts 2015, 84th Leg., R.S., Ch. 615 , Sec. 31(2), eff. September 1, 2015.

(6) Repealed by Acts 2015, 84th Leg., R.S., Ch. 615 , Sec. 31(2), eff. September 1, 2015.

(6-b) Repealed by Acts 2015, 84th Leg., R.S., Ch. 615 , Sec. 31(2), eff. September 1, 2015.

(6-c) Repealed by Acts 2015, 84th Leg., R.S., Ch. 615 , Sec. 31(2), eff. September 1, 2015.

(7) "Public security" means a debt instrument or other public security issued by the Texas Public Finance Authority.

(8) "Public security administrative expenses" means expenses incurred to administer public securities issued under this subchapter, including fees for credit enhancement, paying agents, trustees, and attorneys, and for other professional services.

(9) "Public security obligations" means the principal of a public security and any premium and interest on a public security issued under this subchapter, together with any amount owed under a related credit agreement.

(10) Repealed by Acts 2015, 84th Leg., R.S., Ch. 615 , Sec. 31(2), eff. September 1, 2015.

(11) "Public security resolution" means the resolution or order authorizing public securities to be issued under this subchapter.

Added by Acts 2009, 81st Leg., R.S., Ch. 1408 (H.B. 4409), Sec. 41, eff. June 19, 2009.

Amended by:

Acts 2011, 82nd Leg., 1st C.S., Ch. 2 (H.B. 3), Sec. 42, eff. September 28, 2011.

Acts 2015, 84th Leg., R.S., Ch. 615 (S.B. 900), Sec. 21, eff. September 1, 2015.

Acts 2015, 84th Leg., R.S., Ch. 615 (S.B. 900), Sec. 31(2), eff. September 1, 2015.

Sec. 2210.603. APPLICABILITY OF OTHER LAWS. (a) The board shall issue the public securities as described by Section 2210.604 in accordance with and subject to the requirements of Chapter 1232, Government Code, other than Section 1232.108 of that chapter, and in accordance with and subject to other provisions of Title 9, Government Code, that apply to issuance of a public security by a state agency. In the event of a conflict, this subchapter controls.

(b) A purpose for which public securities are issued under this chapter constitutes an eligible project for purposes of Chapter 1371,

Government Code.

Added by Acts 2009, 81st Leg., R.S., Ch. 1408 (H.B. 4409), Sec. 41, eff. June 19, 2009.

Sec. 2210.604. ISSUANCE OF PUBLIC SECURITIES AUTHORIZED. (a) At the request of the association and with the approval of the commissioner, the Texas Public Finance Authority shall issue Class 1, Class 2, or Class 3 public securities. The association shall submit to the commissioner a cost-benefit analysis of various financing methods and funding structures when requesting the issuance of public securities under this subsection.

(a-1) The association and the commissioner must approve each tranche of commercial paper issued under a commercial paper program established under this chapter.

(b) The association shall specify in the association's request to the board the maximum principal amount of the public securities and the maximum term of the public securities.

(c) The principal amount determined by the association under Subsection (b) may be increased to include an amount sufficient to:

- (1) pay the costs related to issuance of the public securities;
- (2) provide a public security reserve fund;
- (3) capitalize interest for the period determined necessary by the association, not to exceed two years; and
- (4) provide the amount of debt service coverage for public securities determined by the association, in consultation with the authority, to be required for the issuance of marketable public securities.

Added by Acts 2009, 81st Leg., R.S., Ch. 1408 (H.B. 4409), Sec. 41, eff. June 19, 2009.

Amended by:

Acts 2011, 82nd Leg., 1st C.S., Ch. 2 (H.B. 3), Sec. 43, eff. September 28, 2011.

Sec. 2210.605. TERMS OF ISSUANCE. (a) The board shall determine the method of sale, type and form of public security, maximum interest rates, and other terms of the public securities

that, in the board's judgment, best achieve the goals of the association and effect the borrowing at the lowest practicable cost. The board may enter into a credit agreement in connection with the public securities.

(b) Public securities must be issued by the board on behalf of the association.

(c) Repealed by Acts 2015, 84th Leg., R.S., Ch. 615 , Sec. 31(3), eff. September 1, 2015.

Added by Acts 2009, 81st Leg., R.S., Ch. 1408 (H.B. 4409), Sec. 41, eff. June 19, 2009.

Amended by:

Acts 2011, 82nd Leg., 1st C.S., Ch. 2 (H.B. 3), Sec. 44, eff. September 28, 2011.

Acts 2015, 84th Leg., R.S., Ch. 615 (S.B. 900), Sec. 31(3), eff. September 1, 2015.

Sec. 2210.606. ADDITIONAL COVENANTS. The board may make additional covenants with respect to the public securities and the designated income and receipts of the association pledged to their payment, and provide for the flow of funds and the establishment, maintenance, and investment of funds and accounts with respect to the public securities, and the administration of those funds and accounts, as provided in the proceedings authorizing the public securities.

Added by Acts 2009, 81st Leg., R.S., Ch. 1408 (H.B. 4409), Sec. 41, eff. June 19, 2009.

Sec. 2210.607. PUBLIC SECURITY PROCEEDS. The proceeds of public securities issued by the board under this subchapter may be deposited with the Texas Treasury Safekeeping Trust Company.

Added by Acts 2009, 81st Leg., R.S., Ch. 1408 (H.B. 4409), Sec. 41, eff. June 19, 2009.

Sec. 2210.608. USE OF PUBLIC SECURITY PROCEEDS. (a) Public security proceeds, including investment income, shall be held in

trust for the exclusive use and benefit of the association. The association may use the proceeds to:

- (1) pay incurred claims and operating expenses of the association;
- (2) purchase reinsurance for the association;
- (3) pay the costs of issuing the public securities, and public security administrative expenses, if any;
- (4) provide a public security reserve;
- (5) pay capitalized interest and principal on the public securities for the period determined necessary by the association;
- (6) pay private financial agreements entered into by the association as temporary sources of payment of losses and operating expenses of the association; and
- (7) reimburse the association for any cost described by Subdivisions (1)-(6) paid by the association before issuance of the public securities.

(b) Any excess public security proceeds remaining after the purposes for which the public securities were issued are satisfied may be used to purchase or redeem outstanding public securities. If there are no outstanding public security obligations or public security administrative expenses, the excess proceeds shall be transferred to the catastrophe reserve trust fund.

(c) Notwithstanding Subsection (a)(2), the proceeds from public securities issued under Section 2210.072 before an occurrence or series of occurrences that results in incurred losses, including investment income, may not be used to purchase reinsurance for the association.

Added by Acts 2009, 81st Leg., R.S., Ch. 1408 (H.B. 4409), Sec. 41, eff. June 19, 2009.

Amended by:

Acts 2011, 82nd Leg., 1st C.S., Ch. 2 (H.B. 3), Sec. 45, eff. September 28, 2011.

Sec. 2210.609. REPAYMENT OF ASSOCIATION'S PUBLIC SECURITY OBLIGATIONS. (a) The board and the association shall enter into an agreement under which the association shall provide for the payment of all public security obligations from available funds collected by the association and deposited as required by this subchapter. If the

association determines that it is unable to pay the public security obligations and public security administrative expenses, if any, with available funds, the association shall pay those obligations and expenses in accordance with Sections 2210.612, 2210.613, and 2210.6131 as applicable. Class 1, Class 2, or Class 3 public securities may be issued on a parity or subordinate lien basis with other Class 1, Class 2, or Class 3 public securities, respectively.

(b) If any public securities issued under this chapter are outstanding, the authority shall notify the association of the amount of the public security obligations and the estimated amount of public security administrative expenses, if any, each calendar year in a period sufficient, as determined by the association, to permit the association to determine the availability of funds and assess a premium surcharge if necessary.

(c) The association shall deposit all revenue collected under Section 2210.612 in the Class 1 public security trust fund, all revenue collected under Section 2210.613 in the Class 2 public security trust fund, and all revenue collected under Section 2210.6131 in the Class 3 public security trust fund. Money deposited in a fund may be invested as permitted by general law. Money in a fund required to be used to pay public security obligations and public security administrative expenses, if any, shall be transferred to the appropriate funds in the manner and at the time specified in the proceedings authorizing the public securities to ensure timely payment of obligations and expenses. This may include the board establishing funds and accounts with the comptroller that the board determines are necessary to administer and repay the public security obligations. If the association has not transferred amounts sufficient to pay the public security obligations to the board's designated interest and sinking fund in a timely manner, the board may direct the Texas Treasury Safekeeping Trust Company to transfer from the Class 1 public security trust fund, the Class 2 public security trust fund, or the Class 3 public security trust fund to the appropriate account the amount necessary to pay the public security obligation.

(d) The association shall provide for the payment of the public security obligations and the public security administrative expenses by irrevocably pledging revenues received from premiums, premium surcharges, and amounts on deposit in the Class 1 public security trust fund, the Class 2 public security trust fund, and the Class 3

public security trust fund, together with any public security reserve fund, as provided in the proceedings authorizing the public securities and related credit agreements.

(e) An amount owed by the board under a credit agreement shall be payable from and secured by a pledge of revenues received by the association from the Class 1 public security trust fund, the Class 2 public security trust fund, and the Class 3 public security trust fund to the extent provided in the proceedings authorizing the credit agreement.

Added by Acts 2009, 81st Leg., R.S., Ch. 1408 (H.B. 4409), Sec. 41, eff. June 19, 2009.

Amended by:

Acts 2011, 82nd Leg., 1st C.S., Ch. 2 (H.B. 3), Sec. 46, eff. September 28, 2011.

Acts 2015, 84th Leg., R.S., Ch. 615 (S.B. 900), Sec. 22, eff. September 1, 2015.

Sec. 2210.610. PUBLIC SECURITY PAYMENTS. (a) Revenues received from the premium surcharges under Sections 2210.612, 2210.613, and 2210.6131 may be applied only as provided by this subchapter.

(b) The association may pay public security obligations with other legally available funds.

(c) Public security obligations are payable only from sources provided for payment in this subchapter.

Added by Acts 2009, 81st Leg., R.S., Ch. 1408 (H.B. 4409), Sec. 41, eff. June 19, 2009.

Amended by:

Acts 2011, 82nd Leg., 1st C.S., Ch. 2 (H.B. 3), Sec. 47, eff. September 28, 2011.

Acts 2015, 84th Leg., R.S., Ch. 615 (S.B. 900), Sec. 23, eff. September 1, 2015.

Sec. 2210.611. EXCESS REVENUE COLLECTIONS AND INVESTMENT EARNINGS. Revenue collected in any calendar year from a premium surcharge under Sections 2210.612, 2210.613, and 2210.6131 that exceeds the amount of the public security obligations and public

security administrative expenses payable in that calendar year and interest earned on the funds may, in the discretion of the association, be:

(1) used to pay public security obligations payable in the subsequent calendar year, offsetting the amount of the premium surcharge that would otherwise be required to be levied for the year under this subchapter;

(2) used to redeem or purchase outstanding public securities; or

(3) deposited in the catastrophe reserve trust fund.

Added by Acts 2009, 81st Leg., R.S., Ch. 1408 (H.B. 4409), Sec. 41, eff. June 19, 2009.

Amended by:

Acts 2011, 82nd Leg., 1st C.S., Ch. 2 (H.B. 3), Sec. 48, eff. September 28, 2011.

Acts 2015, 84th Leg., R.S., Ch. 615 (S.B. 900), Sec. 24, eff. September 1, 2015.

Sec. 2210.612. PAYMENT OF CLASS 1 PUBLIC SECURITIES. (a) The association shall pay Class 1 public securities issued under Section 2210.072 from:

(1) net premium and other revenue; and

(2) if net premium and other revenue are not sufficient to pay the securities, a catastrophe area premium surcharge collected in accordance with this section.

(b) On approval by the commissioner, the association shall assess, as provided by this section, a premium surcharge to each policyholder of a policy described by Subsection (c). The premium surcharge must be set in an amount sufficient to pay, for the duration of the issued public securities, all debt service not already covered by available funds and all related expenses on the public securities.

(c) The premium surcharge under this section shall be assessed on all policyholders of association policies issued under this chapter.

(d) A premium surcharge under this section is a separate charge in addition to the premiums collected and is not subject to premium tax or commissions. Failure by a policyholder to pay the surcharge

constitutes failure to pay premium for purposes of policy cancellation.

(e) The association may enter financing arrangements as described by Section 2210.072(d) as necessary to obtain public securities issued under Section 2210.072. Nothing in this subsection shall prevent the authorization and creation of one or more programs for the issuance of commercial paper before the date of an occurrence or series of occurrences that results in insured losses under Section 2210.072(a).

Added by Acts 2009, 81st Leg., R.S., Ch. 1408 (H.B. 4409), Sec. 41, eff. June 19, 2009.

Amended by:

Acts 2011, 82nd Leg., 1st C.S., Ch. 2 (H.B. 3), Sec. 49, eff. September 28, 2011.

Acts 2015, 84th Leg., R.S., Ch. 615 (S.B. 900), Sec. 25, eff. September 1, 2015.

Sec. 2210.613. PAYMENT OF CLASS 2 PUBLIC SECURITIES. (a) The association shall pay Class 2 public securities issued under Section 2210.073 from:

(1) net premium and other revenue; and
(2) if net premium and other revenue are not sufficient to pay the securities, a catastrophe area premium surcharge collected in accordance with this section.

(b) On approval by the commissioner, the association shall assess, as provided by this section, a premium surcharge to each policyholder of a policy described by Subsection (c). The premium surcharge must be set in an amount sufficient to pay, for the duration of the issued public securities, all debt service not already covered by available funds and all related expenses on the public securities.

(c) The premium surcharge under this section shall be assessed on all policyholders of association policies issued under this chapter.

(d) A premium surcharge under this section is a separate charge in addition to the premiums collected and is not subject to premium tax or commissions. Failure by a policyholder to pay the surcharge constitutes failure to pay premium for purposes of policy

cancellation.

Added by Acts 2009, 81st Leg., R.S., Ch. 1408 (H.B. 4409), Sec. 41, eff. June 19, 2009.

Amended by:

Acts 2011, 82nd Leg., 1st C.S., Ch. 2 (H.B. 3), Sec. 50, eff. September 28, 2011.

Acts 2015, 84th Leg., R.S., Ch. 615 (S.B. 900), Sec. 26, eff. September 1, 2015.

Sec. 2210.6131. PAYMENT OF CLASS 3 PUBLIC SECURITIES. (a) The association shall pay Class 3 public securities issued under Section 2210.0741 from:

- (1) net premium and other revenue; and
- (2) if net premium and other revenue are not sufficient to pay the securities, a catastrophe area premium surcharge collected in accordance with this section.

(b) On approval by the commissioner, the association shall assess, as provided by this section, a premium surcharge to each policyholder of a policy described by Subsection (c). The premium surcharge must be set in an amount sufficient to pay, for the duration of the issued public securities, all debt service not already covered by available funds and all related expenses on the public securities.

(c) The premium surcharge under this section shall be assessed on all policyholders of association policies issued under this chapter.

(d) A premium surcharge under this section is a separate charge in addition to the premiums collected and is not subject to premium tax or commissions. Failure by a policyholder to pay the surcharge constitutes failure to pay premium for purposes of policy cancellation.

Added by Acts 2015, 84th Leg., R.S., Ch. 615 (S.B. 900), Sec. 27, eff. September 1, 2015.

Sec. 2210.6132. CONTINGENT SOURCE OF PAYMENT FOR CLASS 2 AND CLASS 3 PUBLIC SECURITIES. (a) The commissioner may determine, in consultation with the board and the authority, that:

(1) the authority is unable to issue Class 2 or Class 3 public securities to be payable under Section 2210.613 or 2210.6131, as applicable; or

(2) the issuance of Class 2 or Class 3 public securities to be payable under Section 2210.613 or 2210.6131, as applicable, is financially unreasonable for the association.

(b) If the commissioner makes a determination under Subsection (a), the commissioner shall order the Class 2 or Class 3 public securities, as applicable, to be paid by a premium surcharge assessed by each insurer, the association, and the Texas FAIR Plan Association on all policyholders of policies that are in effect on or after the 180th day after the date the commissioner issues the order. The premium surcharge must be set in an amount sufficient to pay all debt service not already covered by available funds and all related expenses on the public securities.

(c) The premium surcharge under this section shall be assessed on all policyholders of policies that cover insured property that is located in a catastrophe area, including automobiles principally garaged in a catastrophe area. The premium surcharge shall be assessed on each Texas windstorm and hail insurance policy and each property and casualty policy, including an automobile insurance policy, issued for automobiles and other property located in the catastrophe area. A premium surcharge under Subsection (b) applies to:

(1) all policies written under the following lines of insurance:

- (A) fire and allied lines;
- (B) farm and ranch owners;
- (C) residential property insurance;
- (D) private passenger automobile liability and physical damage insurance; and
- (E) commercial automobile liability and physical damage insurance; and

(2) the property insurance portion of a commercial multiple peril insurance policy.

Added by Acts 2015, 84th Leg., R.S., Ch. 615 (S.B. 900), Sec. 27, eff. September 1, 2015.

Sec. 2210.614. REFINANCING PUBLIC SECURITIES. The association may request the board to refinance any public securities issued in accordance with Subchapter B-1, whether Class 1, Class 2, or Class 3 public securities, with public securities payable from the same sources as the original public securities.

Added by Acts 2009, 81st Leg., R.S., Ch. 1408 (H.B. 4409), Sec. 41, eff. June 19, 2009.

Sec. 2210.615. SOURCE OF PAYMENT; STATE DEBT NOT CREATED. (a) A public security or credit agreement is payable solely from revenue as provided by this subchapter.

(b) A public security issued under this subchapter, and any related credit agreement, is not a debt of this state or any state agency or political subdivision of this state, and does not constitute a pledge of the faith and credit of this state or any state agency or political subdivision of this state.

(c) Each public security, and any related credit agreement, issued under this subchapter must state on the security's face that:

(1) neither the state nor a state agency, political corporation, or political subdivision of the state is obligated to pay the principal of or interest on the public security except as provided by this subchapter; and

(2) neither the faith and credit nor the taxing power of the state or any state agency, political corporation, or political subdivision of the state is pledged to the payment of the principal of or interest on the public security.

Added by Acts 2009, 81st Leg., R.S., Ch. 1408 (H.B. 4409), Sec. 41, eff. June 19, 2009.

Sec. 2210.616. STATE NOT TO IMPAIR PUBLIC SECURITY OBLIGATIONS.

(a) The state pledges for the benefit and protection of financing parties, the board, and the association that the state will not take or permit any action that would:

(1) impair the collection of premium surcharges or the deposit of those funds into the applicable trust fund;

(2) reduce, alter, or impair the premium surcharges to be imposed, collected, and remitted to financing parties until the

principal, interest, and premium, and any other charges incurred and contracts to be performed in connection with the related public securities, have been paid and performed in full; or

(3) in any way impair the rights and remedies of the public security owners until the public securities are fully discharged.

(b) A party issuing public securities under this subchapter may include the pledge described by Subsection (a) in any documentation relating to those securities.

Added by Acts 2009, 81st Leg., R.S., Ch. 1408 (H.B. 4409), Sec. 41, eff. June 19, 2009.

Amended by:

Acts 2011, 82nd Leg., 1st C.S., Ch. 2 (H.B. 3), Sec. 53, eff. September 28, 2011.

Acts 2015, 84th Leg., R.S., Ch. 615 (S.B. 900), Sec. 28, eff. September 1, 2015.

Sec. 2210.6165. PROPERTY RIGHTS. If public securities issued under this subchapter are outstanding, the rights and interests of the association, a successor to the association, any member of the association, or any member of the Texas FAIR Plan Association, including the right to impose, collect, and receive a premium surcharge authorized under this subchapter, are only contract rights until those revenues are first pledged for the repayment of the association's public security obligations as provided by Section 2210.609.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 2 (H.B. 3), Sec. 54, eff. September 28, 2011.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 615 (S.B. 900), Sec. 29, eff. September 1, 2015.

Sec. 2210.617. ENFORCEMENT BY MANDAMUS. A writ of mandamus and any other legal and equitable remedies are available to a party at interest to require the association or another party to fulfill an agreement and to perform functions and duties under:

- (1) this subchapter;
- (2) the Texas Constitution; or

(3) a relevant public security resolution.

Added by Acts 2009, 81st Leg., R.S., Ch. 1408 (H.B. 4409), Sec. 41, eff. June 19, 2009.

Sec. 2210.618. EXEMPTION FROM TAXATION. A public security issued under this subchapter, any transaction relating to the public security, and profits made from the sale of the public security are exempt from taxation by this state or by a municipality or other political subdivision of this state.

Added by Acts 2009, 81st Leg., R.S., Ch. 1408 (H.B. 4409), Sec. 41, eff. June 19, 2009.

Sec. 2210.619. NO PERSONAL LIABILITY. The members of the association, members of the association board of directors, association employees, the board, the employees of the Texas Public Finance Authority, the commissioner, and department employees are not personally liable as a result of exercising the rights and responsibilities granted under this subchapter.

Added by Acts 2009, 81st Leg., R.S., Ch. 1408 (H.B. 4409), Sec. 41, eff. June 19, 2009.

Sec. 2210.620. AUTHORIZED INVESTMENTS. Public securities issued under this subchapter are authorized investments under:

- (1) Subchapter B, Chapter 424;
- (2) Subchapter C, Chapter 425; and
- (3) Sections 425.203-425.213.

Added by Acts 2009, 81st Leg., R.S., Ch. 1408 (H.B. 4409), Sec. 41, eff. June 19, 2009.

SUBCHAPTER N. LEGISLATIVE OVERSIGHT BOARD

Sec. 2210.651. DEFINITION. In this subchapter, "board" means the windstorm insurance legislative oversight board.

Added by Acts 2009, 81st Leg., R.S., Ch. 1408 (H.B. 4409), Sec. 41, eff. June 19, 2009.

Sec. 2210.652. COMPOSITION OF BOARD. The windstorm insurance legislative oversight board is composed of eight members as follows:

(1) four members of the senate appointed by the lieutenant governor, including the chairperson of the Senate Business and Commerce Committee, who shall serve as co-chairperson of the board; and

(2) four members of the house of representatives appointed by the speaker of the house of representatives.

Added by Acts 2009, 81st Leg., R.S., Ch. 1408 (H.B. 4409), Sec. 41, eff. June 19, 2009.

Sec. 2210.653. POWERS AND DUTIES OF BOARD. (a) The board shall:

(1) receive information about rules proposed by the department relating to windstorm insurance and may submit comments to the commissioner on the proposed rules;

(2) monitor windstorm insurance in this state, including:

(A) the adequacy of rates;

(B) the operation of the association; and

(C) the availability of coverage; and

(3) review recommendations for legislation proposed by the department or the association.

(b) The board may request reports and other information from the department and the association as necessary to implement this subchapter.

Added by Acts 2009, 81st Leg., R.S., Ch. 1408 (H.B. 4409), Sec. 41, eff. June 19, 2009.

Sec. 2210.654. REPORT. (a) Not later than November 15 of each even-numbered year, the board shall report on the board's activities under Section 2210.653 to:

(1) the governor;

(2) the lieutenant governor; and

(3) the speaker of the house of representatives.

(b) The report must include:

(1) an analysis of any problems identified; and

(2) recommendations for any legislative action necessary to address those problems and to foster stability, availability, and competition within the windstorm insurance industry.

Added by Acts 2009, 81st Leg., R.S., Ch. 1408 (H.B. 4409), Sec. 41, eff. June 19, 2009.

SUBCHAPTER O. DEPOPULATION PROGRAM

Sec. 2210.701. DEPOPULATION PROGRAM. (a) The association shall administer, subject to commissioner approval, a depopulation program that encourages the transfer of association policies to insurers through the voluntary market or assumption reinsurance.

(b) An insurer engaged in the business of property and casualty insurance in this state may elect to participate in the depopulation program.

Added by Acts 2015, 84th Leg., R.S., Ch. 615 (S.B. 900), Sec. 30, eff. September 1, 2015.

Sec. 2210.702. ASSUMPTION REINSURANCE DEPOPULATION. (a) The association shall make available to insurers who elect to participate in the depopulation program association policy information necessary for the insurers to determine whether to reinsure a policy ceded to the insurer by the association. The commissioner shall by rule establish the information that is necessary to provide to an insurer under this subsection.

(b) If an insurer elects to reinsure a policy under this section, the reinsurance must be provided as assumption reinsurance by novation and the insurer is legally and contractually responsible for the association policy ceded to the insurer on the effective date of the reinsurance agreement regardless of whether the association continues to provide some services on the policy. The association is not liable under the policy on and after the effective date of the assumption reinsurance agreement. Except as specifically provided in an agreement between the association and the insurer, the insurer shall administer the policy and process, adjust, and pay claims in

accordance with the policy.

(c) If an insurer elects to provide reinsurance under this section, the insurer shall comply with the applicable provisions of Chapters 202 and 493.

Added by Acts 2015, 84th Leg., R.S., Ch. 615 (S.B. 900), Sec. 30, eff. September 1, 2015.

Sec. 2210.703. RENEWAL OF REINSURED POLICIES; COMPARABLE COVERAGE. (a) An insurer electing to offer a policy under Section 2210.702 shall offer a renewal of that policy to the association policyholder for each of the next three years subject to the insurer's rate and underwriting guidelines as filed under this code.

(b) An insurer may not offer a policy to an association policyholder under this section unless the policy contains generally comparable coverage and premiums to the association policy as determined by commissioner rule. The premiums for a policy of generally comparable coverage may not exceed 115 percent of the premiums for the association policy.

(c) Subchapter L-1 does not apply to a policy renewed under this section.

Added by Acts 2015, 84th Leg., R.S., Ch. 615 (S.B. 900), Sec. 30, eff. September 1, 2015.

Sec. 2210.704. CONFIDENTIALITY OF INFORMATION; USE OF POLICYHOLDER'S AGENT. (a) An insurer may use information concerning a specific policy or insured provided by the association under Section 2210.702(a) only for the purposes of this subchapter and may not use or disclose the information for any other purpose.

(b) If an insurer elects to renew a policy for an association policyholder identified from information provided to the insurer under Section 2210.702, the insurer must offer the policy through the insurance agent of record for the association policyholder under the prevailing terms, conditions, and commissions of the agent.

(c) An insurer that offers to renew a policy under Section 2210.703 shall allow the policyholder's agent to enter into a limited service agreement with the insurer for the agent to continue to provide services to the policyholder.

Added by Acts 2015, 84th Leg., R.S., Ch. 615 (S.B. 900), Sec. 30, eff. September 1, 2015.

Sec. 2210.705. TRANSFER OF POLICIES. The commissioner shall by rule establish the procedure for the transfer of reinsured policies. The rules may not contain deadlines that require a property and casualty insurer or agent or a policyholder to take action or make a decision on or after June 1 or before December 1 in any year. The rule must provide that a reinsurance agreement include:

(1) the opportunity for the policyholder to opt out of the reinsurance agreement not more than 60 days after the policyholder receives notice of the reinsurance agreement;

(2) a transfer of the earned premium on a reinsured policy to a trust account to be held until the expiration of the opt-out period described by Subdivision (1) when the earned premium for the final reinsured policy will be transferred to the reinsurer;

(3) a period of not less than 60 days for the agent of record to accept an appointment or other written agreement with the reinsurer; and

(4) any other requirements as the commissioner determines necessary for the protection of policyholders and the policyholders' agents.

Added by Acts 2015, 84th Leg., R.S., Ch. 615 (S.B. 900), Sec. 30, eff. September 1, 2015.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 525 (S.B. 615), Sec. 16, eff. September 1, 2019.

CHAPTER 2211. FAIR PLAN

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 2211.001. DEFINITIONS. In this chapter:

(1) "Association" means the FAIR Plan Association established under this chapter.

(2) "FAIR Plan" means a Fair Access to Insurance Requirements Plan established under Section 2211.051.

(3) "Governing committee" means the governing committee of the association.

(4) "Inspection bureau" means the organization or organizations designated by the association under Section 2211.153.

(5) "Insurer" means an authorized insurer writing property insurance in this state, including:

(A) a Lloyd's plan; and

(B) a reciprocal or interinsurance exchange.

(6) "Net direct premiums" means gross direct written premiums less return premiums on canceled contracts, regardless of reinsurance assumed or ceded, written on residential property under this chapter.

(6-a) "Property owners' association insurance" means property and liability insurance covering:

(A) common areas and facilities of a homeowners' association; or

(B) common elements of a condominium owners' association.

(7) "Residential property insurance" means the coverage provided by a homeowners insurance policy, residential fire and allied lines insurance policy, or farm and ranch owners insurance policy against loss incurred to real or tangible personal property at a fixed location.

(8) "Underserved area" or "underserved areas" means an area or areas designated as underserved by the commissioner by rule.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 44 (H.B. 998), Sec. 1, eff. September 1, 2023.

Sec. 2211.002. IMMUNITY. Liability does not exist on the part of, and a cause of action does not arise against, an insurer, the inspection bureau, the association, the governing committee, the commissioner, an authorized representative of the commissioner, or an agent or employee of an insurer, the inspection bureau, the association, or the governing committee for:

(1) an inspection required by this chapter;

(2) an act or omission in connection with an inspection; or

(3) a statement made:

- (A) in a report and communication concerning the insurability of property;
- (B) in the determinations required by this subchapter or Subchapter B, C, D, or F; or
- (C) at a hearing conducted in connection with an inspection.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2211.003. APPEALS; JUDICIAL REVIEW. (a) An applicant or affected insurer is entitled to appeal to the association. The association's decision may be appealed to the commissioner not later than the 30th day after the date of the decision.

(b) An order or decision made by the commissioner under this chapter is subject to judicial review in accordance with Subchapter D, Chapter 36.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER B. ESTABLISHMENT AND ADMINISTRATION OF FAIR PLAN

Sec. 2211.051. ESTABLISHMENT OF FAIR PLAN. (a) The commissioner may establish a Fair Access to Insurance Requirements Plan to deliver residential property insurance to residents of this state in underserved areas if the commissioner determines, after a public hearing, that:

(1) in all or any part of the state, residential property insurance is not reasonably available in the voluntary market to a substantial number of insurable risks; or

(2) at least 25 percent of the applicants to the residential property market assistance program who are qualified under that program's plan of operation have not been placed with an insurer in the preceding six months.

(b) The commissioner may include in the plan established under Subsection (a) the delivery of property owners' association insurance in underserved areas as provided by Section 2211.1515 if the commissioner determines, after notice and a hearing, that in all or any part of the area designated under Section 2211.1515(a), property

owners' association insurance is not reasonably available in the voluntary market to a substantial number of insurable risks.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.065(a), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.065(a), eff. September 1, 2007.

Acts 2023, 88th Leg., R.S., Ch. 44 (H.B. 998), Sec. 2, eff. September 1, 2023.

Sec. 2211.052. ADMINISTRATION OF FAIR PLAN; COMPOSITION OF GOVERNING COMMITTEE. (a) The governing committee shall administer the FAIR Plan under a plan of operation.

(b) The governing committee is composed of 11 members appointed by the commissioner as follows:

- (1) five members who represent the interests of insurers;
- (2) four public members who reside in this state; and
- (3) two members who are general property and casualty agents.

(c) The commissioner or an employee of the department designated by the commissioner serves as an ex officio member.

(d) Each member of the governing committee who represents the interests of insurers must be a full-time employee of an insurer that is a member of the association.

(e) The commissioner may remove a member of the governing committee without cause and may replace the member in accordance with Subsection (b).

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.065(b), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.065(b), eff. September 1, 2007.

Sec. 2211.0521. MEETINGS OF GOVERNING BODY. (a)

Notwithstanding Chapter 551, Government Code, or any other law, members of the governing committee may meet by telephone conference call, video conference, or other similar telecommunication method. The governing committee may use telephone conference call, video conference, or other similar telecommunication method for purposes of establishing a quorum or voting or for any other meeting purpose in accordance with this subsection and Subsection (b). This subsection applies without regard to the subject matter discussed or considered by the members of the governing committee at the meeting.

(b) A meeting held by telephone conference call, video conference, or other similar telecommunication method:

(1) is subject to the notice requirements applicable to other meetings of the governing committee;

(2) may not be held unless notice of the meeting specifies the location of the meeting at which at least one member of the governing committee is physically present;

(3) must be audible to the public at the location specified in the notice under Subdivision (2); and

(4) must provide two-way audio communication between all members of the governing committee attending the meeting during the entire meeting, and if the two-way audio communication link with members attending the meeting is disrupted so that a quorum of the governing committee is no longer participating in the meeting, the meeting may not continue until the two-way audio communication link is reestablished.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 3B.065(c), eff. September 1, 2007.

Added by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. [3167](#)), Sec. 9.065(c), eff. September 1, 2007.

Sec. 2211.053. AMENDMENTS TO PLAN OF OPERATION. (a) The governing committee may, on the committee's own initiative or at the commissioner's request, propose amendments to the plan of operation.

(b) Amendments to the plan must be adopted by the commissioner by rule.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. [2017](#)), Sec. 2, eff. April 1, 2007.

Sec. 2211.054. CONTENTS OF PLAN OF OPERATION. The plan of operation must:

- (1) provide for a nonprofit association to issue residential property insurance and, if applicable, property owners' association insurance under this chapter and distribute the losses and expenses in writing that insurance in this state;
- (2) provide that all insurers that write residential property insurance shall participate in the association in accordance with Sections 2211.101(b) and (c);
- (3) provide that a participating insurer is entitled to receive credit in accordance with Section 2211.101(d);
- (4) provide for the immediate binding of eligible risks;
- (5) provide for the use of premium installment payment plans, adequate marketing, and service facilities;
- (6) provide for the establishment of reasonable service standards;
- (7) provide procedures for efficient, economical, fair, and nondiscriminatory administration of the association;
- (8) provide procedures for determining the net level of participation required for each insurer in the association;
- (9) provide for the use of deductibles and other underwriting devices;
- (10) provide for assessment of all members in amounts sufficient to operate the association;
- (11) establish maximum limits of liability to be placed through the program;
- (12) establish commissions to be paid to the insurance agents submitting applications;
- (13) provide that the association issue policies in the association's own name;
- (14) provide reasonable underwriting standards for determining insurability of a risk;
- (15) provide procedures for the association to assume and cede reinsurance; and
- (16) provide any other procedure or operational matter the governing committee or the commissioner considers necessary.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. [2017](#)), Sec. 2, eff. April

1, 2007.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 44 (H.B. 998), Sec. 3, eff. September 1, 2023.

Sec. 2211.055. ASSOCIATION DUTIES WITH RESPECT TO POLICIES.

(a) The association may, for FAIR Plan purposes only:

(1) issue insurance policies and endorsements to those policies in the association's own name or a trade name adopted for that purpose; and

(2) act on behalf of all participating insurers in connection with those policies and act in any other manner necessary to accomplish the purposes of this chapter, including:

(A) issuing insurance policies;

(B) collecting premiums;

(C) issuing cancellations; and

(D) paying commissions, losses, judgments, and

expenses.

(b) In connection with an insurance policy issued by the association:

(1) service of a notice, proof of loss, legal process, or other communication with regard to the policy must be made on the association; and

(2) an action by the insured constituting a claim under the policy may be brought only against the association, and the association is the proper party for all purposes in an action brought under or in connection with the policy.

(c) The requirements of Subsection (b) must be stated in an insurance policy issued by the association.

(d) The form and content of an insurance policy issued by the association are subject to the commissioner's approval.

(e) The association may assume and cede reinsurance as provided by the plan of operation.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2211.056. FILING AND APPROVAL OF RATES. (a) The

association shall file with the commissioner for approval the proposed rates and supplemental rate information to be used in connection with the issuance of insurance policies or endorsements.

(b) The association shall set rates in an amount sufficient to:

(1) carry all claims to maturity; and

(2) meet the expenses incurred in the writing and servicing of the business.

(c) Not later than the 60th day after the date the association files the proposed rates, the commissioner shall enter an order approving or disapproving, wholly or partly, the proposed rates. The commissioner may, on notice to the association, extend the period for entering an order under this section an additional 30 days.

(d) An order disapproving a rate must state:

(1) the grounds for the disapproval; and

(2) the findings in support of the disapproval.

(e) The association may not issue an insurance policy or endorsement until the commissioner approves the rates to be applied to the policy or endorsement.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. [2017](#)), Sec. 2, eff. April 1, 2007.

Sec. 2211.057. POWERS OF COMMISSIONER. The commissioner is charged with the authority to supervise the association and the inspection bureau. The commissioner also has the power to:

(1) examine the operation of the association and the inspection bureau through free access to all the books, records, files, papers, and documents relating to the operation of the association and the inspection bureau;

(2) summon, qualify, and examine as a witness any person who has knowledge of the operation of the association or the inspection bureau, including a member of the governing committee or an officer or employee of the association or the inspection bureau;

(3) take any action necessary to enable this state and the association to fully participate in any federal reinsurance program that is enacted for purposes similar to the purposes of this chapter;

(4) require reports from the association concerning risks the association insures under this chapter as the commissioner considers necessary; and

(5) adopt policy forms and endorsements, promulgate rates, and adopt rating and rule manuals for use by the association.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2211.058. ANNUAL OPERATING REPORT. (a) Not later than March 31 of each year, the association shall compile and submit to the commissioner an operating report covering the preceding calendar year.

(b) The report is a public record.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2211.059. ASSETS OF ASSOCIATION. On dissolution of the association, all assets of the association shall be deposited in the general revenue fund.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.067(a), eff. September 1, 2007.

Added by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.067(a), eff. September 1, 2007.

SUBCHAPTER C. INSURER PARTICIPATION IN FAIR PLAN

Sec. 2211.101. COVERAGE PROVIDED TO INSURED IN UNDERSERVED AREA. (a) In accordance with the plan of operation, the association shall develop and administer a program for participation by each insurer that writes residential property insurance in this state.

(b) Except as provided by this subsection, each insurer, as a condition of the insurer's authority to engage in the business of residential property insurance in this state, shall participate in the association in accordance with this chapter, including participating in the association's assessments in the proportion that the insurer's net direct premiums written in this state during the preceding calendar year bear to the aggregate net direct premiums written in this state by all participating insurers. The Texas Windstorm Insurance Association established by Chapter 2210 may not

participate in the association for any purpose.

(c) An insurer's participation under Subsection (b) in the association's assessments must be determined in accordance with the residential property statistical plan adopted by the commissioner.

(d) A participating insurer is entitled to receive credit for similar insurance voluntarily written in an underserved area. The participation of an insurer entitled to receive credit under this subsection must be reduced in accordance with the plan of operation.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.065(d), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.065(d), eff. September 1, 2007.

Sec. 2211.102. LIABILITY OF INSURERS TO ASSOCIATION; ASSESSMENTS. The participating insurers are liable to the association as provided by this chapter and the plan of operation for the expenses and liabilities incurred by the association as provided by this chapter and the plan. The association shall make assessments against the participating insurers as required to meet those expenses and liabilities.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2211.103. RECOMPUTATION OF REIMBURSEMENT RATIOS. If a participating insurer fails to pay an assessment because of the insurer's insolvency, the association shall immediately recompute the reimbursement ratios to exclude from the ratios the amount of that assessment the commissioner determines is uncollectible, so that the uncollectible amount is assumed by and redistributed among the remaining participating insurers.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2211.104. ADDITIONAL ASSESSMENT IN EVENT OF DEFICIT; PREMIUM SURCHARGE AUTHORIZED. (a) If the association incurs a deficit, the association, at the commissioner's direction, shall:

(1) request the issuance of public securities as authorized by Subchapter E; or

(2) assess participating insurers in accordance with this section.

(b) As reimbursement for assessments paid under this section or service fees paid under Section 2211.209, each insurer may charge a premium surcharge on every property insurance policy insuring property in this state that the insurer issues, the effective date of which is within the three-year period beginning on the 90th day after the date of the assessment or the 90th day after the date the service fee under Section 2211.209 is paid, as applicable.

(c) The insurer shall compute the amount of the surcharge under Subsection (b) as a uniform percentage of the premium on each policy described by Subsection (b). The percentage must be equal to one-third of the ratio of the amount of the participating insurer's assessment or service fee payment to the amount of the insurer's direct earned premiums, as reported to the department in the insurer's financial statement for the calendar year preceding the year in which the assessment or service fee payment is made so that, over the three-year period, the aggregate of all surcharges by the insurer under this section is at least equal to the amount of the assessment or service fee payment.

(d) The amount of any assessment paid and surcharged under this section may be carried by the insurer as an admitted asset of the insurer for all purposes, including exhibition in annual statements under Section 862.001, until collected.

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

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.066(a), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.066(a), eff. September 1, 2007.

Sec. 2211.105. RETENTION AND USE OF PROFITS BY ASSOCIATION.

(a) The association shall retain any profits of the association to be used for the purposes of the association.

(b) The association:

(1) shall use the profits to mitigate losses, including purchasing reinsurance and offsetting future assessments; and

(2) may not distribute the profits to insurers.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER D. COVERAGE PROVIDED TO INSUREDS

Sec. 2211.151. MANDATORY COVERAGE PROVIDED TO CERTAIN INSUREDS.

The association shall make residential property insurance available to each applicant in an underserved area whose property is insurable in accordance with reasonable underwriting standards but who, after diligent efforts, is unable to obtain residential property insurance through the voluntary market, as evidenced by two declinations from insurers authorized to engage in the business of, and writing, residential property insurance in this state.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2211.1515. MANDATORY PROPERTY OWNERS' ASSOCIATION POLICIES IN CERTAIN AREAS. (a) This section applies only to the area designated by the commissioner by rule. In determining the boundaries of the area, the commissioner shall:

(1) to the extent practicable, ensure the area is not more than 10 miles beyond the Texas Windstorm Insurance Association catastrophe area designated under Section 2210.005; and

(2) follow geographical features.

(b) If the commissioner makes the determination described by Section 2211.051(b), the association shall make property owners' association insurance available to each applicant in an underserved area of the area designated under Subsection (a) whose property is insurable in accordance with reasonable underwriting standards but who, after diligent efforts, is unable to obtain property owners' association insurance through the voluntary market, as evidenced by

two declinations from insurers authorized to engage in the business of, and writing, property owners' association insurance in this state.

(c) If the area designated under Subsection (a) changes after the association issues a policy under Subsection (b), the policy is valid until renewal regardless of whether the insured property is located in the area designated under Subsection (a) after the change.

Added by Acts 2023, 88th Leg., R.S., Ch. 44 (H.B. 998), Sec. 4, eff. September 1, 2023.

Sec. 2211.152. DESIGNATION OF AREA AS UNDERSERVED. The commissioner by rule shall designate the areas determined to be underserved. In determining which areas to designate as underserved, the commissioner shall consider the factors specified in Section 2004.002.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2211.153. INSPECTION BUREAU. The association, with the approval of the commissioner, shall designate one or more organizations as the inspection bureau. The inspection bureau shall:

(1) make inspections to determine the condition of a property for which residential property insurance or property owners' association insurance is sought; and

(2) perform other duties authorized by the association or the commissioner.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 44 (H.B. 998), Sec. 5, eff. September 1, 2023.

Sec. 2211.154. PROPERTY INSPECTION. (a) A person who has an insurable interest in real or tangible personal property at a fixed location in an underserved area and who, after diligent effort, is

unable to obtain residential property insurance, or a homeowners' or condominium owners' association located in an underserved area as provided by Section 2211.1515 that, after diligent effort, is unable to obtain property owners' association insurance, as evidenced by two current declinations from insurers authorized to engage in the business of residential property insurance or property owners' association insurance, as applicable, in this state and actually writing residential property insurance or property owners' association insurance in this state, is entitled on application to the association to an inspection and evaluation of the property by representatives of the inspection bureau.

(b) A general property and casualty agent or personal lines property and casualty agent may make an application on behalf of the applicant. The applicant or agent must submit the application on a form prescribed by the association.

(c) Promptly after the application is received, the inspection bureau shall make an inspection and file an inspection report with the association. The inspection report must be made available to the applicant on request. The association shall prescribe the manner and scope of the inspection and inspection report for residential property in accordance with the plan of operation.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 548 (S.B. 1263), Sec. 2.17, eff. September 1, 2007.

Acts 2023, 88th Leg., R.S., Ch. 44 (H.B. 998), Sec. 6, eff. September 1, 2023.

Sec. 2211.155. INSPECTION RESULTS; REINSPECTION. (a) If, after an inspection, the inspection bureau determines that property meets the underwriting standards established in the plan of operation, the applicant must be informed in writing of that determination and the association shall issue a policy or binder. If the property does not meet the underwriting standards, the applicant must be informed in writing of the reason for the failure of the property to meet the standards.

(b) If, at any time, an applicant whose property did not meet

the underwriting standards makes improvements to the property or the property's condition that the applicant believes are sufficient to make the property meet the standards, an inspection bureau representative shall reinspect the property on request. In any case, the applicant is eligible for one reinspection on or before the 60th day after the date of the initial inspection.

(c) If, on reinspection, the property meets the underwriting standards, the applicant must be informed in writing of that fact and the association shall issue a policy or binder.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 44 (H.B. 998), Sec. 7, eff. September 1, 2023.

Sec. 2211.156. CERTAIN COVERAGE EXCLUDED. The FAIR Plan may not provide windstorm and hail insurance coverage for a risk eligible for that coverage under Chapter 2210.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2211.157. COVERAGE FOR CERTAIN WINDSTORM AND HAIL DAMAGE; COVERAGE FOR CERTAIN PROPERTY LOCATED OVER WATER. (a) A policy issued by the association may include coverage against loss or damage by windstorm or hail for:

(1) a building or other structure that is built wholly or partially over water; and

(2) the corporeal movable property contained in a building or structure described by Subdivision (1).

(b) The association may impose appropriate limits of coverage and deductibles for coverage described by Subsection (a).

(c) The governing committee of the association shall submit any proposed changes to the plan of operation necessary to implement Subsections (a) and (b) to the commissioner for the approval of the commissioner in the manner provided by Section 2211.053.

(d) The commissioner shall adopt rules as necessary to implement this section, including any rules necessary to implement

changes in the plan of operation proposed under Subsections (a) and (b).

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.068(a), eff. September 1, 2007.

Added by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.068(a), eff. September 1, 2007.

SUBCHAPTER E. REVENUE BOND PROGRAM

Sec. 2211.201. PURPOSE. The legislature finds that issuing public securities to provide a method to raise funds to provide residential property insurance and property owners' association insurance in this state through the association is to benefit the public and to further a public purpose.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 44 (H.B. 998), Sec. 8, eff. September 1, 2023.

Sec. 2211.202. DEFINITIONS. In this subchapter:

(1) "Board" means the board of directors of the Texas Public Finance Authority.

(2) "Bond" means a debt instrument or other public security issued by the Texas Public Finance Authority.

(3) "Public security resolution" means the resolution or order authorizing public securities to be issued under this subchapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2211.203. APPLICABILITY OF OTHER LAWS. The following laws apply to public securities issued under this subchapter to the extent consistent with this subchapter:

(1) Chapters 1201, 1202, 1204, 1205, 1231, 1232, and 1371, Government Code; and

(2) Subchapter A, Chapter 1206, Government Code.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2211.204. ISSUANCE OF PUBLIC SECURITIES AUTHORIZED. At the request of the association and subject to Section 2211.205, the Texas Public Finance Authority shall issue public securities to:

- (1) fund the association, including to:
 - (A) establish and maintain reserves to pay claims;
 - (B) pay operating expenses; and
 - (C) purchase reinsurance;
- (2) pay costs related to issuing the public securities; and
- (3) pay other costs related to the public securities as determined by the board.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2211.205. LIMITATION ON AMOUNT OF PUBLIC SECURITIES. The Texas Public Finance Authority may issue on behalf of the association public securities in a total amount not to exceed \$75 million.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2211.206. TERMS OF ISSUANCE. (a) Public securities issued under this subchapter may be issued at a public or private sale.

- (b) Public securities must:
 - (1) be issued in the name of the association; and
 - (2) mature not more than 10 years after the date issued.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2211.207. CONTENTS OF PUBLIC SECURITY RESOLUTION;

ADMINISTRATION OF ACCOUNTS. (a) In a public security resolution, the board may:

(1) provide for the flow of funds and the establishment, maintenance, and investment of funds and special accounts with regard to the public securities, including an interest and sinking fund account, a reserve account, and other accounts; and

(2) make additional covenants with regard to the public securities and the designated income and receipts of the association pledged to the payment of the public securities.

(b) The association shall administer the accounts in accordance with this chapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2211.208. SOURCE OF PAYMENT. (a) Public securities issued under this subchapter are payable only from:

(1) the service fee established under Section 2211.209; or

(2) other amounts the association is authorized to levy, charge, and collect.

(b) The public securities are obligations solely of the association and do not create a pledge, gift, or loan of the faith, credit, or taxing authority of this state.

(c) Each public security must:

(1) include a statement that the state is not obligated to pay any amount on the security and that the faith, credit, and taxing authority of this state are not pledged, given, or loaned to those payments; and

(2) state on the security's face that the security:

(A) is payable solely from the revenue pledged for that purpose; and

(B) is not a legal or moral obligation of the state.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2211.209. SERVICE FEE. (a) A service fee may be assessed against:

(1) each participating insurer; and

(2) the association.

(b) The commissioner shall set the service fee in an amount sufficient to pay all debt service on the public securities issued under this subchapter. Each participating insurer and the association shall pay the service fee as required by the commissioner by rule.

(c) The comptroller shall collect the service fee and the department shall reimburse the comptroller in the manner described by Section 201.052.

(d) The commissioner, in consultation with the comptroller, may coordinate payment and collection of the service fee with other payments made by participating insurers and collected by the comptroller.

(e) As a condition of engaging in the business of insurance in this state, a participating insurer agrees that, if the insurer leaves the property insurance market in this state, the insurer remains obligated to pay the insurer's share of the service fee assessed under this section until the public securities are retired. The amount assessed against an insurer under this subsection must be:

(1) proportionate to the insurer's share of the property insurance market, including residential property insurance, in this state as of the last complete reporting period before the date the insurer ceases to engage in the property insurance business in this state; and

(2) based on the insurer's gross premiums for property insurance, including residential property insurance, for the insurer's last reporting period.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2211.210. EXEMPTION FROM TAXATION. Public securities issued under this subchapter, any interest from the public securities, and all assets pledged to secure the payment of the public securities are exempt from taxation by the state or a political subdivision of this state.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2211.211. AUTHORIZED INVESTMENTS. Public securities issued under this subchapter are authorized investments under Subchapter B, Chapter 424, and Subchapters C and D, Chapter 425.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2211.212. STATE PLEDGE REGARDING PUBLIC SECURITY OWNER RIGHTS AND REMEDIES. (a) The state pledges to and agrees with the owners of public securities issued in accordance with this subchapter that the state will not limit or alter the rights vested in the association to fulfill the terms of agreements made with the owners or impair the rights and remedies of the owners until the following obligations are fully discharged:

- (1) the public securities;
- (2) any bond premium;
- (3) interest; and
- (4) all costs and expenses related to an action or proceeding by or on behalf of the owners.

(b) The association may include the state's pledge and agreement under Subsection (a) in an agreement with the owners of the public securities.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2211.213. PAYMENT ENFORCEABLE BY MANDAMUS. A writ of mandamus and any other legal or equitable remedy are available to a party in interest to require the association or another party to fulfill an agreement or perform a function or duty under:

- (1) this subchapter;
- (2) the Texas Constitution; or
- (3) a public security resolution.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER F. PENALTIES

Sec. 2211.251. SANCTIONS AND ADMINISTRATIVE PENALTIES. If the association, the inspection bureau, or a participating insurer is found to be in violation of or to have failed to comply with this chapter, that entity is subject to:

- (1) the sanctions authorized by Chapter 82; and
- (2) administrative penalties authorized by Chapter 84.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2211.252. ADDITIONAL DISCIPLINARY PROCEDURES. In addition to the remedies provided by Section 2211.251, the commissioner may use any other disciplinary procedures authorized by this code, including the cease and desist procedures authorized by Chapter 83.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

**CHAPTER 2212. SELF-INSURANCE TRUSTS FOR HEALTH CARE
LIABILITY CLAIMS**

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 2212.001. DEFINITIONS. In this chapter:

- (1) "Charitable organization" has the meaning assigned by Section 84.003, Civil Practice and Remedies Code.
- (2) "Dentist" means a person licensed to practice dentistry in this state.
- (3) "Health care liability claim" means a cause of action against a physician or dentist for treatment, lack of treatment, or other claimed departure from accepted standards of health care or safety that proximately results in injury to or death of the patient, whether the patient's claim or cause of action sounds in tort or contract.
- (4) "Physician" means a person licensed to practice medicine in this state.
- (5) "Trust" means a self-insurance trust organized and operated under this chapter.
- (6) "Volunteer health care provider" has the meaning assigned by Section 84.003, Civil Practice and Remedies Code.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.069(a), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.069(a), eff. September 1, 2007.

Sec. 2212.002. TRUST NOT ENGAGED IN BUSINESS OF INSURANCE. A trust is not engaged in the business of insurance under this code and other laws of this state, and this code, other than this chapter, does not apply to the trust, except as provided by Section 2212.052.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER B. CREATION AND OPERATION OF TRUST

Sec. 2212.051. CREATION OF TRUST. (a) Subject to Subsection (b), an incorporated association, a purpose of which is to unite in one compact organization the entire profession licensed to practice medicine or dentistry in this state, or a portion of the members of the profession licensed to practice medicine who are practicing a particular specialty within the practice of medicine in the state or are practicing within a particular region of the state, may create a trust to self-insure physicians or dentists and agree, by contract or otherwise, to insure other members of the organization or association against health care liability claims and related risks.

(b) The organization or association must:

- (1) have been in continuing existence for at least two years;
- (2) have established a health care liability claim trust or other agreement to provide coverage against health care liability claims and related risks; and
- (3) employ appropriate professional staff and consultants for program management.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2212.052. MINIMUM REQUIREMENTS. (a) The department may require a trust to satisfy reasonable minimum requirements that ensure the trust is able to satisfy the trust's contractual obligations.

(b) On request, a trust shall provide books, records, and documents required by the department to fulfill the requirements of this section relating to the trust's solvency.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2212.053. FILING REQUIREMENTS. (a) A trust shall file with the department:

(1) all rates and forms, for informational purposes only; and

(2) the trust's independently audited annual financial statement.

(b) An audited annual financial statement filed under this section may not be considered an examination document.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 42 (S.B. 784), Sec. 2.05, eff. September 1, 2015.

Sec. 2212.054. POWERS OF TRUST. (a) A trust may:

(1) purchase, on behalf of the members of the association that created the trust, medical professional liability insurance, specific excess insurance, aggregate excess insurance, and reinsurance, as necessary in the opinion of the trustees;

(2) purchase required risk management services; and

(3) pay claims that arise under any deductible provisions.

(b) A trust's investment powers and limitations are the same as the investment powers and limitations of a state bank with trust powers.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2212.055. GUARANTEE OF CERTAIN LIABILITIES. The trust shall adopt rules to guarantee all contingent liabilities in the event of dissolution.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2212.056. ADMINISTRATIVE SANCTIONS. If a trust is found to have violated this code or a rule adopted by the commissioner that is declared applicable to the trust, the commissioner may order sanctions under Chapter 82 for the violation.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER C. INSURANCE CONTRACTS ISSUED BY TRUST

Sec. 2212.101. COVERAGE UNDER CONTRACT. A contract of professional liability insurance issued by a trust may include coverage of:

(1) a professional association or partnership of physicians, with respect to health care liability claims and related risks if a majority of the persons having a proprietary interest in the association or partnership are members of the association that created the trust;

(2) proprietary members, associates, stockholders, and executive officers and directors of an association or partnership described by Subdivision (1), with respect to potential vicarious liability for acts or omissions of others giving rise to health care liability claims and related risks;

(3) an insured physician and, as applicable, an insured professional association or partnership, including proprietary members, associates, stockholders, and executive officers and directors of the association or partnership, with respect to liability of an insured arising out of:

(A) injury to a patient related to ownership, maintenance, or use of premises for the practice of medicine, including necessary or incidental operations;

(B) service by an insured physician as a member of a committee, board, or similar group of a hospital medical staff or of a professional association or society with respect to medical staff privileges, accreditation, or disciplinary matters relating to competency or patient safety and risk reduction programs; or

(C) a health care liability claim or related risk based in whole or part on an act or omission occurring before the date a contract of professional insurance is issued by the trust; or

(4) an applicant for membership in the association that created the trust, pending final action on the application, with respect to health care liability claims and related risks, including coverage described by Subdivision (1), (2), or (3), as applicable.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2212.102. COVERAGE FOR VOLUNTEER HEALTH CARE PROVIDERS.

(a) The trust, in accordance with Section 2212.054, may make available professional liability insurance covering a volunteer health care provider for an act or omission resulting in death, damage, or injury to a patient while the person is acting in the course and scope of the person's duties as a volunteer health care provider as described by Chapter 84, Civil Practice and Remedies Code.

(b) This section does not affect the liability of a volunteer health care provider who is serving as a direct service volunteer of a charitable organization. Section 84.004(c), Civil Practice and Remedies Code, applies to the volunteer health care provider without regard to whether the volunteer health care provider obtains liability insurance under this section.

(c) The trust may make professional liability insurance available under this section to a volunteer health care provider without regard to whether the volunteer health care provider is a physician or dentist.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.070(a), eff. September 1, 2007.

Added by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.070(a), eff. September 1, 2007.

CHAPTER 2213. SELF-INSURANCE TRUSTS FOR BANKS AND SAVINGS AND LOAN ASSOCIATIONS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 2213.001. DEFINITIONS. In this chapter:

(1) "Bank" means a bank chartered under federal or state law.

(2) "Plan" means a self-insurance trust's plan of organization and operation.

(3) "Savings and loan association" means a savings and loan association chartered under federal or state law.

(4) "Self-insurance trust" means a self-insurance trust organized and operated under this chapter.

(5) "Trustees" means the trustees of a self-insurance trust.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2213.002. SELF-INSURANCE TRUST NOT ENGAGED IN BUSINESS OF INSURANCE. (a) A self-insurance trust is not engaged in the business of insurance under this code or other laws of this state.

(b) Other than this chapter, the provisions of this code, including the Texas Property and Casualty Insurance Guaranty Act, Chapter 462, do not apply to a self-insurance trust.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2213.003. RULES. The commissioner may adopt:

(1) necessary rules to carry out the provisions of this chapter relating to bank self-insurance trusts; and

(2) reasonable rules necessary to carry out the provisions of this chapter relating to savings and loan self-insurance trusts.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER B. CREATION AND OPERATION OF SELF-INSURANCE TRUST

Sec. 2213.051. CREATION OF BANK SELF-INSURANCE TRUST; COVERAGE.

(a) A group or association of banks or bankers, composed of any number of members, may create a bank self-insurance trust to self-insure banks that are members of the group or association, or that have any officers who are members of the group or association, against losses described by this section.

(b) The bank self-insurance trust may self-insure a bank described by Subsection (a) against losses resulting from:

(1) dishonest acts and criminal acts of employees;

(2) a robbery or other act commonly included within a bank's bond coverage; and

(3) indemnification for a wrongful act committed by a director, officer, or employee of a member of the group or association, subject to the limitations under Chapter 8, Business Organizations Code.

(c) The trustees shall determine, according to the plan, the amount of coverage to be provided to a bank participating in the bank self-insurance trust.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2213.052. CREATION OF SAVINGS AND LOAN SELF-INSURANCE TRUST; COVERAGE. (a) Two or more savings and loan associations that have their principal offices located in this state may create a savings and loan self-insurance trust to provide insurance and indemnity coverage for the savings and loan self-insurance trust's members and the officers and directors of the savings and loan self-insurance trust's members.

(b) Insurance and indemnity coverage provided by the savings and loan self-insurance trust is limited to savings and loan blanket bonds covering losses resulting from:

(1) dishonest acts and criminal acts of employees; or

(2) robbery.

(c) The trustees shall determine, according to the plan, the amount of coverage to be provided to a savings and loan association participating in the savings and loan self-insurance trust.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2213.053. PLAN OF ORGANIZATION AND OPERATION; TRUSTEES.

(a) Before organizing and operating a self-insurance trust, the group or association of banks or bankers or the savings and loan associations, as applicable, proposing to organize the self-insurance trust shall:

(1) select trustees to administer the self-insurance trust; and

(2) prepare a detailed plan of organization and operation in the form and manner prescribed by the commissioner.

(b) The group or association of banks or bankers or the savings and loan associations shall submit the proposed plan to the commissioner for examination, suggested changes, and final approval.

(c) The commissioner shall approve the proposed plan only if the commissioner is satisfied that the self-insurance trust is able and will continue to be able to pay valid claims made to the self-insurance trust.

(d) After final approval, the plan may be amended with the commissioner's approval.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2213.054. MINIMUM REQUIREMENTS; COMMISSIONER SUPERVISION.

(a) After approval of a self-insurance trust's plan, the self-insurance trust is subject to continuing supervision by the commissioner relating to:

(1) the solvency of the self-insurance trust; and

(2) the approval of the self-insurance trust's policy forms.

(b) The commissioner may set minimum requirements to ensure that a self-insurance trust is able to satisfy the self-insurance trust's contractual obligations.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2213.055. CREATION OF TRUST FUND. (a) The trustees shall

create a trust fund to pay claims made under the coverage provided by the self-insurance trust under Section 2213.051 or 2213.052, as applicable.

(b) The trustees shall administer and control the trust fund and shall pay claims from and invest the money of the trust fund as provided by the plan.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2213.056. PERSONNEL; PAYMENT OF EXPENSES. (a) The trustees shall employ appropriate professional employees and consultants for management of the self-insurance trust program.

(b) The trustees shall pay the salaries of professional employees and consultants and other costs of administering the self-insurance trust program from the trust fund.

(c) The total amount paid for salaries and administration may not exceed an amount set by the commissioner. The amount set by the commissioner may not exceed 35 percent of the total amount of money in the trust fund in any year.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER C. PARTICIPATION IN SELF-INSURANCE TRUST

Sec. 2213.101. PARTICIPATION. A bank that is a member, or that has an officer who is a member, of a group or association of banks or bankers organizing a bank self-insurance trust or of savings and loan associations organizing a savings and loan self-insurance trust may participate in the applicable self-insurance trust by:

(1) entering into a contract or agreement with the trustees for coverage that the self-insurance trust may provide under Section 2213.051 or 2213.052, as applicable; and

(2) paying the required contribution to the trust fund in the amount determined by the trustees in accordance with the plan.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBTITLE H. RATEMAKING IN GENERAL**CHAPTER 2251. RATES****SUBCHAPTER A. GENERAL PROVISIONS FOR RATES**

Sec. 2251.001. PURPOSE. The purposes of this subchapter and Subchapters B, C, D, and E are to:

(1) promote the public welfare by regulating insurance rates to prohibit excessive, inadequate, or unfairly discriminatory rates;

(2) promote the availability of insurance;

(3) promote price competition among insurers to provide rates and premiums that are responsive to competitive market conditions;

(4) prohibit price-fixing agreements and other anticompetitive behavior by insurers; and

(5) provide regulatory procedures for the maintenance of appropriate information reporting systems.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2251.002. DEFINITIONS. In this chapter:

(1) "Commercial property insurance" means insurance coverage against loss caused by or resulting from loss, damage, or destruction of real or personal property provided through a commercial property insurance policy. The term includes any combination of:

(A) commercial fire or allied lines;

(B) commercial inland marine insurance;

(C) commercial crime coverage;

(D) boiler and machinery insurance other than explosion;

(E) glass insurance provided as part of other coverage; and

(F) as authorized by commissioner rule, insurance covering other perils or providing other coverages or other lines of first party property insurance.

(1-a) "Disallowed expenses" includes:

(A) administrative expenses, other than acquisition, loss control, and safety engineering expenses, that exceed 110

percent of the industry median for those expenses;

(B) lobbying expenses;

(C) advertising expenses, other than for advertising:

(i) directly related to the services or products provided by the insurer; or

(ii) designed and directed at loss prevention;

(D) amounts paid by an insurer:

(i) as damages in an action brought against the insurer for bad faith, fraud, or any matters other than payment under the insurance contract; or

(ii) as fees, fines, penalties, or exemplary damages for a civil or criminal violation of law;

(E) contributions to:

(i) social, religious, political, or fraternal organizations; or

(ii) organizations engaged in legislative advocacy;

(F) except as authorized by commissioner rule, fees and assessments paid to advisory organizations;

(G) any amount determined by the commissioner to be excess premiums charged by the insurer; and

(H) any unreasonably incurred expenses, as determined by the commissioner after notice and hearing.

(2) "Filer" means an insurer that files rates, prospective loss costs, or supplementary rating information under this chapter.

(3) "Prospective loss cost" means that portion of a rate that:

(A) does not include a provision for expenses or profit, other than loss adjustment expenses; and

(B) is based on historical aggregate losses and loss adjustment expenses projected by development to the ultimate value of those losses and expenses and projected through trending to a future point in time.

(4) "Rate" means the cost of insurance per exposure unit, whether expressed as a single number or as a prospective loss cost, adjusted to account for the treatment of expenses, profit, and individual insurer variation in loss experience, before applying individual risk variations based on loss or expense considerations.

(5) "Rating manual" means a publication or schedule that lists rules, classifications, territory codes and descriptions, rates, premiums, and other similar information used by an insurer to

determine the applicable premium charged an insured.

(6) "Residential property insurance" means insurance coverage against loss to real or tangible personal property at a fixed location that is provided through a homeowners insurance policy, including a tenants insurance policy, a condominium owners insurance policy, or a residential fire and allied lines insurance policy.

(7) "Supplementary rating information" means any manual, rating schedule, plan of rules, rating rules, classification systems, territory codes and descriptions, rating plans, and other similar information used by the insurer to determine the applicable premium for an insured. The term includes factors and relativities, including increased limits factors, classification relativities, deductible relativities, premium discount, and other similar factors and rating plans such as experience, schedule, and retrospective rating.

(8) "Supporting information" means:

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

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

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

(D) any other information the department receives from a filer as a response to a request under Section 38.001.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 1147 (H.B. 1951), Sec. 3.004, eff. September 1, 2011.

Acts 2017, 85th Leg., R.S., Ch. 254 (H.B. 1298), Sec. 1, eff. May 29, 2017.

Sec. 2251.003. APPLICABILITY OF CERTAIN SUBCHAPTERS. (a) This subchapter and Subchapters B, C, and D apply to:

(1) an insurer to which Article 5.13 applies, other than the Texas Windstorm Insurance Association, the FAIR Plan Association, and the Texas Automobile Insurance Plan Association; and

(2) except as provided by Subsection (c), a Lloyd's plan, reciprocal or interinsurance exchange, and county mutual insurance company with respect to the lines of insurance described by Subsection (b).

(b) Except as provided by Section 2251.0031, this subchapter and Subchapters B, C, and D apply to all lines of the following kinds of insurance written under an insurance policy or contract issued by an insurer authorized to engage in the business of insurance in this state:

- (1) general liability insurance;
- (2) residential and commercial property insurance, including farm and ranch insurance and farm and ranch owners insurance;
- (3) personal and commercial casualty insurance, except as provided by Section 2251.004;
- (4) medical professional liability insurance;
- (5) fidelity, guaranty, and surety bonds other than criminal court appearance bonds;
- (6) personal umbrella insurance;
- (7) personal liability insurance;
- (8) guaranteed auto protection (GAP) insurance;
- (9) involuntary unemployment insurance;
- (10) financial guaranty insurance;
- (11) inland marine insurance;
- (12) rain insurance;
- (13) hail insurance on farm crops;
- (14) personal and commercial automobile insurance;
- (15) multi-peril insurance; and
- (16) identity theft insurance issued under Chapter 706.

(c) Sections 2251.008, 2251.052, 2251.101, 2251.102, 2251.103, 2251.104, 2251.105, and 2251.107 do not apply to a Lloyd's plan or a reciprocal or interinsurance exchange with respect to commercial property insurance, inland marine insurance, rain insurance, or hail insurance on farm crops.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.071(a), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.071(a), eff. September 1, 2007.

Acts 2015, 84th Leg., R.S., Ch. 312 (S.B. 1554), Sec. 2, eff. September 1, 2015.

Acts 2021, 87th Leg., R.S., Ch. 42 (S.B. 1367), Sec. 2, eff. September 1, 2021.

Sec. 2251.0031. EXCEPTIONS FOR CERTAIN LINES. (a) Except as provided by Subsection (d), Subchapter C does not apply to any line of the following kinds of insurance written under a commercial insurance policy or contract issued by an insurer authorized to engage in the business of insurance in this state:

- (1) surety bonds;
- (2) fidelity bonds;
- (3) commercial inland marine;
- (4) boiler and machinery;
- (5) environmental impairment or pollution liability;
- (6) kidnap and ransom;
- (7) political risk or expropriation;
- (8) commercial excess liability or umbrella liability;
- (9) directors' and officers' liability;
- (10) fiduciary liability;
- (11) employment practices liability;
- (12) errors and omission and professional liability other than medical professional liability;
- (13) media liability;
- (14) product liability, product recall, or completed operations;
- (15) commercial cybersecurity, including first- and third-party commercial lines coverage for losses arising out of or relating to data privacy breaches, network security, computer viruses, and similar exposures;
- (16) highly protected commercial property;
- (17) commercial flood insurance not provided through the National Flood Insurance Program; or
- (18) any combination of only the kinds of insurance listed in this subsection or exempted under Subsection (c).

(b) For purposes of Subsection (a), "highly protected commercial property" is commercial property that is subject to a much

lower than normal probability of loss due to low-hazard occupancy or property type, superior construction, special fire protection equipment and procedures, and management commitment to loss prevention.

(c) The commissioner by rule may exempt a commercial line of insurance or commercial risk not listed in Subsection (a) from the rate filing requirements of Subchapter C to promote enhanced competition or more effectively use the resources of the department that might otherwise be used to review commercial lines filings.

(d) Notwithstanding Subsection (a), the commissioner may temporarily require rate filings under Subchapter C for a specific kind of insurance listed in Subsection (a) for a period of not longer than one year if, after notice and hearing, the commissioner issues an order that:

(1) includes a finding that a reasonable degree of competition does not exist for that specific kind of insurance; and

(2) specifies the relevant tests and test results used to determine the degree of competition for that kind of insurance.

(e) In the absence of a finding described by Subsection (d) with respect to a specific kind of insurance, a competitive market is presumed to exist for that kind of insurance.

(f) The commissioner may adopt reasonable and necessary rules to implement this section.

Added by Acts 2021, 87th Leg., R.S., Ch. 42 (S.B. [1367](#)), Sec. 3, eff. September 1, 2021.

Sec. 2251.004. REGULATION OF INLAND MARINE RATES. The commissioner shall adopt rules governing the manner in which rates for the various classifications of risks insured under inland marine insurance, as determined by the commissioner, are regulated.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. [2017](#)), Sec. 2, eff. April 1, 2007.

Sec. 2251.005. NOTICE OF RATE INCREASE FOR RESIDENTIAL PROPERTY INSURANCE POLICIES. (a) An insurer shall notify a policyholder of a residential property insurance policy issued by the insurer of a rate increase scheduled to take effect on the policy's renewal that will

result in a premium amount to be paid by the policyholder that is at least 10 percent greater than the lesser of:

(1) the premium amount paid by the policyholder for coverage under the policy during the 12-month period preceding the policy's renewal date; or

(2) the premium amount paid by the policyholder for coverage under the policy during the policy period preceding the policy's renewal date.

(b) An insurer shall send the notice required by Subsection (a) before the renewal date and not later than the 30th day before the date the rate increase is scheduled to take effect.

(c) An insurer may send the notice described by Subsection (a) to any policyholder of a residential property insurance policy issued by the insurer, regardless of whether the policyholder's premium amount will increase as a result of the scheduled rate change.

(d) The commissioner by rule may exempt an insurer from the notice requirements of this section for a short-term policy, as defined by the commissioner, that is written by the insurer.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2251.006. CONSIDERATION OF CERTAIN OTHER LAW. In reviewing rates under this chapter, the commissioner shall consider any state or federal law that may affect rates for liability coverage included in an insurance policy subject to this chapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2251.007. ADMINISTRATIVE PROCEDURE ACT APPLICABLE. Chapter 2001, Government Code, applies to all rate hearings conducted under this chapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2251.008. ANNUAL REPORT OF INSURER; LEGISLATIVE REPORT.

(a) The commissioner shall require each insurer subject to this subchapter to annually file with the commissioner information relating to changes in losses, premiums, and market share since January 1, 1993. The commissioner may require an insurer subject to this subchapter to report to the commissioner, in the form and in the time required by the commissioner, any other information the commissioner determines is necessary to comply with this section.

(b) Annually, the commissioner shall report to the governor, the lieutenant governor, the speaker of the house of representatives, the legislature, and the public regarding:

(1) the information provided to the commissioner, other than information made confidential by law, in the insurers' reports under Subsection (a); and

(2) market conduct, especially rates and consumer complaints.

(c) The report required by this section must cover a calendar year and:

(1) for each insurer that writes a line of insurance subject to this subchapter, must state the insurer's:

(A) market share;

(B) profits and losses;

(C) average loss ratio; and

(D) whether the insurer submitted a rate filing during the year covered in the report; and

(2) for each rate filing submitted under Subdivision (1)(D), must indicate any significant impact on policyholders, the overall rate change from the rate previously used by the insurer stated as a percentage, and any rate changes for the previous 12, 24, and 36 months.

(d) Except as provided by Subsection (e), the annual report required by this section must be made available to the governor, lieutenant governor, speaker of the house of representatives, legislature, and public not later than the 90th day after the last day of the calendar year covered by the report.

(e) If the commissioner determines that it is not feasible to provide the report required by this section within the period specified by Subsection (d) for all lines of insurance subject to this subchapter, the department:

(1) shall make the annual report, as applicable to lines of residential property insurance and personal automobile insurance,

available within the period specified by Subsection (d); and
 (2) may delay publication of the annual report as it relates to other lines of insurance subject to this subchapter until a date specified by the commissioner.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 151 (S.B. 611), Sec. 2, eff. May 21, 2007.

Acts 2015, 84th Leg., R.S., Ch. 42 (S.B. 784), Sec. 1.02, eff. September 1, 2015.

SUBCHAPTER B. RATE STANDARDS

Sec. 2251.051. EXCESSIVE, INADEQUATE, AND UNFAIRLY DISCRIMINATORY RATES. (a) A rate is excessive, inadequate, or unfairly discriminatory for purposes of this chapter as provided by this section.

(b) A rate is excessive if the rate is likely to produce a long-term profit that is unreasonably high in relation to the insurance coverage provided.

(c) A rate is inadequate if:

(1) the rate is insufficient to sustain projected losses and expenses to which the rate applies; and

(2) continued use of the rate:

(A) endangers the solvency of an insurer using the rate; or

(B) has the effect of substantially lessening competition or creating a monopoly in a market.

(d) A rate is unfairly discriminatory if the rate:

(1) is not based on sound actuarial principles;

(2) does not bear a reasonable relationship to the expected loss and expense experience among risks; or

(3) is based wholly or partly on the race, creed, color, ethnicity, or national origin of the policyholder or an insured.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2251.052. RATE STANDARDS. (a) In setting rates, an insurer shall consider:

- (1) past and prospective loss experience:
 - (A) inside this state; and
 - (B) outside this state if the data from this state are not credible;
- (2) the peculiar hazards and experiences of individual risks, past and prospective, inside and outside this state;
- (3) the insurer's actuarially credible historical premium, exposure, loss, and expense experience;
- (4) catastrophe hazards in this state;
- (5) operating expenses, excluding disallowed expenses;
- (6) investment income;
- (7) a reasonable margin for profit; and
- (8) any other factors inside and outside this state:
 - (A) determined to be relevant by the insurer; and
 - (B) not disallowed by the commissioner.

(b) A rate may not be excessive, inadequate, unreasonable, or unfairly discriminatory for the risks to which the rate applies.

(c) The insurer may:

- (1) group risks by classification to establish rates and minimum premiums; and
- (2) modify classification rates to produce rates for individual risks in accordance with rating plans that establish standards for measuring variations in those risks on the basis of any factor listed in Subsection (a).

(d) In setting rates that apply only to policyholders in this state, an insurer shall use available premium, loss, claim, and exposure information from this state to the full extent of the actuarial credibility of that information. The insurer may use experience from outside this state as necessary to supplement information from this state that is not actuarially credible.

(e) In determining rating territories and territorial rates, an insurer shall use methods based on sound actuarial principles.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER C. RATE FILINGS

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

(b) The commissioner by rule shall:

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

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

(B) statistics or other information to support the rates to be used by the insurer;

(C) information necessary to evidence that the computation of the rate does not include disallowed expenses for personal lines; and

(D) information concerning policy fees, service fees, and other fees that are charged or collected by the insurer under Section 550.001 or 4005.003; and

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

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

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

(c) This section does not apply to rates for use with an insured that has:

(1) total insured property values of \$5 million or more;

(2) total annual gross revenues of \$10 million or more; or

(3) a total premium of \$25,000 or more for property insurance, \$25,000 or more for general liability insurance, or \$50,000 or more for multi-peril insurance.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 1147 (H.B. 1951), Sec. 3.005, eff. September 1, 2011.

Acts 2015, 84th Leg., R.S., Ch. 42 (S.B. 784), Sec. 1.03, eff. September 1, 2015.

Acts 2021, 87th Leg., R.S., Ch. 42 (S.B. 1367), Sec. 4, eff. September 1, 2021.

Sec. 2251.102. FILING REQUIREMENTS FOR INSURERS WITH LESS THAN FIVE PERCENT OF MARKET. In determining filing requirements under Section 2251.101 for an insurer with less than five percent of the market, the commissioner shall consider insurer and market-specific attributes, as applicable. The commissioner shall determine filing requirements for those insurers accordingly to accommodate premium volume and loss experience, targeted markets, limitations on coverage, and any potential barriers to market entry or growth.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

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

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

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

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

(e) An insurer that files a rate that is disapproved under this section is entitled to a hearing on written request made to the commissioner not later than the 30th day after the date the order

disapproving the rate takes effect.

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

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 1147 (H.B. 1951), Sec. 3.006, eff. September 1, 2011.

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

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

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

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

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

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

Added by Acts 2011, 82nd Leg., R.S., Ch. 1147 (H.B. 1951), Sec. 3.007, eff. September 1, 2011.

Sec. 2251.104. COMMISSIONER DISAPPROVAL OF RATE IN EFFECT; HEARING. (a) The commissioner may disapprove a rate that is in effect only after a hearing. The commissioner shall provide the filer at least 20 days' written notice.

(b) The commissioner must issue an order disapproving a rate under Subsection (a) not later than the 15th day after the close of the hearing. The order must:

(1) specify in what respects the rate fails to meet the requirements of this chapter; and

(2) state the date on which further use of the rate is prohibited, which may not be earlier than the 45th day after the close of the hearing under this section.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 1147 (H.B. 1951), Sec. 3.008, eff. September 1, 2011.

Sec. 2251.105. GRIEVANCE. (a) An insured who is aggrieved with respect to any filing under this chapter that is in effect, or the public insurance counsel, may apply to the commissioner in writing for a hearing on the filing. The application must specify the grounds for the applicant's grievance.

(b) The commissioner shall hold a hearing on an application filed under Subsection (a) not later than the 30th day after the date the commissioner receives the application if the commissioner determines that:

(1) the application is made in good faith;

(2) the applicant would be aggrieved as alleged if the grounds specified in the application were established; and

(3) the grounds specified in the application otherwise justify holding the hearing.

(c) The commissioner shall provide written notice of a hearing under Subsection (b) to the applicant and each insurer that made the filing not later than the 10th day before the date of the hearing.

(d) If, after the hearing, the commissioner determines that the filing does not meet the requirements of this chapter, the commissioner shall issue an order:

(1) specifying in what respects the filing fails to meet those requirements; and

(2) stating the date on which the filing is no longer in effect, which must be within a reasonable period after the order date.

(e) The commissioner shall send copies of the order issued under Subsection (d) to the applicant and each affected insurer.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2251.106. ROLE OF PUBLIC INSURANCE COUNSEL. (a) On request to the commissioner, the public insurance counsel may review all rate filings and additional information provided by an insurer under this chapter. Confidential information reviewed under this subsection remains confidential.

(b) The public insurance counsel, not later than the 30th day after the date of a rate filing under this chapter, may file with the commissioner a written objection to:

(1) an insurer's rate filing; or

(2) the criteria on which the insurer relied to determine the rate.

(c) A written objection filed under Subsection (b) must contain the reasons for the objection.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2251.107. PUBLIC INFORMATION. (a) Each filing made, and any supporting information filed, under this chapter is public information subject to Chapter 552, Government Code, including any applicable exception from required disclosure under that chapter.

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

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 1147 (H.B. 1951), Sec. 3.009, eff. September 1, 2011.

**SUBCHAPTER D. PRIOR APPROVAL OF RATES UNDER
CERTAIN CIRCUMSTANCES**

Sec. 2251.151. REQUIREMENT TO FILE RATES FOR PRIOR APPROVAL UNDER CERTAIN CIRCUMSTANCES. (a) The commissioner by order may require an insurer to file with the department for the commissioner's approval all rates, supplementary rating information, and any supporting information in accordance with this subchapter if the commissioner determines that:

(1) the insurer's rates require supervision because of the insurer's financial condition or rating practices; or

(2) a statewide insurance emergency exists.

(a-1) If an insurer files a petition under Subchapter D, Chapter 36, for judicial review of an order disapproving a rate under this chapter, the insurer must use the rates in effect for the insurer at the time the petition is filed and may not file and use any higher rate for the same line of insurance subject to this chapter before the matter subject to judicial review is finally resolved unless the insurer, in accordance with this subchapter, files the new rate with the department, along with any applicable supplementary rating information and supporting information, and obtains the commissioner's approval of the rate.

(b) From the date of the filing of the rate with the department to the effective date of the new rate, the insurer's previously filed rate that is in effect on the date of the filing remains in effect.

(c) The commissioner may require an insurer to file the insurer's rates under this section until the commissioner determines that the conditions described by Subsection (a) no longer exist.

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

section.

(d) For purposes of this section, a rate is filed with the department on the date the department receives the rate filing.

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

(f) The commissioner by rule shall define:

- (1) the financial conditions and rating practices that may subject an insurer to this section under Subsection (a)(1); and
- (2) the process by which the commissioner determines that a statewide insurance emergency exists under Subsection (a)(2).

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 1096 (H.B. 3358), Sec. 1, eff. September 1, 2007.

Acts 2011, 82nd Leg., R.S., Ch. 1147 (H.B. 1951), Sec. 3.010, eff. September 1, 2011.

Sec. 2251.152. RATE APPROVAL REQUIRED; EXCEPTION. (a) An insurer subject to this subchapter may not use a rate until the rate has been filed with the department and approved by the commissioner in accordance with this subchapter.

(b) Notwithstanding Subsection (a), after a rate filing is approved under this subchapter, an insurer, without prior approval of the commissioner, may use any rate subsequently filed by the insurer if the subsequently filed rate does not exceed the lesser of:

(1) 107.5 percent of the rate approved by the commissioner;
or

(2) 110 percent of any rate used by the insurer in the previous 12-month period.

(c) Filed rates under Subsection (b) take effect on the date specified by the insurer.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2251.153. COMMISSIONER ACTION. (a) Not later than the 30th day after the date a rate is filed with the department under this subchapter, the commissioner shall:

(1) approve the rate if the commissioner determines that the rate complies with the requirements of this chapter; or

(2) disapprove the rate if the commissioner determines that the rate does not comply with the requirements of this chapter.

(b) Except as provided by Subsection (c), if a rate has not been approved or disapproved by the commissioner before the expiration of the 30-day period described by Subsection (a), the rate is considered approved and the insurer may use the rate unless the rate proposed in the filing represents an increase of 12.5 percent or more from the insurer's previously filed rate.

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

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2251.155. RATE FILING APPROVAL BY COMMISSIONER; USE OF RATE. (a) The commissioner shall approve a rate filing under this subchapter if the proposed rate is adequate, not excessive, and not unfairly discriminatory.

(b) If the commissioner approves a rate filing under this section, the commissioner shall provide the insurer with a written or electronic notification of the approval. The insurer may use the rate on receipt of the approval notice.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2251.156. RATE FILING DISAPPROVAL BY COMMISSIONER;

HEARING. (a) If the commissioner disapproves a rate filing under Section 2251.153(a)(2), the commissioner shall issue an order disapproving the filing in accordance with Section 2251.103(d).

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

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

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 1147 (H.B. 1951), Sec. 3.011, eff. September 1, 2011.

SUBCHAPTER F. EXEMPTIONS FOR CERTAIN INSURERS FROM RATE FILING AND APPROVAL REQUIREMENTS

Sec. 2251.251. APPLICABILITY OF SUBCHAPTER. This subchapter applies to:

(1) an insurer, including an insurance company, a reciprocal or interinsurance exchange, a mutual insurance company, a capital stock insurance company, a county mutual insurance company, a Lloyd's plan, or any other legal entity authorized to write residential property insurance in this state; and

(2) an insurer's affiliate, as described by this code, if the affiliate is authorized to write residential property insurance.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2251.252. EXEMPTION FROM CERTAIN OTHER LAW. (a) Except as provided by Subsections (b), (c), and (d), an insurer is exempt from the rate filing and approval requirements of this chapter if the insurer, during the calendar year preceding the date filing is otherwise required under this chapter, issued residential property insurance policies in this state that accounted for less than two percent of the total amount of premiums collected by insurers for residential property insurance policies issued in this state, more than 50 percent of which cover property:

(1) valued at less than \$100,000; and

(2) located in an area designated by the commissioner as underserved for residential property insurance under Chapter 2004.

(b) If an insurer described by Subsection (a) is a member of an affiliated insurance group, this subchapter applies to the insurer only if the total aggregate premium collected by the group accounts for less than two percent of the total amount of premiums collected by insurers for residential property insurance policies issued in this state.

(c) An insurer described by Subsection (a) that proposes to increase the premium rates charged policyholders for a residential property insurance product by an amount that is 10 percent or more over the amount the insurer charged policyholders for the same or an equivalent residential property insurance product during the preceding calendar year must file the insurer's proposed rates in accordance with this chapter and, if applicable, obtain approval of the proposed rates as provided by this chapter.

(d) An insurer described by Subsection (a) that increases the premium rates charged policyholders for a residential property insurance product by an annual average amount of eight percent or greater for three consecutive calendar years must file the insurer's proposed rates in accordance with this chapter in the calendar year following the three consecutive years and, if applicable, obtain approval of the proposed rates as provided by this chapter. In calculating the three consecutive calendar years' average premium increases, an insurer is not required to consider a year in which there is a weather-related catastrophe or other major natural disaster that requires the commissioner to extend the claim-handling deadlines under Section 542.059(b).

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2021, 87th Leg., R.S., Ch. 5 (S.B. 965), Sec. 1, eff. September 1, 2021.

CHAPTER 2252. RATE ADMINISTRATION
SUBCHAPTER A. GENERAL PROVISIONS

Sec. 2252.001. APPLICABILITY OF CHAPTER. (a) Except as

provided by Subsections (b) and (c), this chapter applies to an insurer, including a corporation, reciprocal or interinsurance exchange, mutual insurance company, association, Lloyd's plan, or other organization, writing casualty insurance or writing fidelity, surety, or guaranty bonds, on risks or operations in this state.

(b) This chapter does not apply to:

- (1) a farm mutual insurance company or association regulated under Chapter 911; or
- (2) a county mutual insurance company regulated under Chapter 912.

(c) This chapter does not apply to the writing of:

- (1) automobile insurance;
- (2) life, health, or accident insurance;
- (3) professional liability insurance;
- (4) reinsurance;
- (5) aircraft insurance;
- (6) fraternal benefit insurance;
- (7) fire insurance;
- (8) workers' compensation insurance;
- (9) marine insurance, including noncommercial inland marine insurance and ocean marine insurance;
- (10) title insurance;
- (11) explosion insurance, except insurance against loss from personal injury or property damage resulting accidentally from:
 - (A) a steam boiler;
 - (B) a heater or pressure vessel;
 - (C) an electrical device;
 - (D) an engine; or
 - (E) all machinery and appliances used in connection with or in the operation of a boiler, heater, vessel, electrical device, or engine described by Paragraphs (A)-(D); or
- (12) insurance coverage for any of the following conditions or risks:
 - (A) weather or climatic conditions, including lightning, tornado, windstorm, hail, cyclone, rain, or frost and freeze;
 - (B) earthquake or volcanic eruption;
 - (C) smoke or smudge;
 - (D) excess or deficiency of moisture;
 - (E) flood;

(F) the rising water of an ocean or an ocean's tributary;

(G) bombardment, invasion, insurrection, riot, civil war or commotion, military or usurped power, or any order of a civil authority made to prevent the spread of a conflagration, epidemic or catastrophe;

(H) vandalism or malicious mischief;

(I) strike or lockout;

(J) water or other fluid or substance resulting from:
 (i) the breakage or leakage of a sprinkler, pump, or other apparatus erected for extinguishing fire, or a water pipe or other conduit or container; or

(ii) casual water entering a building through a leak or opening in the building or by seepage through building walls;
 or

(K) accidental damage to a sprinkler, pump, fire apparatus, pipe, or other conduit or container described by Paragraph (J)(i).

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2252.002. CONSTRUCTION OF CHAPTER. This chapter does not limit in any manner the kinds or classes of insurance that an insurer may write under an appropriate statute or the insurer's charter or certificate of authority.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER B. RATING SYSTEMS

Sec. 2252.051. INSURER TO PROVIDE RATE INFORMATION. (a) An insurer shall provide all information relevant to a rate used by the insurer to:

(1) any person who is or will be affected by the rate or by a modification of the rate; or

(2) the authorized representative of a person described by Subdivision (1).

(b) The insurer shall provide the information within a

reasonable time after receipt of a written request for the information and on payment of any reasonable charge set by the insurer.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2252.052. RIGHT TO HEARING ON RATING SYSTEM. (a) An insurer shall provide within this state reasonable means by which a person aggrieved by the application of the insurer's rating system may be heard on written request to review the manner in which the rating system has been applied in connection with the insurance afforded the person.

(b) The person may be heard under this section in person or through the person's authorized representative.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2252.053. APPEAL OF DECISION ON RATING SYSTEM. Any party affected by an action taken by an insurer or rating organization in response to a request for a hearing under Section 2252.052 may appeal that action to the commissioner not later than the 10th day after the date the party receives written notice of the action.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER C. LOSS AND EXPENSE EXPERIENCE

Sec. 2252.101. RECORDING AND REPORTING OF LOSS AND EXPENSE EXPERIENCE AND OTHER DATA. (a) The commissioner shall adopt reasonable rules and statistical plans for the recording and reporting of loss experience and other required data by insurers. The rules and plans must ensure that each insurer's total loss and expense experience is made available at least as frequently as biennially in the form and with the detail necessary to aid in determining whether rating plans comply with the standards provided by this chapter, Chapter 1901, Chapter 2251, or Subchapter B, Chapter

5.

(b) In adopting the rules and statistical plans, the commissioner shall have due regard for:

(1) the rating plans used under this chapter, Chapter 1901, Chapter 2251, or Subchapter B, Chapter 5; and

(2) the rules and forms of plans used in other states to ensure that the rules and plans are as uniform as is practicable.

(c) Each insurer shall use the statistical plans adopted under this section to record and report loss experience and other required data in accordance with the rules adopted by the commissioner.

(d) The commissioner may designate other agencies to gather and compile the loss experience and other data.

(e) The commissioner may adopt modifications to statistical plans adopted under this section.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2252.102. RULES AND PLANS REQUIRING INTERCHANGE OF LOSS EXPERIENCE. The commissioner may adopt reasonable rules and plans requiring the interchange of loss experience necessary for the application of rating plans.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2252.103. EXCHANGE OF RATE INFORMATION WITH OTHER STATES. To further the uniform administration of rating laws, the department or an insurer may:

(1) exchange information and experience data with insurance supervisory officials, insurers, and rating organizations in other states; and

(2) consult and cooperate with the individuals or entities described by Subdivision (1) with respect to ratemaking and the application of rating systems.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER D. PROHIBITED ACTS

Sec. 2252.151. PROHIBITED CONDUCT RELATED TO RATES AND PREMIUMS. (a) A person or organization may not knowingly give false or misleading information to the department or commissioner, an insurer, or any other entity that will in any manner affect the proper determination of rates or premiums.

(b) An insurer or agent who knowingly misrepresents the actual or replacement value of real or personal property to achieve an unfair competitive rate advantage commits an offense.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

CHAPTER 2253. RATING TERRITORIES

Sec. 2253.001. RATING TERRITORIES. (a) Notwithstanding any other provision of this code, an insurer, in writing residential property or personal automobile insurance, may use rating territories that subdivide a county only if:

(1) the county is subdivided; and

(2) the rate for any subdivision in the county is not greater than 15 percent higher than the rate used in any other subdivision in the county by that insurer.

(b) The commissioner by rule may allow a greater rate difference than the rate difference specified by Subsection (a).

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.073(a), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.073(a), eff. September 1, 2007.

CHAPTER 2254. PREMIUM REFUND FOR CERTAIN PERSONAL LINES

Sec. 2254.001. DEFINITIONS. In this chapter:

(1) "Insurer" means an insurance company, reciprocal or interinsurance exchange, mutual insurance company, capital stock company, county mutual insurance company, Lloyd's plan, or other legal entity authorized to write residential property insurance or

personal automobile insurance in this state. The term includes an affiliate, as described by this code, that is authorized to write residential property insurance. The term does not include:

(A) the Texas Windstorm Insurance Association under Chapter 2210; or

(B) the FAIR Plan Association under Chapter 2211.

(2) "Personal automobile insurance" means motor vehicle insurance coverage for the ownership, maintenance, or use of a private passenger, utility, or miscellaneous type motor vehicle, including a motor home, trailer, or recreational vehicle, that is:

(A) owned or leased by one or more individuals; and

(B) not used primarily for the delivery of goods, materials, or services, other than for use in farm or ranch operations.

(3) "Residential property insurance" means insurance coverage against loss to real or tangible personal property at a fixed location that is provided through:

(A) a homeowners policy, including a tenants policy;

(B) a condominium owners policy; or

(C) a residential fire and allied lines policy.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2254.002. INAPPLICABILITY OF CHAPTER. This chapter does not apply to rates for personal automobile insurance or residential property insurance for which an insurer obtains prior rate approval under Subchapter D, Chapter 2251.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2254.003. REFUND OR DISCOUNT BASED ON EXCESSIVE OR UNFAIRLY DISCRIMINATORY PREMIUM RATES. (a) This section applies to a rate for personal automobile insurance or residential property insurance filed on or after the effective date of Chapter 206, Acts of the 78th Legislature, Regular Session, 2003.

(b) Except as provided by Section 2254.004(c), if the commissioner determines that an insurer has charged a rate for

personal automobile insurance or residential property insurance that is excessive or unfairly discriminatory, as described by Section 2251.051, the commissioner may:

(1) order the insurer to refund directly to each affected policyholder the portion of the premium, plus interest on that amount, that is excessive or unfairly discriminatory, if that portion of the premium is at least 7.5 percent of the total premium charged for the coverage; or

(2) if that portion of the premium is less than 7.5 percent of the total premium, order the insurer to provide, to each affected policyholder:

(A) who renews the policy, a future premium discount equal to the amount of the excessive or unfairly discriminatory portion of the premium, plus interest on that amount; and

(B) who does not renew or whose coverage is otherwise terminated, a refund in the amount described by Subdivision (1).

(c) The rate for interest assessed under Subsection (b) is the lesser of 18 percent or the sum of six percent and the prime rate for the calendar year in which the commissioner's order finding that the rate is excessive or unfairly discriminatory is issued. For purposes of this subsection, the prime rate is the prime rate as published in The Wall Street Journal for the first day of the calendar year that is not a Saturday, Sunday, or legal holiday. The period for the refund and interest begins on the date the department first provides the insurer with formal written notice that the insurer's filed rate is excessive or unfairly discriminatory, and interest continues to accrue until the refund is paid. An insurer may not be required to pay any interest penalty if the insurer prevails in an appeal of the commissioner's order under Subchapter D, Chapter 36.

(d) An insurer may not claim a premium tax credit to which the insurer is otherwise entitled unless the insurer complies with Subsection (b).

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. [2017](#)), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 484 (H.B. [2551](#)), Sec. 1, eff. June 16, 2007.

Acts 2011, 82nd Leg., R.S., Ch. 1147 (H.B. [1951](#)), Sec. 3.012, eff. September 1, 2011.

Sec. 2254.004. RATE HEARING BY STATE OFFICE OF ADMINISTRATIVE HEARINGS. (a) Not later than the 20th day after the date of an order under Section 2254.003, the insurer may request that the State Office of Administrative Hearings conduct a rate hearing to determine whether the rate that is subject to the order is excessive or unfairly discriminatory.

(b) The office of public insurance counsel may participate in and present evidence at the hearing.

(c) After completion of the hearing, the administrative law judge shall:

(1) prepare a proposal for decision under Section 40.058; and

(2) remand the matter to the commissioner recommending that the commissioner affirm the order or that:

(A) the commissioner complete an additional review of the order not later than the 10th day after the date the commissioner receives the proposal;

(B) the parties enter into negotiations; or

(C) the commissioner take within a period specified by the administrative law judge other appropriate action with respect to the order.

(d) The commissioner's action or failure to act on a proposal or recommendation under Subsection (c) is subject to judicial review under Subchapter D, Chapter 36.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBTITLE I. POLICY FORMS IN GENERAL

CHAPTER 2301. POLICY FORMS

SUBCHAPTER A. POLICY FORMS GENERALLY

Sec. 2301.001. PURPOSE. The purposes of this subchapter are to:

(1) promote the availability of insurance;

(2) regulate the insurance forms used for lines of insurance to which this subchapter applies to ensure that the forms are not unjust, unfair, inequitable, misleading, or deceptive; and

(3) provide regulatory procedures for the maintenance of appropriate information reporting systems.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2301.002. DEFINITIONS. In this subchapter:

(1) "Commercial property insurance" means insurance coverage against loss caused by or resulting from loss, damage, or destruction of real or personal property provided through a commercial property insurance policy. The term includes any combination of:

(A) commercial fire or allied lines;

(B) commercial inland marine insurance;

(C) commercial crime coverage;

(D) boiler and machinery insurance other than explosion;

(E) glass insurance provided as part of other coverage;

and

(F) as authorized by commissioner rule, insurance covering other perils or providing other coverages or other lines of first party property insurance.

(1-a) "Form" means an insurance policy form or a printed endorsement form.

(2) "Residential property insurance" means insurance coverage against loss to real or tangible personal property at a fixed location that is provided through a homeowners insurance policy, including a tenants insurance policy, a condominium owners insurance policy, or a residential fire and allied lines insurance policy.

(3) "Supporting information" means any information required by the department to be filed.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 254 (H.B. 1298), Sec. 2, eff. May 29, 2017.

Sec. 2301.003. APPLICABILITY OF SUBCHAPTER. (a) This subchapter applies to:

(1) an insurer to which Article 5.13 applies, other than the Texas Windstorm Insurance Association, the FAIR Plan Association, and the Texas Automobile Insurance Plan Association; and

(2) except as provided by Subsections (c) and (d), a Lloyd's plan, reciprocal or interinsurance exchange, and county mutual insurance company with respect to the lines of insurance described by Subsection (b).

(b) Except as provided by Section 2301.0031, this subchapter applies to all lines of the following kinds of insurance written under an insurance policy or contract issued by an insurer authorized to engage in the business of insurance in this state:

(1) general liability insurance;

(2) residential and commercial property insurance, including farm and ranch insurance and farm and ranch owners insurance;

(3) personal and commercial casualty insurance, except as provided by Section 2301.005;

(4) medical professional liability insurance;

(5) fidelity, guaranty, and surety bonds other than criminal court appearance bonds;

(6) personal umbrella insurance;

(7) personal liability insurance;

(8) guaranteed auto protection (GAP) insurance;

(9) involuntary unemployment insurance;

(10) financial guaranty insurance;

(11) inland marine insurance;

(12) rain insurance;

(13) hail insurance on farm crops;

(14) personal and commercial automobile insurance;

(15) multi-peril insurance; and

(16) identity theft insurance issued under Chapter 706.

(c) Section 2301.009 does not apply to a Lloyd's plan or a reciprocal or interinsurance exchange with respect to commercial property insurance.

(d) This subchapter does not apply to a Lloyd's plan or reciprocal or interinsurance exchange with respect to inland marine insurance, rain insurance, or hail insurance on farm crops.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.071(b), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.071(b), eff. September 1, 2007.

Acts 2021, 87th Leg., R.S., Ch. 42 (S.B. 1367), Sec. 5, eff. September 1, 2021.

Sec. 2301.0031. EXCEPTIONS FOR CERTAIN LINES. (a) Except as provided by Subsection (d), Sections 2301.006, 2301.007(a) and (b), and 2301.008 do not apply to any line of the following kinds of insurance written under a commercial insurance policy or contract issued by an insurer authorized to engage in the business of insurance in this state:

- (1) surety bonds;
- (2) fidelity bonds;
- (3) commercial inland marine;
- (4) boiler and machinery;
- (5) environmental impairment or pollution liability;
- (6) kidnap and ransom;
- (7) political risk or expropriation;
- (8) commercial excess liability or umbrella liability;
- (9) directors' and officers' liability;
- (10) fiduciary liability;
- (11) employment practices liability;
- (12) errors and omission and professional liability other than medical professional liability;
- (13) media liability;
- (14) product liability, product recall, or completed operations;
- (15) commercial cybersecurity, including first- and third-party commercial lines coverage for losses arising out of or relating to data privacy breaches, network security, computer viruses, and similar exposures;
- (16) highly protected commercial property;
- (17) commercial flood insurance not provided through the National Flood Insurance Program; or

(18) any combination of only the kinds of insurance listed in this subsection or exempted under Subsection (c).

(b) For purposes of Subsection (a), "highly protected commercial property" is commercial property that is subject to a much lower than normal probability of loss due to low-hazard occupancy or property type, superior construction, special fire protection equipment and procedures, and management commitment to loss prevention.

(c) The commissioner by rule may exempt a commercial line of insurance or commercial risk not listed in Subsection (a) from the form filing requirements of this subchapter to promote enhanced competition or more effectively use the resources of the department that might otherwise be used to review commercial lines filings.

(d) Notwithstanding Subsection (a), the commissioner may temporarily impose the requirements of Sections 2301.006, 2301.007(a) and (b), and 2301.008 for a specific kind of insurance listed in Subsection (a) for a period of not longer than one year if, after notice and hearing, the commissioner issues an order that:

- (1) includes a finding that a reasonable degree of competition does not exist for that specific kind of insurance; and
- (2) specifies the relevant tests and test results used to determine the degree of competition for that kind of insurance.

(e) In the absence of a finding described by Subsection (d) with respect to a specific kind of insurance, a competitive market is presumed to exist for that kind of insurance.

(f) The commissioner may adopt reasonable and necessary rules to implement this section.

Added by Acts 2021, 87th Leg., R.S., Ch. 42 (S.B. [1367](#)), Sec. 6, eff. September 1, 2021.

Sec. 2301.004. EXEMPTION FOR LARGE RISKS. Sections 2301.006, 2301.007(a) and (b), and 2301.008 do not apply to forms for use with an insured that has:

- (1) total insured property values of \$5 million or more;
- (2) total annual gross revenues of \$10 million or more; or
- (3) a total premium of \$25,000 or more for property insurance, \$25,000 or more for general liability insurance, or \$50,000 or more for multiperil insurance.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2301.005. REGULATION OF INLAND MARINE FORMS. The commissioner shall adopt rules governing the manner in which forms for the various classifications of risks insured under inland marine insurance, as determined by the commissioner, are regulated.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2301.006. FILING AND APPROVAL OF FORMS. (a) Except as provided by Section 2301.008, an insurer may not deliver or issue for delivery in this state a form for use in writing insurance described by Section 2301.003 unless the form has been filed with and approved by the commissioner.

(b) An insurer must file the form not later than the 60th day before the date an insurer uses the form or delivers the form for use.

(c) A filed form is approved at the expiration of 60 days after the date the form is filed unless the commissioner by order approves or disapproves the form during the 60-day period. The commissioner's approval of a filed form constitutes a waiver of any unexpired portion of the 60-day period.

(d) The commissioner may extend by not more than 10 days the 60-day period described by Subsection (c) during which the commissioner may approve or disapprove a form filed by an insurer. The commissioner shall notify the insurer of the extension before the expiration of the 60-day period.

(e) A filed form for which an extension has been granted under Subsection (d) is considered approved at the expiration of the extension period described by that subsection absent an earlier approval or disapproval of the form.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2301.007. DISAPPROVAL OF FORMS; WITHDRAWAL OF APPROVAL.

(a) The commissioner may disapprove a form filed under Section 2301.006 or withdraw approval of a form if the form:

(1) violates any law, including a rule adopted under this code; or

(2) contains a provision or has a title or heading that is unjust or deceptive, encourages misrepresentation, or violates public policy.

(b) For good cause shown, the commissioner may withdraw approval of a form after notice and hearing.

(c) An order issued by the commissioner disapproving a form, or a notice of the commissioner's intention to withdraw approval of a form, must state the grounds for the disapproval or withdrawal of approval in sufficient detail to reasonably inform the insurer of those grounds.

(d) An order of withdrawal of approval of a form takes effect on the date prescribed by the commissioner in the order. The commissioner may not prescribe a date earlier than the 30th day after the effective date of the order, as prescribed by the commissioner.

(e) An insurer may not use a form in this state after the commissioner disapproves the form or withdraws approval of the form.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

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

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2301.009. PUBLIC INSPECTION OF INFORMATION. Each filing made, and any supporting information filed, under this subchapter is open to public inspection as of the date of the filing.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April

1, 2007.

Sec. 2301.010. CONTRACTUAL LIMITATIONS PERIOD AND CLAIM FILING PERIOD IN CERTAIN PROPERTY INSURANCE FORMS. (a) This section applies only to an insurer that issues windstorm and hail insurance in the catastrophe area, as defined by Section 2210.003.

(b) Notwithstanding Section 16.070, Civil Practice and Remedies Code, and for the purpose described by Section 2210.053(b), a policy form or printed endorsement form for residential or commercial property insurance that is filed by an insurer described by Subsection (a) or adopted by the department under this subchapter for use by an insurer described by Subsection (a) may provide for a contractual limitations period for filing suit on a first-party claim under the policy. The contractual limitations period may not end before the earlier of:

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

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

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

(d) A contractual provision contrary to Subsection (b) or (c) is void. If a contractual provision is voided under this subsection, the voiding of the provision 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.

(e) The department, to encourage the authorized insurers to write windstorm and hail insurance in the catastrophe area, as defined by Section 2210.003, and in other areas of the state, may approve policy or contractual provisions other than those described by Subsections (b) and (c) that are consistent with sound underwriting and insurance principles, provided that the policy or contractual provisions meet the requirements of Sections 2301.007(a) and 2301.053.

(f) An insurer using a policy form or endorsement form in this state that includes a provision described by Subsection (b) or (c) shall, at the time the policy or endorsement is issued or renewed, disclose in writing to an applicant or insured the contractual limitations or claims filing period, as applicable, in the policy or endorsement.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 2 (H.B. 3), Sec. 55, eff. September 28, 2011.

**SUBCHAPTER B. POLICY FORMS FOR PERSONAL AUTOMOBILE
INSURANCE COVERAGE AND RESIDENTIAL PROPERTY INSURANCE COVERAGE**

Sec. 2301.051. DEFINITIONS. In this subchapter:

(1) "Insurer" means an insurance company, reciprocal or interinsurance exchange, mutual insurance company, capital stock insurance company, county mutual insurance company, Lloyd's plan, or other legal entity authorized to write personal automobile insurance or residential property insurance in this state. The term includes an affiliate, as described by this code, that is authorized to write and is writing personal automobile insurance or residential property insurance in this state. The term does not include:

- (A) the Texas Windstorm Insurance Association;
- (B) the FAIR Plan Association; or
- (C) the Texas Automobile Insurance Plan Association.

(2) "Personal automobile insurance" means automobile insurance coverage for the ownership, maintenance, or use of a private passenger, utility, or miscellaneous type motor vehicle, including a motor home, trailer, or recreational vehicle, that is:

- (A) owned or leased by one or more individuals; and
- (B) not primarily used for the delivery of goods, materials, or services, other than for use in farm or ranch operations.

(3) "Residential property insurance" means insurance coverage against loss to tangible personal property or to residential real property at a fixed location that is provided through a homeowners insurance policy, including a tenants insurance policy, a condominium owners insurance policy, or a residential fire and allied lines insurance policy.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April

1, 2007.

Sec. 2301.052. REGULATION OF POLICY FORMS AND ENDORSEMENTS.

(a) Notwithstanding any other provision of this code and except as provided by this section, Subchapter A applies to an insurer with respect to insurance policy forms and endorsements for personal automobile insurance and residential property insurance.

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

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2301.053. REQUIREMENTS FOR FORMS; PLAIN-LANGUAGE REQUIREMENT. (a) Each form filed in accordance with this subchapter must comply with applicable state and federal law.

(b) Each form for a personal automobile insurance policy must provide the coverages mandated under Subchapters C and D, Chapter 1952, unless the coverages are rejected by the named insured in the manner provided by those subchapters.

(c) A form may not be used unless the form is written in plain language. For purposes of this section, a form is written in plain language if:

(1) the form achieves the minimum score established by the commissioner on the Flesch reading ease test or an equivalent test selected by the commissioner; or

(2) at the commissioner's option, the form conforms to the language requirements in a National Association of Insurance Commissioners model act relating to plain language.

(d) Subsection (c) does not apply to policy language that is mandated by state or federal law.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2301.054. CERTAIN CONTRACTS OR AGREEMENTS PROHIBITED; REVOCATION OF CERTIFICATE OF AUTHORITY. (a) A contract or agreement that is not written into an application for personal automobile insurance coverage and the personal automobile insurance policy is void and violates this code.

(b) A contract or agreement described by Subsection (a) constitutes grounds for the revocation of an insurer's certificate of authority to write personal automobile insurance in this state.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2301.055. RULES. The commissioner may adopt reasonable and necessary rules to implement this subchapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2301.056. REQUIREMENT FOR FORMS; DECLARATIONS PAGE REQUIREMENT. (a) A residential property insurance policy form must include a declarations page that:

(1) lists and identifies each type of deductible under the residential property insurance policy; and

(2) states the exact dollar amount of each deductible under the residential property insurance policy.

(b) If a residential property insurance policy or an endorsement attached to the policy contains a provision that may cause the exact dollar amount of a deductible under the policy to change, the declarations page must identify or include a written disclosure that clearly identifies the applicable policy provision or endorsement. The policy provision or endorsement must explain how any change in the applicable deductible amount is determined.

(c) A disclosure containing a list required by Subsection (a)(1), or a disclosure containing an identification of each applicable policy provision or endorsement, may be provided on a page separate from the declarations page.

Added by Acts 2013, 83rd Leg., R.S., Ch. 730 (S.B. 112), Sec. 1, eff. September 1, 2013.

Sec. 2301.057. CERTAIN DOCUMENTS NOT PART OF FORM. (a) A document providing a summary of a policy of personal automobile insurance or residential property insurance or a summary of an endorsement to such a policy or other ancillary material, including an advertisement for the policy or endorsement, is not part of the policy or endorsement form.

(b) A summary described by Subsection (a) does not modify the provisions of the insurance policy for which the summary was provided.

(c) A summary described by Subsection (a) is not admissible as evidence of the coverage provided by the insurance policy for which the summary is provided.

Added by Acts 2019, 86th Leg., R.S., Ch. 125 (H.B. 1555), Sec. 1, eff. May 23, 2019.

Sec. 2301.058. PROVISION OF POLICY DOCUMENTS AND RELATED MATERIALS IN LANGUAGE OTHER THAN ENGLISH. (a) An insurer may provide a customer a version of a personal automobile or residential property insurance policy or endorsement, or related explanatory or advertising material, in a language other than English. The version of the document must state, in the language of the version, that the English version of the insurance policy document controls.

(b) In the case of a dispute or complaint, the English version of the insurance policy document controls.

Added by Acts 2019, 86th Leg., R.S., Ch. 183 (H.B. 1554), Sec. 1, eff. May 24, 2019.

TITLE 11. TITLE INSURANCE
SUBTITLE A. GENERAL PROVISIONS
CHAPTER 2501. GENERAL PROVISIONS

Sec. 2501.001. SHORT TITLE. This title may be cited as the Texas Title Insurance Act.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2501.002. PURPOSE; LEGISLATIVE INTENT. (a) The purpose of this title is to completely regulate the business of title insurance on real property and, as described by Subtitle F, on personal property, including the direct issuance of policies and the reinsurance of any assumed risks, to:

(1) protect consumers and purchasers of title insurance policies; and

(2) provide adequate and reasonable rates of return for title insurance companies and title insurance agents.

(b) It is the express legislative intent that this title accomplish the purpose described by Subsection (a).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 543 (S.B. 1153), Sec. 2, eff. September 1, 2007.

Sec. 2501.003. DEFINITIONS. In this title:

(1) "Abstract plant" means an abstract plant as defined by the department under Section 2501.004.

(2) "Attorney" means:

(A) a person who is licensed to practice law and is a member of the State Bar of Texas; or

(B) a Texas professional corporation organized to provide professional legal services.

(3) "Direct operation" means the operations of a title insurance company under a license issued to the company under Subchapter B, Chapter 2651. A reference in this title to a title insurance agent shall be construed to include a direct operation unless the context indicates otherwise.

(4) "Escrow officer" means an attorney, a bona fide employee of an attorney licensed as an escrow officer, a bona fide employee of a direct operation, or a bona fide employee of a title insurance agent whose responsibilities include:

(A) countersigning title insurance forms;

(B) supervising the preparation and delivery of title insurance forms;

(C) signing escrow checks; or

(D) closing the transaction, as described by Section

2501.006.

(5) "Foreign title insurance company" means a title insurance company organized under the laws of a jurisdiction other than this state.

(6) "Joint abstract plant operation" means a joint abstract plant operation as defined by the department under Section 2501.004.

(7) "Person" includes an individual, corporation, association, partnership, or trust.

(8) "Premium" means the premium rates promulgated by the commissioner under Subchapters D and E, Chapter 2703, and includes a charge for:

(A) title examination and closing the transaction, regardless of whether the examination or closing is performed by an attorney; and

(B) issuing the policy.

(9) "Residential real property" means real property that is improved and is designed principally for occupancy by one to four families. The term includes an individual unit of a condominium or cooperative.

(10) "Thing of value" includes any payment, advance, funds, loan, service, or other consideration.

(11) "Title examination" means the search and examination of a title to determine the conditions of the title to be insured and to evaluate the risk to be undertaken in the issuance of a title insurance policy or other title insurance form.

(12) "Title insurance" means:

(A) insurance that insures, guarantees, or indemnifies an owner of real property, or another interested in the real property, against loss or damage resulting from:

(i) a lien or encumbrance on or defect in the title to the real property; or

(ii) the invalidity or impairment of a lien on the real property;

(B) personal property title insurance, as defined by Chapter 2751; or

(C) any business that is substantially equivalent to the insurance described by Paragraphs (A) and (B) and is conducted in a manner designed to evade the provisions of this title.

(13) "Title insurance agent" means a person owning or leasing and controlling an abstract plant or as a participant in a

bona fide joint abstract plant operation and authorized in writing by a title insurance company to solicit insurance and collect premiums and to issue or countersign policies on the company's behalf.

(14) "Title insurance company" means:

(A) a domestic company organized under this title to engage in the business of title insurance, as described by Section 2501.005;

(B) a foreign title insurance company that:
 (i) meets the requirements of this title; and
 (ii) holds a certificate of authority to engage in business in this state; or

(C) any other domestic or foreign company that:
 (i) meets the requirements of this title; and
 (ii) holds a certificate of authority to insure a title to real property in this state.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.
 Amended by:

Acts 2007, 80th Leg., R.S., Ch. 543 (S.B. [1153](#)), Sec. 3, eff. September 1, 2007.

Sec. 2501.004. ABSTRACT PLANT; JOINT ABSTRACT PLANT OPERATION.

(a) For purposes of this title, the department shall define "abstract plant" and "joint abstract plant operation."

(b) To provide for the safety and protection of policyholders, the department shall require that an abstract plant:

- (1) be geographically arranged;
- (2) cover a period beginning not later than January 1, 1979, and be kept current; and
- (3) be adequate for use in insuring titles, as determined by the department.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.
 Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1025 (H.B. [4338](#)), Sec. 1, eff. September 1, 2009.

Sec. 2501.005. BUSINESS OF TITLE INSURANCE. (a) For purposes of this title, a person engages in the business of title insurance if

the person:

- (1) as insurer, guarantor, or surety, makes or proposes to make a contract or policy of title insurance or its equivalent;
- (2) transacts or proposes to transact any phase of title insurance, including:
 - (A) soliciting;
 - (B) title examination other than an examination conducted by an attorney;
 - (C) closing the transaction other than a closing conducted by an attorney;
 - (D) executing a contract of title insurance; and
 - (E) insuring and transacting matters arising out of the contract after the contract is executed, including reinsurance; or
- (3) makes a guaranty or warranty of a title search or a title examination, or any component of a title search or title examination, if the person is not the person who performs the search or examination.

(b) A person engages in the business of title insurance if the person engages in or proposes to engage in any business that is substantially equivalent to the business of title insurance as described by this section, regardless of whether that conduct is performed in a manner designed to evade the provisions of this title.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2501.006. CLOSING THE TRANSACTION. (a) For purposes of this title, "closing the transaction" describes the investigation that is made:

- (1) on behalf of a title insurance company, title insurance agent, or direct operation before the title insurance policy is issued; and
 - (2) to determine proper execution, acknowledgment, and delivery of all conveyances, mortgage papers, and other title instruments necessary to consummate a transaction.
- (b) Closing the transaction includes a determination that:
- (1) all delinquent taxes have been paid;
 - (2) in the case of an owner title insurance policy, all current taxes, based on the latest available information, have been properly prorated between the purchaser and seller;

- (3) the consideration has been passed;
- (4) all proceeds have been properly disbursed;
- (5) a final search of the title has been made; and
- (6) all necessary papers have been filed for record.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2501.007. REFERENCES TO TITLE. In this title, a reference to this title includes a reference to:

- (1) Chapter 223;
- (2) Chapter 271; and
- (3) Subchapter U, Chapter 171, Tax Code.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.077, eff. September 1, 2005.

Sec. 2501.008. THIRD-PARTY CHARGES. A title insurance company, title insurance agent, or direct operation may charge, separate from the title insurance premium, actual costs or a reasonable estimate of costs incurred in connection with a closing and settlement, including:

- (1) a charge by a third party for an electronic filing fee; or
- (2) a fee of a third party for the provision of an ad valorem tax report.

Added by Acts 2009, 81st Leg., R.S., Ch. 1159 (H.B. 3073), Sec. 1, eff. January 1, 2010.

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

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

Added by Acts 2011, 82nd Leg., R.S., Ch. 1011 (H.B. 2408), Sec. 1, eff. September 1, 2011.

CHAPTER 2502. PROHIBITED CONDUCT

SUBCHAPTER A. PROHIBITED CONDUCT IN GENERAL

Sec. 2502.001. ENGAGING IN CERTAIN INSURANCE BUSINESS PROHIBITED. (a) A domestic or foreign corporation operating under this title may not engage in the business of any kind of insurance other than title insurance.

(b) A company may not engage in the business of title insurance if the company engages in the business of another kind of insurance.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2502.002. COVERAGE FOR UNMARKETABILITY OF TITLE PROHIBITED. (a) An insurance company may not insure against loss or damage by reason of unmarketability of title.

(b) The commissioner may not adopt a rule or form providing for coverage prohibited by this section.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2502.003. INSURING AROUND DEFINED; PROHIBITIONS AND EXCEPTIONS. (a) Except as provided by Subsection (c), a title insurance company may not wilfully issue a binder for title insurance or a title insurance policy showing no outstanding enforceable recorded liens on real property against which the company knows an outstanding enforceable recorded lien exists.

(b) A title insurance company knows that an outstanding enforceable recorded lien exists against real property if, based on an examination of the title under which the binder for title insurance or title insurance policy is issued, the company determines that the lien is valid and enforceable.

(c) The commissioner by rule may approve circumstances under which a title insurance company may issue a binder for title insurance or a title insurance policy otherwise prohibited by Subsection (a).

(d) Except as otherwise provided by this section, a title

insurance company may determine the insurability of title to real property and any other matter that the company considers to be insurable under a binder for title insurance or a title insurance policy issued in connection with the property.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2502.004. GUARANTEE OF MORTGAGE PAYMENT PROHIBITED. (a) A title insurance company may not guarantee the payment of a mortgage on real property.

(b) A title insurance company that violates this section forfeits its authority to engage in business in this state and shall immediately surrender its certificate of authority.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2502.005. CIVIL PENALTY. (a) A person is liable to the state for a civil penalty of not more than \$5,000 if the person:

(1) wilfully violates Section 2502.003 or 2502.004; or
(2) violates an order of the commissioner refusing to approve an application to issue a binder for title insurance or a title insurance policy prohibited by Section 2502.003(a).

(b) The department may bring an action in a Travis County district court to recover the penalty provided by this section.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2502.006. CERTAIN EXTRA HAZARDOUS COVERAGES PROHIBITED.

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

(1) a preference or preferential transfer under 11 U.S.C. Section 547;
(2) a fraudulent transfer under 11 U.S.C. Section 548;
(3) a transfer that is fraudulent as to present and future creditors under Section 24.005, Business & Commerce Code, or a

similar law of another state; or

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

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

(c) Title insurance issued in or on a form prescribed by the commissioner shall be considered to comply with this section.

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

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

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

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

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

Added by Acts 2011, 82nd Leg., R.S., Ch. 1059 (S.B. 322), Sec. 1, eff. September 1, 2011.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1063 (S.B. 735), Sec. 1, eff. September 1, 2011.

SUBCHAPTER B. REBATES AND DISCOUNTS

Sec. 2502.051. REBATES AND DISCOUNTS PROHIBITED. A commission, rebate, discount, portion of a title insurance premium, or other thing of value may not be directly or indirectly paid, allowed, or permitted by a person engaged in the business of title insurance or received or accepted by a person for engaging in the business of

title insurance or for soliciting or referring title insurance business.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2502.052. CERTAIN DIVISIONS OF REAL PROPERTY CHARGES PROHIBITED. Other than for services actually performed, a person may not give or accept any portion, split, or percentage of a charge made or received for a settlement or closing performed in connection with a transaction involving the conveyance or mortgaging of real property located in this state.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2502.053. CERTAIN COMPENSATORY PAYMENTS NOT PROHIBITED. This subchapter does not prohibit:

(1) payment for services actually performed by a title insurance company, title insurance agent, or direct operation in connection with title examination or with closing the transaction or furnishing title evidence if:

(A) the payment does not exceed the percentage of premium or other amount established by the commissioner for the payment; and

(B) the person receiving the payment is licensed as provided by this title;

(2) payment of bona fide compensation to a bona fide employee principally employed by a title insurance company, title insurance agent, or direct operation;

(3) reasonable payment for goods or facilities actually provided and received; or

(4) payment for services actually performed by an attorney in connection with title examination or with closing the transaction, if the payment does not exceed a reasonable charge for the services.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2502.054. CERTAIN DIVISIONS OF PREMIUMS NOT PROHIBITED.

(a) For purposes of this section, a subsidiary is a company at least

50 percent of the voting stock of which is owned by the title insurance company or by a wholly owned subsidiary of the title insurance company.

(b) This subchapter does not:

(1) prohibit a title insurance company from:

(A) appointing as its title insurance agent for a county a person who owns or leases and operates an abstract plant for that county; and

(B) arranging for a division of premiums with the agent as set by the commissioner; or

(2) affect the division of a premium between a title insurance company and its subsidiary title insurance agent when the company directly issues a title insurance policy or contract under Section 2704.002.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2502.055. PROMOTIONAL AND EDUCATIONAL ACTIVITIES NOT REBATES. (a) The activities described in this section are not rebates. Nothing in this subchapter prohibits a title insurance company or a title insurance agent from:

(1) engaging in promotional and educational activities that are not conditioned on the referral of title insurance business and not prohibited by Subchapter B, Chapter 541;

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

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

(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.

(b) "Market rate" means the price at which a seller, under no obligation or duress to sell, is willing to accept and a buyer, under no obligation or duress to buy, is willing to pay in an arms-length transaction. The market rate is determined by comparing the rights or items purchased or sold to similar rights or items that have been recently purchased by others or sold to others, including others not in the title insurance business.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 631 (H.B. 2565), Sec. 7, eff. September 1, 2005.

Acts 2011, 82nd Leg., R.S., Ch. 1011 (H.B. 2408), Sec. 2, eff. September 1, 2011.

Sec. 2502.056. MONETARY FORFEITURE. (a) A person who pays or receives a commission, rebate, discount, or other thing of value for soliciting or referring title insurance business in violation of Section 2502.051 is engaging in the unauthorized business of insurance.

(b) After notice and opportunity for hearing, a person who makes or receives a payment described by Subsection (a) is liable for a monetary forfeiture in an amount not less than the value of or more than three times the value of the payment.

(c) A monetary forfeiture under Subsection (b) is in addition to any other penalty provided by law.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2502.057. CERTAIN COMPENSATORY PAYMENTS RELATED TO CERTAIN ELECTRIC ENERGY PROJECTS PERMITTED. (a) This section applies with respect to a utility project that is:

(1) designed to produce, generate, transmit, distribute, sell, or furnish electric energy; and

(2) valued on completion at more than \$25 million.

(b) A payment for furnishing title evidence for the issuance of a title insurance policy related to a project described by Subsection (a) may be:

(1) a flat fee or fee calculated on an hourly basis that:

(A) is payable on the date the title evidence is furnished; and

(B) does not exceed \$25,000; or

(2) a portion of the title insurance premium:

(A) based on the percentage established by the commissioner for payment by a title insurance company, title insurance agent, or direct operation for services performed by another title insurance company, title insurance agent, or direct operation; and

(B) payable on the date of the issuance of the policy for which the evidence is furnished.

(c) The payment must be:

(1) made by the proposed insured to the title insurance company, title insurance agent, or direct operation that furnishes the title evidence; and

(2) credited against the title insurance premium charged for the issuance of the title insurance policy for which the evidence is furnished.

(d) Nothing in this section may be construed to allow the payment of an amount in violation of the premium rates promulgated or the division of premium established by the commissioner.

(e) This section does not apply to a payment to a reinsurer for the assumption of reinsurance described by Subchapter G, Chapter 2551.

Added by Acts 2013, 83rd Leg., R.S., Ch. 1056 (H.B. [3106](#)), Sec. 1, eff. September 1, 2013.

SUBTITLE B. ORGANIZATION OF TITLE INSURANCE COMPANIES

CHAPTER 2551. TITLE INSURERS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 2551.001. APPLICABILITY OF TITLE AND OTHER LAW. (a) Except as provided by Subsection (c) and unless the business of title insurance or title insurance companies are expressly mentioned, the provisions of this code other than this title do not apply to:

(1) a corporation incorporated or engaging in business exclusively under this title; or

(2) any title insurance business engaged in by a corporation created under:

- (A) Subdivision 57, Article 1302, Revised Statutes;
- (B) Chapter 861; or
- (C) any other law.

(b) A law enacted after September 7, 1951, does not apply to a title insurance company or title insurance business described by Subsection (a) unless the law expressly states that it applies.

(c) To the extent applicable, the following provisions of this code apply to a title insurance company:

- (1) Articles 1.09-1 and 21.47;
- (2) Subsection (b), Article 1.04D;
- (3) Chapters 33, 82, 83, 84, 86, 102, 261, 281, 401, 402, 493, 494, 541, 547, 555, 701, 801, 802, 824, 828, 1805, and 2204;
- (4) Chapter 31, other than Section 31.005;
- (5) Chapter 32, other than Section 32.022(b);
- (6) Chapter 36, other than Sections 36.003, 36.004, and 36.101-36.106;
- (7) Subchapter A, Chapter 38;
- (8) Subchapters A-G, Chapter 101;
- (9) Chapter 982, other than Sections 982.003, 982.051, 982.101, 982.105, 982.106(b), 982.109, and 982.113; and
- (10) Sections 37.052, 39.001, 39.002, 81.001, 81.002, 81.004, 201.004, 201.005, 201.051, 201.055, 403.001, 403.051, 403.101, 521.002-521.004, 805.021, 822.001, 822.051, 822.052(1), (2), and (3), 822.053, 822.057, except Subsection (a)(4), 822.058, 822.059, 822.060, 822.155, 822.157, 822.158, except Subsection (a)(5), 841.004, 841.251, 841.252(a)-(c), and 4001.103.

(d) This title governs in any conflict between a provision listed by Subsection (c) and a provision of this title.

(e) This title does not regulate the practice of law by an attorney. The actions of an attorney in examining title, in examining records regarding an interest insured under Chapter 2751, or in closing a real property or personal property transaction, regardless of whether a title insurance policy is issued, does not constitute the business of title insurance, unless the attorney elects to be licensed as an escrow officer.

(f) Subsection (e) does not prohibit the commissioner from promulgating a premium for title insurance.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 543 (S.B. 1153), Sec. 4, eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2I.001, eff. April 1, 2009.

Acts 2009, 81st Leg., R.S., Ch. 447 (H.B. 2353), Sec. 1, eff. September 1, 2009.

Sec. 2551.002. APPLICABILITY OF LAW GOVERNING CORPORATIONS. A title insurance company is subject to the Texas Business Corporation Act, the Texas Miscellaneous Corporation Laws Act (Article 1302-1.01 et seq., Vernon's Texas Civil Statutes), and any other law of this state that governs corporations in general, to the extent those laws are not inconsistent with this title.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2551.003. RULEMAKING; AUTHORITY OF DEPARTMENT AND COMMISSIONER. (a) The commissioner may adopt and enforce rules:

(1) that prescribe underwriting standards and practices on which a title insurance contract must be issued;

(2) that define risks that may not be assumed under a title insurance contract, including risks that may not be assumed because of the insolvency of the parties to the transaction; and

(3) that the commissioner determines are necessary to accomplish the purposes of this title.

(b) With respect to a company operating under this title that engages in the kinds of business described by Section 2551.051(b)(1) or (2) in a manner that might subject the company to another regulatory statute of this state, all examination and regulation shall be exercised by the department rather than any other state agency named in the other regulatory statute, as long as the corporation engages in the business of title insurance.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

SUBCHAPTER B. FORMATION

Sec. 2551.051. FORMATION; GENERAL PURPOSES AND POWERS. (a) A private corporation may be created and licensed under this title for

the following purposes:

(1) to compile and own or lease, or to acquire and own or lease, records or abstracts of title to real property or interests in real property in this state or other jurisdictions, to insure titles to that real property or interests in that real property, and to indemnify the owners of that real property, or the holders of interests in or liens on that real property, against loss or damage resulting from an encumbrance on or defect in the title to the real property or interests in the real property;

(2) in transactions in which title insurance is to be or is being issued, to supervise or approve the signing of legal instruments affecting the interest to be insured, disbursement of money, prorations, delivery of legal instruments, closing of transactions, or issuance of commitments for title insurance specifying the requirements for title insurance and the defects in title necessary to be cured or corrected; and

(3) to issue personal property title insurance under Chapter 2751.

(b) A corporation described by Subsection (a) may exercise any of the following powers by including the power in the corporation's charter:

(1) to make and sell abstracts of title in any county of this state or another state;

(2) to accumulate and lend money and to purchase, sell or deal in notes, bonds, and securities, but without banking privileges;

(3) to act as trustee under a lawful trust committed to the corporation by contract or will or by appointment by a court as trustee, receiver, or guardian; and

(4) to act as executor or guardian under the terms of a will or as an administrator of a decedent's estate under the appointment of a court.

(c) Notwithstanding any other provision of this section, a corporation described by Subsection (a) is not authorized to practice law, as that term is defined by the courts of this state. A corporation described by Subsection (a) is not authorized to prepare a legal instrument described by Subsection (a)(2).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 543 (S.B. [1153](#)), Sec. 5, eff.

September 1, 2007.

Sec. 2551.052. NAME. (a) The name of a corporation chartered or operating under this title may contain the words "Title and Trust Company."

(b) The name of a corporation chartered or operating under this title may not contain the word "Trust" alone. If the word "Trust" appears in the corporation's letterhead or literature, the corporation shall include the words "Without Banking Privileges."

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2551.053. STOCK AND SURPLUS REQUIREMENTS. (a) A title insurance company must have a paid-up capital of at least \$1 million and a surplus of at least \$1 million.

(b) The capital stock and minimum surplus requirements of a title insurance company must be maintained intact over and above all outstanding liabilities, except contingent liabilities on title insurance policies.

(c) If a title insurance company suffers the impairment of its capital stock or minimum surplus requirements, the company shall immediately report the impairment to the department.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 967 (S.B. 2065), Sec. 5.007, eff. September 1, 2017.

Sec. 2551.054. PURCHASE OF OWN STOCK. (a) Subject to Section 2551.053(a) and the Texas Business Corporation Act, a title insurance company may purchase its own shares of stock. A purchase of its own shares is not considered an investment and does not constitute a violation of a provision of this code relating to admissible investments.

(b) A title insurance company that purchases its own shares must, not later than the 10th day after the date of purchase, file with the commissioner a statement listing:

(1) the name of each shareholder from whom the shares have

been purchased; and

(2) the amount paid for the shares.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2551.055. CHARTER OF CORPORATION ENGAGING IN BUSINESS OF TITLE INSURANCE. (a) The incorporators of a corporation engaging in the business of title insurance and incorporated under this title, Subdivision 57, Article 1302, Revised Statutes, Chapter 40, Acts of the 41st Legislature, Regular Session, 1929 (Article 1302a, Vernon's Texas Civil Statutes), or any other law shall file the corporation's original charter only with the department and shall certify the charter only to the department.

(b) Only the department may collect from a company described by this section any filing fees required by law.

(c) A corporation described by this section is not subject to another law to the extent that the law conflicts with this section.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2551.056. REGULATION OF CERTAIN CORPORATIONS. (a) A corporation incorporated under Subdivision 57, Article 1302, Revised Statutes, before February 27, 1929, and engaging in business in this state on February 27, 1929:

(1) may continue to engage in business;

(2) is subject to this title; and

(3) shall comply with the requirements of this title regarding investments and deposits.

(b) A shareholder in a company acting under this title is not liable in the event of default in the payment of any debt or liability of the company beyond the shareholder's subscription for stock.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

SUBCHAPTER C. AUTHORITY TO ENGAGE IN BUSINESS

Sec. 2551.101. CERTIFICATE OF AUTHORITY REQUIRED. A title insurance company may not engage in the business of title insurance

in this state unless the company holds a certificate of authority issued under this title.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2551.102. ISSUANCE OF CERTIFICATE OF AUTHORITY. (a) Subject to Subsection (c), the department shall issue a certificate of authority to engage in the business of title insurance if, following any examination the department considers proper, the department makes a determination favorable to the title insurance company with respect to:

(1) the payment of capital stock and surplus as required by this title; and

(2) the value of the assets used to pay the capital stock and surplus.

(b) The title insurance company shall pay the expense of any examination conducted under Subsection (a).

(c) Issuance of a certificate of authority to a foreign corporation is governed by Section 2553.001.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

SUBCHAPTER D. GENERAL POWERS AND DUTIES

Sec. 2551.151. ADMISSIBLE INVESTMENTS. (a) A title insurance company shall hold all investments in cash or in the following:

(1) an abstract plant or plants, provided that:

(A) the corporation is organized under this title and has the right to engage in the business of title insurance;

(B) except as provided by Subsection (b), the investment is not more than 50 percent of the corporation's capital stock; and

(C) the valuation of the plant or plants is approved by the department;

(2) securities described by Subchapter D, Chapter 425, other than Sections 425.202 and 425.229-425.232, or investments authorized for title insurance companies under the laws of any other state in which the company is authorized to engage in business;

(3) real property or any real property interest that is:

(A) required for the company's convenient accommodation

in the transaction of business with reasonable regard to future needs;

(B) acquired in connection with a claim under a title insurance policy;

(C) acquired in satisfaction or on account of loans, mortgages, liens, judgments, or decrees previously owed to the company in the course of business;

(D) acquired in partial payment of the consideration of the sale of real property owned by the company if the transaction results in a net reduction in the company's investment in real property; or

(E) reasonably necessary to maintain or enhance the sale value of real property previously acquired or held by the company under this subdivision;

(4) a first mortgage note secured by any of the following, provided that the amount of the note does not exceed 80 percent of the appraised value of the security for the note:

(A) an abstract plant and connected personal property in or outside this state;

(B) stock of a title insurance agent in or outside this state;

(C) a construction contract to build an abstract plant and connected personal property; or

(D) any two or more of the items listed in this subdivision;

(5) the shares of any federal home loan bank in an amount necessary to qualify for membership and any additional amounts approved by the commissioner;

(6) foreign securities that are substantially of the same kinds, classes, and investment grade as securities otherwise qualified for investment under this section, provided that, unless the investment is also qualified under Subdivision (2), the aggregate amount of foreign investments made under this subdivision does not exceed:

(A) five percent of the insurer's admitted assets at the end of the preceding year;

(B) two percent of the insurer's admitted assets at the end of the preceding year invested in the securities of all entities domiciled in any one foreign country; and

(C) one-half of one percent of the insurer's admitted

assets at the end of the preceding year invested in the securities of any one individual entity domiciled in a foreign country;

(7) securities lending, repurchase, reverse repurchase, and dollar roll transactions, as described by Section 425.121; or

(8) money market funds, as described by Section 425.123.

(b) If a corporation maintains with the department a deposit described by Subchapter E in the amount of \$100,000, the corporation may invest more than 50 percent of the corporation's capital stock under Subsection (a)(1), as considered necessary by the corporation's board of directors.

(c) A corporation created or operating under this title may own or acquire more than one abstract plant in any one county, but only one abstract plant in any one county is admissible as an investment under Subsection (a)(1).

(d) A title insurance company may not hold real property acquired under Subsection (a)(3)(B), (C), or (D) for more than 10 years without written approval of the department.

(e) Any investment that does not qualify under this section and was owned by the title insurance company on October 1, 1967, continues to qualify.

(f) If any otherwise valid investment qualified under this section exceeds in amount any of the limitations on investment provided by this section, the investment is inadmissible only to the extent that it exceeds the limitation.

(g) A title insurance company may invest in a certified capital company in the manner provided by Chapter 228.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.
Amended by:

Acts 2005, 79th Leg., Ch. 99 (H.B. 532), Sec. 2, eff. September 1, 2005.

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2I.002, eff. April 1, 2009.

Sec. 2551.152. ANNUAL STATEMENT. (a) Not later than March 1 of each year, each title insurance company shall file with the commissioner a verified statement.

(b) The statement must be in a form required by the commissioner and must:

(1) provide a statement of the business engaged in by the title insurance company during the preceding year; and

(2) describe the condition of the company's affairs on December 31 of the preceding year.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2551.153. FEES. The general laws applicable to payment of a filing fee by a corporation having capital stock apply to a corporation subject to this title.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2551.154. TRANSFER OF CERTAIN BUSINESS TO STATE BANKS OR TRUST COMPANIES. (a) This section applies to a corporation chartered under Section 2551.051, or its antecedents, Article 9.01, Texas Insurance Code, or Chapter 40, Acts of the 41st Legislature, Regular Session, 1929 (Article 1302a, Vernon's Texas Civil Statutes), and empowered to act as:

(1) trustee under a lawful trust committed to the corporation by contract or will or by appointment by a court as trustee, receiver, or guardian; and

(2) executor or guardian under the terms of a will or as an administrator of a decedent's estate under the appointment of the court.

(b) A corporation described by Subsection (a) may transfer and assign to one of the following entities all of the corporation's fiduciary business in which the corporation is named or acts as guardian, trustee, executor, or administrator or in any other fiduciary capacity:

(1) a state bank created under Subtitle A, Title 3, Finance Code, or a predecessor to that law; or

(2) a state trust company created under Chapter 181, Finance Code, or a predecessor to that law.

(c) On a corporation's transfer or assignment to a state bank or trust company under this section, the state bank or trust company shall, without the necessity of any action in a court of this state or any action by the creator or beneficiary of the trust or estate:

(1) continue the guardianship, trust, executorship,

administration, or other fiduciary relationship related to the trust or estate;

(2) perform all of the duties and obligations of the corporation related to the trust or estate; and

(3) exercise any powers and authority:

(A) related to the trust or estate; and

(B) exercised by the corporation at the time of the transfer or assignment.

(d) A transfer or assignment by a corporation under this section is not a resignation or refusal by the corporation to act on behalf of the guardianship, trust, executorship, administration, or other fiduciary relationship.

(e) On a corporation's transfer or assignment to a state bank or trust company under this section, the naming or designation by a testator or the creator of a living trust of the corporation to act as trustee, guardian, or executor or in any other fiduciary capacity includes the naming or designation of the state bank or trust company and authorizes the state bank or trust company to act in that capacity.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

SUBCHAPTER E. REQUIRED DEPOSIT

Sec. 2551.201. DEPOSIT REQUIRED; AMOUNT. (a) Except as provided by Section 2551.202, a title insurance company shall deposit and maintain in the state treasury, or other depository in this state named by the company and approved by the department, either:

(1) cash; or

(2) securities described by Section 2551.151.

(b) A title insurance company's deposit under this section must be in an amount equal to the lesser of:

(1) one-fourth of the authorized capital of the company;

or

(2) \$100,000.

(c) A deposit under this section is for the benefit of all policyholders.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2551.202. EXCEPTION: FOREIGN TITLE INSURANCE COMPANY.

(a) A foreign title insurance company is not required to make a deposit under Section 2551.201 if the company has on deposit with insurance regulatory bodies in the United States an aggregate amount of deposit that:

(1) is equal to the amount required by Section 2551.201; and

(2) secures all policyholders of the company, regardless of their location.

(b) The foreign title insurance company must file with the department a certificate of deposit under the hand and seal of each insurance regulatory body holding a deposit of the company.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2551.203. WITHDRAWAL AND SUBSTITUTION OF DEPOSIT. A title insurance company may withdraw the deposit of securities made under Section 2551.201, or any portion of the deposit, after substituting other securities of a sufficient value to maintain the amount of deposit required under that section.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2551.204. USE OF DEPOSIT. (a) Except as otherwise provided by Subsection (e), a deposit made under this subchapter may be used only to pay an obligation connected with title insurance.

(b) On the insolvency or dissolution of a title insurance company, the company's deposit shall be used to protect title insurance policyholders even if no accrued title insurance claims exist and other unpaid obligations do exist, except as permitted by Subsection (e).

(c) A title insurance company's deposit must be applied to:

(1) the complete payment of any obligations and liabilities of the company connected with title insurance business; and

(2) the establishment of adequate reserves or reinsurance to protect any subsequently accruing or maturing title insurance obligations and liabilities.

(d) The amount, handling, and distribution of any reserves required under Subsection (c)(2) are subject to the control and

discretion of the department and are reviewable in judicial proceedings governed by rules applicable to review of rates under Subchapters D and E, Chapter 2703.

(e) Any deposit amount remaining after payments under Subsection (c) must be applied to:

- (1) payment of other obligations and liabilities of the title insurance company; or
- (2) distribution to shareholders.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

SUBCHAPTER F. RESERVES

Sec. 2551.251. STATUTORY PREMIUM RESERVE REQUIRED. (a) Each domestic title insurer shall establish and maintain a statutory premium reserve. The reserve is cumulative. The reserve must consist of the amounts required under Sections 2551.252-2551.260 and must be established and maintained during the period and for the uses and purposes provided by those sections.

(b) The reserve required under this section:

- (1) is considered to be unearned portions of the original premium; and
- (2) must be charged as a reserve liability of the title insurer in determining the insurer's financial condition.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2551.252. AMOUNTS ADDED TO RESERVE FOR CALENDAR YEAR 1997; REDUCTIONS. (a) The total charges of a domestic title insurer for title insurance policies written or assumed on or after January 1, 1997, and before January 1, 1998, are computed by adding the following, as described in the insurer's annual statement:

- (1) the direct premium written by the insurer;
- (2) the escrow and settlement service fees paid directly to and collected by the insurer;
- (3) other title fees and service charges paid directly to and collected by the insurer, including fees for closing protection letters; and
- (4) premiums for any reinsurance assumed by the insurer, less premiums for reinsurance ceded by the insurer during that year.

(b) The amount a domestic title insurer must set aside in the statutory premium reserve for the 1997 calendar year is computed by multiplying the total charges computed under Subsection (a) by:

- (1) 6-1/5 percent if the insurer had \$250 million or more in direct premium written for the year 1996; or
- (2) 3-1/2 percent if the insurer had less than \$250 million in direct premium written for the year 1996.

(c) A domestic title insurer shall reduce additions to the statutory premium reserve set aside for title insurance policies written or assumed during the year 1997 over a 20-year period beginning in the year after the year in which the policies are written or assumed, as provided by Subsection (d), by:

- (1) 26 percent of the additions in the first year following the year of addition;
- (2) 20 percent of the additions in the second year following the year of addition;
- (3) 10 percent of the additions in the third year following the year of addition;
- (4) nine percent of the additions in the fourth year following the year of addition;
- (5) five percent of the additions in the fifth and sixth years following the year of addition;
- (6) three percent of the additions in the seventh, eighth, and ninth years following the year of addition;
- (7) two percent of the additions in the 10th through 14th years following the year of addition; and
- (8) one percent of the additions in the last six years of the 20-year period.

(d) A domestic title insurer shall make the annual reductions under Subsection (c) in increments of one-fourth of the appropriate percentage of the additions each on March 31, June 30, September 30, and December 31 of each year.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2551.253. AMOUNTS ADDED TO RESERVE FOR CALENDAR YEARS AFTER 1997; REDUCTIONS. (a) Out of total charges for title insurance policies written or assumed on or after January 1, 1998, and before January 1, 2005, a domestic title insurer shall add to and

set aside in the statutory premium reserve an amount equal to the total of the following, as described in the insurer's annual statement:

(1) 25 cents per \$1,000 of net retained liability if the insurer had \$250 million or more in direct written premiums written for the most recent calendar year; or

(2) 30 cents per \$1,000 of net retained liability if the insurer had less than \$250 million in direct written premiums written for the most recent calendar year.

(b) Out of total charges for title insurance policies written or assumed on or after January 1, 2005, a domestic title insurer shall add to and set aside in the statutory premium reserve an amount equal to the total of 18.5 cents per \$1,000 of net retained liability for the most recent calendar year, as described in the insurer's annual statement.

(c) A domestic title insurer shall reduce additions to the statutory premium reserve set aside for title insurance policies written or assumed after the year 1997 over a 20-year period beginning in the year after the year in which the policies are written or assumed in the manner and under the same percentages applied under Sections 2551.252(c) and (d).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.
Amended by:

Acts 2005, 79th Leg., Ch. 56 (H.B. 885), Sec. 1, eff. September 1, 2005.

Sec. 2551.254. TRANSITIONAL RELEASE; TRANSITIONAL CHARGE. (a) In addition to the requirements described by Sections 2551.252 and 2551.253, each domestic title insurer shall compute a total statutory premium reserve balance for all policy years combined as of December 31, 1996.

(b) A domestic title insurer shall compute the balance under Subsection (a) as if Section 2551.252 were in effect during the 20-year period ending December 31, 1996. That balance, less the total actual statutory premium reserve balance carried by the insurer on December 31, 1996, is the insurer's transitional charge if the resulting amount is more than zero or is the insurer's transitional release if the resulting amount is zero or less.

(c) If a domestic title insurer has a transitional charge under Subsection (b), in addition to any changes to the statutory premium reserve otherwise required by this subchapter, the insurer shall add to its statutory premium reserve, on December 31 of each year for 10 consecutive years beginning on December 31, 1997, an amount equal to one-tenth of the transitional charge.

(d) If a domestic title insurer has a transitional release under Subsection (b), in addition to any changes to the statutory premium reserve otherwise required by this subchapter, the insurer shall reduce its statutory premium reserve, on December 31 of each year for 10 consecutive years beginning on December 31, 1997, by an amount equal to one-tenth of the transitional release.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2551.255. RUNOFF BALANCE. (a) At the end of each calendar year beginning in 1997, each domestic title insurer shall compute a total statutory premium reserve balance for all policy years before January 1, 1997, combined. The balance shall be computed as of the year-end evaluation date and as if Section 2551.252 were in effect during the 20-year period ending December 31, 1996. The balance computed under this subsection is the runoff balance.

(b) A domestic title insurer shall reduce its statutory premium reserve by an amount equal to the difference between:

- (1) the runoff balance computed under Subsection (a); and
- (2) the runoff balance computed for the preceding calendar year.

(c) The reduction of the statutory premium reserve under Subsection (b) is in addition to any other changes to the statutory premium reserve required by this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2551.256. ACTUARIAL CERTIFICATION. (a) Each domestic or foreign title insurer shall file annually with the insurer's annual statement required under Section 2551.152 an actuarial certification made by a member in good standing of the American Academy of Actuaries.

(b) An actuarial certification must:

(1) conform to the annual statement instructions for a title insurer adopted by the National Association of Insurance Commissioners; and

(2) include the actuary's professional opinion of the insurer's reserves as of the date of the annual statement.

(c) The reserves analyzed under this section must include reserves for known claims, including adverse development on known claims, and reserves for incurred but not reported claims.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2551.257. SUPPLEMENTAL RESERVE. Each domestic or foreign title insurer shall establish a supplemental reserve in an amount equal to the amount by which the actuarially certified reserves exceed the total of the known claim reserve and statutory premium reserve as set forth in the insurer's annual statement required under Section 2551.152.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2551.258. REEVALUATION OF CERTAIN RESERVE REQUIREMENTS.

(a) The commissioner may:

(1) reevaluate the adequacy of the statutory premium reserves required under Section 2551.253; and

(2) based on an actuarial review, change by order the amount of the statutory premium reserve required of any domestic title insurer or all domestic title insurers.

(b) Any change in the amount of a statutory premium reserve under Subsection (a)(2) is considered a statutory premium reserve and is not considered a supplemental reserve.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 56 (H.B. 885), Sec. 2, eff. September 1, 2005.

Sec. 2551.259. STATUTORY PREMIUM RESERVE AND SUPPLEMENTAL

RESERVE FUND. The statutory premium reserve and supplemental reserve fund shall be:

- (1) held in cash; or
- (2) invested in first mortgage notes or other securities admissible for investment by title insurers under Section 2551.151.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2551.260. EFFECT OF INSOLVENCY OR DISSOLUTION. On the insolvency or dissolution of a title insurer, the statutory premium reserve and supplemental reserve fund shall be used to protect title insurance policyholders, even if no accrued title insurance claims exist and other unpaid obligations do exist.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2551.261. RESERVE FOR UNPAID LOSSES AND LOSS EXPENSES.

(a) A title insurance company shall establish and maintain, in addition to any other reserves, a reserve against:

- (1) unpaid losses; and
- (2) loss expense for costs of defense of an insured and other costs expected to be paid to other parties in the defense, settlement, or processing of a claim under the terms of a title insurance policy.

(b) A title insurance company shall compute the amount of the reserve required by this section by carefully estimating any loss and loss expense likely to be incurred on a proper disposition of each claim presented, under notice from or on behalf of the insured, of a title defect in or lien or adverse claim against a title insured by the company.

(c) The total expenses of the title insurance company are equal to the estimate under Subsection (b) for payment of loss and costs of defense of the insured and other costs expected to be paid to other parties in the defense, settlement, or processing of the claim under the terms of the title insurance policy. The title insurance company shall revise the estimate at least annually and may additionally revise the estimate as circumstances warrant.

(d) The amounts set aside in the reserve in any year shall be deducted in determining the net profits for that year of any title

insurance company.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

SUBCHAPTER G. LIABILITY AND REINSURANCE

Sec. 2551.301. MAXIMUM POLICY LIABILITY. (a) Except as provided by Subsection (b), a title insurance company may issue a title insurance policy on any real property located in this state involving a potential policy liability of not more than 50 percent of the sum of the company's surplus as regards policyholders and the company's statutory premium reserves as stated in the most recent annual statement of the company.

(b) A title insurance company may exceed the limit described by Subsection (a) if the excess liability is reinsured in due course in accordance with Section 2551.302, 2551.305, or 2551.3055.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 38 (S.B. 572), Sec. 1, eff. September 1, 2015.

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

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

(2) the title insurance company acquires reinsurance in accordance with Section 2551.305 or 2551.3055.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 543 (S.B. 1153), Sec. 6, eff. September 1, 2007.

Acts 2011, 82nd Leg., R.S., Ch. 1059 (S.B. 322), Sec. 2, eff. September 1, 2011.

Acts 2015, 84th Leg., R.S., Ch. 38 (S.B. 572), Sec. 2, eff. September 1, 2015.

Sec. 2551.304. ACCEPTANCE OF REINSURANCE. A title insurance company may accept a reinsurance risk on real property located in this state or on interests described by Section 2751.002(2) only from an authorized title insurance company.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 543 (S.B. 1153), Sec. 7, eff. September 1, 2007.

Sec. 2551.305. REINSURANCE FROM NON-ADMITTED TITLE INSURER. Notwithstanding any other provision of this subchapter, a title insurance company may acquire reinsurance on an individual policy or facultative basis from a title insurance company not authorized to engage in the business of title insurance in this state if the title insurance company from which the reinsurance is acquired:

(1) 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

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

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.
Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 1059 (S.B. 322), Sec. 3, eff. September 1, 2011.

Acts 2013, 83rd Leg., R.S., Ch. 1056 (H.B. 3106), Sec. 2, eff. September 1, 2013.

Acts 2015, 84th Leg., R.S., Ch. 38 (S.B. 572), Sec. 3, eff. September 1, 2015.

Sec. 2551.3055. REINSURANCE FROM INSURER OTHER THAN TITLE INSURER. Notwithstanding any other provision of this subchapter, a title insurance company may obtain reinsurance by a reinsurance treaty or other reinsurance agreement from an assuming insurer with a financial strength rating of B+ or better from the A. M. Best Company, which reinsurance meets the requirements of Subchapter C, Chapter 493, if the title insurance company has provided the department with notice that:

(1) contains representations that the title insurance company was unable after diligent effort to procure sufficient reinsurance from another title insurance company; and

(2) summarizes the terms of the reinsurance treaty or other reinsurance agreement that the title insurance company will obtain.

Added by Acts 2015, 84th Leg., R.S., Ch. 38 (S.B. 572), Sec. 3, eff. September 1, 2015.

SUBCHAPTER H. ENFORCEMENT AND INTERVENTION

Sec. 2551.351. FORFEITURE OF RIGHT TO ENGAGE IN BUSINESS. (a) A foreign or domestic corporation forfeits any right to engage in business in this state if the corporation:

(1) issues any form of title insurance policy, or any other adopted or approved form, on real property in this state other than a form prescribed by the department;

(2) charges any premium rate on an owner, mortgagee, or other title insurance policy, or on any other adopted or approved form, on real property in this state other than a premium rate prescribed by the commissioner; or

(3) otherwise engages in the business of title insurance in relation to real property in this state on a form or for a premium rate not prescribed by the department or commissioner.

(b) This section does not apply to a premium rate charged in connection with a reinsurance transaction between two or more title insurance companies, provided that the reinsurance contract complies with Subchapter G.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2551.352. REVOCATION OF PERMIT AND FORFEITURE OF CHARTER.

(a) A domestic corporation engaged in the business of title insurance that violates this title is subject to:

(1) revocation by the commissioner of the corporation's permit; and

(2) forfeiture of the corporation's charter.

(b) A foreign corporation engaged in the business of title insurance that violates this title is subject to revocation by the commissioner of the corporation's permit.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2551.353. PROCEDURE FOR REVOCATION OF CERTIFICATE. (a) If the commissioner determines that a domestic or foreign corporation that holds a certificate of authority to engage in business in this state has violated this title, the commissioner shall notify the company that the commissioner intends to revoke the company's certificate of authority on the expiration of the 30-day period following the date actual notice is delivered or mailed under this section.

(b) Notice under this section must:

- (1) be in writing; and
- (2) be delivered to an executive officer of the company by personal service or by registered mail.

(c) If a company receiving notice under this section does not fully comply before the expiration of the period described by Subsection (a), the commissioner shall revoke the company's certificate of authority.

(d) A company whose certificate of authority is revoked under this section is ineligible for another certificate of authority until the later of:

- (1) the date on which the company fully and in good faith complies; or
- (2) the first anniversary of the date of the revocation.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2551.354. APPEAL OF COMMISSIONER ACTION. (a) A company qualified or seeking to qualify under this title and aggrieved by an action of the commissioner, including any action against the company, may file an appeal of the commissioner's action in a district court in Travis County.

(b) The appeal must be filed not later than the 30th day after the date the commissioner issues the order or ruling, except that if the order or ruling is directed against the company, whether or not directed against any other party, the company has 30 days after the date of receipt of official notice of the commissioner's action to review the action.

(c) An appeal under this section is subject to the same standard of review as an appeal under this code in accordance with Section 36.203.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

CHAPTER 2553. FOREIGN OR ALIEN CORPORATIONS

Sec. 2553.001. AUTHORITY TO ENGAGE IN BUSINESS OF TITLE INSURANCE. (a) A corporation organized under the laws of another state may engage in the business of title insurance in this state on exactly the same basis and is subject to the same rules, prices, and supervision as provided for a corporation that is organized under the laws of this state and engaged in the business of title insurance under this title.

(b) To engage in the business of title insurance in this state, a foreign corporation must file with the department:

(1) an application for a permit or certificate of authority; and

(2) a financial statement demonstrating the condition of the corporation.

(c) The department shall prescribe the form of the application and financial statement.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2553.002. CAPITAL AND SURPLUS REQUIREMENTS. (a) A foreign corporation may not engage in the business of title insurance in this state unless the corporation has unimpaired capital in an amount of at least \$1 million and a surplus in an amount of at least \$1 million.

(b) The foreign corporation must demonstrate the required capital and surplus from its financial statement and any other examination the department may want to conduct.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2553.003. TAXES AND FEES. (a) A corporation organized and incorporated under the laws of another state, territory, or

country for the purpose of engaging in the business of title insurance shall pay the same filing fees and occupation tax as a foreign casualty company is required to pay to obtain a permit to engage in the business of insurance in this state.

(b) A foreign title insurance company described by Subsection (a) is not required to pay a franchise tax.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

SUBTITLE C. FINANCIAL SOLVENCY

CHAPTER 2601. SUPERVISION, LIQUIDATION, REHABILITATION, REORGANIZATION, OR CONSERVATION OF TITLE INSURANCE COMPANIES AND AGENTS

Sec. 2601.001. SUPERVISION, LIQUIDATION, REHABILITATION, REORGANIZATION, OR CONSERVATION OF TITLE INSURANCE COMPANIES AND AGENTS. Each title insurance agent and title insurance company is subject to Chapters 441 and 443.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 2I.003, eff. April 1, 2009.

CHAPTER 2602. TEXAS TITLE INSURANCE GUARANTY ASSOCIATION

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 2602.001. SHORT TITLE. This chapter may be cited as the Texas Title Insurance Guaranty Act.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2602.002. PURPOSES AND FINDINGS. (a) This chapter is for:

- (1) the purposes and findings stated in Sections 441.001, 441.003, 441.005, and 441.006;
- (2) the protection of holders of covered claims; and
- (3) the protection of consumers served by impaired agents.

(b) This chapter and the powers granted and functions authorized by this chapter shall be exercised to accomplish the

purposes of this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2I.004, eff. April 1, 2009.

Acts 2009, 81st Leg., R.S., Ch. 1025 (H.B. 4338), Sec. 2, eff. September 1, 2009.

Sec. 2602.003. DEFINITIONS. In this chapter:

(1) "Affiliate" means a person who, directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with an impaired title insurance company on December 31 of the year preceding the date the company becomes impaired.

(2) "Agent" includes:

(A) a title insurance agent, as defined by Section 2501.003; and

(B) a direct operation or a title insurance company's wholly owned subsidiary or affiliate that performs the services usually and customarily performed by a title insurance agent.

(3) "Association" means the Texas Title Insurance Guaranty Association.

(4) "Board" means the board of directors of the association.

(5) "Impaired agent" means a title agent or direct operation that is designated by the commissioner as an impaired agent and is:

(A) placed by a court in this state or another state under an order of supervision, conservatorship, rehabilitation, or liquidation;

(B) placed under an order of supervision or conservatorship under Chapter 441;

(C) placed under an order of rehabilitation or liquidation under Chapter 443; or

(D) otherwise found by a court of competent jurisdiction to be insolvent or otherwise unable to pay obligations as they come due.

(6) "Impaired title insurance company" means a title

insurance company that is designated by the commissioner as an impaired title insurance company and is:

(A) placed by a court in this state or another state under an order of supervision, conservatorship, rehabilitation, or liquidation;

(B) placed under an order of supervision or conservatorship under Chapter 441;

(C) placed under an order of rehabilitation or liquidation under Chapter 443; or

(D) otherwise found by a court of competent jurisdiction to be insolvent or otherwise unable to pay obligations as they come due.

(7) "Net direct written premiums" means the gross amount of premiums paid by policyholders for issuance of title insurance policies insuring risks located in this state and to which this chapter applies, without deduction for premiums for reinsurance ceded to other title insurance companies and not including premiums for reinsurance accepted from other authorized title insurance companies.

(8) "Payment of covered claims" means:

(A) the actual payment of claims; or

(B) the use of money of the impaired title insurance company and money derived from assessments or guaranty fees for consummation of contracts of reinsurance or assumption of liabilities or contracts of substitution to provide for liabilities arising from covered claims.

(9) "Trust funds or escrow accounts" includes accounts subject to annual audit under Subchapter D, Chapter 2651.

(10) "Unauthorized insurer" means a person, firm, association, or corporation that has engaged in activities prohibited by Subchapter C, Chapter 101, while engaging in the business of title insurance.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1025 (H.B. [4338](#)), Sec. 3, eff. September 1, 2009.

Acts 2017, 85th Leg., R.S., Ch. 967 (S.B. [2065](#)), Sec. 5.008, eff. September 1, 2017.

Sec. 2602.004. DESCRIPTION OF CONTROL. (a) For purposes of this chapter, control is the power to direct, or cause the direction of, the management and policies of a person, other than power that results from an official position with or corporate office held by the person. The power may be possessed directly or indirectly by any means, including through the ownership of voting securities or by contract, other than a commercial contract for goods or nonmanagement services.

(b) A person is presumed to control another person if the person directly or indirectly owns, controls, holds with the power to vote, or holds proxies representing 10 percent or more of the voting securities of the other person. This presumption may be rebutted by a showing that the person does not in fact control the other person.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2602.005. APPLICABILITY; CONFLICT WITH OTHER LAWS. (a) This chapter applies to:

(1) a title insurance company engaging in business under this title;

(2) all title insurance, direct or reinsurance, written by a title insurance company engaging in business under this title; and

(3) trust funds or escrow accounts of:

(A) title insurance companies engaging in business under this title; or

(B) agents authorized to engage in business in this state and engaging in business under and governed by this title.

(b) If this chapter conflicts with another law relating to the subject matter of this chapter or its application, other than Chapter 441 or 443, this chapter controls. If this chapter conflicts with Chapter 441 or 443, that chapter controls.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 2I.005, eff. April 1, 2009.

Sec. 2602.006. CONSTRUCTION. (a) This chapter shall be liberally construed to implement the purposes of this chapter

described by Section 2602.002, which shall be used to aid and guide interpretation of this chapter.

(b) This chapter does not:

- (1) expand or diminish a right or obligation between or among policyholders, title insurance companies, or agents; or
- (2) require a person to assign, waive, or relinquish a claim, right, or cause of action arising under Chapter 541 of this code or Subchapter E, Chapter 17, Business & Commerce Code.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2602.007. PROHIBITED USE OF PROTECTION PROVIDED BY CHAPTER. (a) A title insurance company or agent may not advertise or refer to this chapter as an inducement to the purchase of title insurance.

(b) The use by a person of the protection provided by this chapter in the sale of insurance is unfair competition and an unfair practice under Chapter 541.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2602.008. IMMUNITY. (a) Liability does not exist and a cause of action does not arise against any of the following persons for a good faith action or omission of the person in exercising the person's powers and performing the person's duties under this chapter:

- (1) the commissioner or the commissioner's representative;
- (2) the association or the association's agent, representative, or employee;
- (3) a title insurance company or the company's agent or employee;
- (4) a board member; and
- (5) a special deputy receiver or the special deputy receiver's agent or employee.

(b) The attorney general shall defend any action to which Subsection (a) applies that is brought against a person listed in that subsection, including an action instituted after the defendant's service with the association, commissioner, or department has terminated. This subsection does not require the attorney general to

defend a person or entity with respect to an issue other than the applicability or effect of the immunity created by Subsection (a). The attorney general is not required to defend a person listed in Subsection (a)(2), (3), (4), or (5) against an action regarding the disposition of a claim filed with the association under this chapter or any issue other than the applicability or effect of the immunity created by Subsection (a). The association may contract with the attorney general under Chapter 771, Government Code, for legal services not covered by this subsection.

(c) A title insurance company that reinsures or assumes the policies of an impaired title insurance company is not liable, and a cause of action does not arise against that company:

- (1) for an action or omission by the impaired title insurance company or an officer, director, employee, attorney, or agent of the impaired title insurance company;
- (2) by subrogation; or
- (3) under any type of indemnity agreement.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.
Amended by:

Acts 2019, 86th Leg., R.S., Ch. 775 (H.B. 1614), Sec. 1, eff. September 1, 2019.

Sec. 2602.009. ASSOCIATION AND TITLE INSURANCE COMPANIES AS INTERESTED PARTIES. The association and each title insurance company assessed under this chapter are interested parties under Sections 3(h) and 12(b), Article 21.28.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2602.010. RULES. The commissioner shall adopt reasonable rules as necessary to implement and supplement this chapter and its purposes.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2602.011. INFORMATION PROVIDED BY AND TO COMMISSIONER.

- (a) The commissioner shall notify the association of the existence

of an impaired title insurance company or impaired agent not later than the third day after the date on which the commissioner gives notice of the designation of impairment to the impaired agent or impaired title insurance company. The association is entitled to a copy of any complaint seeking an order of receivership with a finding of insolvency against a title insurance company at the time the complaint is filed with a court.

(b) The commissioner shall notify the board when the commissioner receives a report from the commissioner of insurance or other analogous officer of another state that indicates that a title insurance company has been designated impaired in another state. The report to the board must contain all significant details of the action taken or the report received.

(c) The commissioner shall report to the board when the commissioner has reasonable cause to believe from a completed or continuing examination of any title insurance company that the company may be an impaired title insurance company. The board may use this information in performing its duties under this chapter. The board shall keep the report and the information contained in the report confidential until it is made public by the commissioner or other lawful authority.

(d) On the board's request, the commissioner shall provide the association with a statement of the net direct written premiums of each title insurance company.

(e) The commissioner may require that the association notify the insureds of the impaired title insurance company and any other interested party of the designation of impairment and of the person's rights under this chapter. Notification by publication in a newspaper of general circulation is sufficient notice under this section.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.
Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1025 (H.B. [4338](#)), Sec. 4, eff. September 1, 2009.

Sec. 2602.012. APPEALS. (a) A title insurance company may appeal to the commissioner an action or ruling of the association relating to an assessment.

(b) An action or ruling of the commissioner under this chapter may be appealed as provided by Subchapter D, Chapter 36.

(c) A title insurance company appealing an assessment shall pay the assessment. The association may use the money to meet its obligations while the appeal is pending. If the appeal on the assessment is upheld, the association shall return to the company the amount paid in error or excess.

(d) Venue in a suit relating to an action or ruling under this chapter is in Travis County. Each party to the action may appeal, and the appeal is at once returnable to the appellate court and has precedence over all cases of a different character pending before the court. The commissioner or association is not required to give an appeal bond in an appeal of a cause of action arising under this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2602.013. VENUE. An action against the association or an action against the association's board member, agent, representative, or employee that arises from the exercise of the person's powers or performance of the person's duties under this chapter must be brought in a district court in Travis County.

Added by Acts 2019, 86th Leg., R.S., Ch. 775 (H.B. 1614), Sec. 2, eff. September 1, 2019.

SUBCHAPTER B. GOVERNANCE OF TEXAS TITLE INSURANCE GUARANTY ASSOCIATION

Sec. 2602.051. ASSOCIATION AS LEGAL ENTITY; SUPERVISION; MEMBERSHIP. (a) The Texas Title Insurance Guaranty Association is a nonprofit legal entity.

(b) The association is subject to the applicable insurance laws of this state and the immediate supervision of the commissioner.

(c) A title insurance company may not engage in the business of title insurance in this state unless the company is a member of the association.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2602.052. BOARD OF DIRECTORS. (a) The association's powers are exercised through a board of directors consisting of nine individuals appointed by the commissioner.

(b) Three board members must be officers or employees of title insurance companies. Two board members must be officers or employees of agents. Four board members must be public representatives.

(c) Board members other than public representatives shall be chosen to give fair representation to all title insurance companies and agents, considering the following categories:

- (1) premium income;
- (2) geographical location; and
- (3) segments of the industry represented in this state.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2602.053. ELIGIBILITY TO SERVE AS PUBLIC REPRESENTATIVE.

(a) In this section, "immediate family" includes parents, a spouse, children, brothers, and sisters residing in the same household.

(b) To be eligible to serve as a public representative on the board, an individual must have resided in this state during the five years preceding appointment and may not be:

(1) licensed by or subject to the regulation of the department;

(2) financially involved in an organization subject to the regulation of the department other than by ownership of an insurance policy or contract;

(3) a member of the immediate family of an individual who is financially involved in an organization subject to the regulation of the department;

(4) engaged in or employed by an entity having a contract with an organization subject to the regulation of the department;

(5) employed by, on the board of directors of, or a holder of an elective office by or under the authority of a unit of federal, state, or local government or an organization that receives a significant part of its funding from a unit of federal, state, or local government;

(6) employed by or associated with an organization formed to represent license holders of the department or organizations or individuals subject to the regulation of the department; or

(7) required to register as a lobbyist under Chapter 305, Government Code, because of activities on behalf of an organization representing the regulated industry.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2602.054. TERM; VACANCY. (a) Board members serve staggered six-year terms, with the terms of three members expiring each odd-numbered year. A member may serve more than one term.

(b) A member shall serve until a successor is appointed.

(c) If a member other than a public representative ceases to be an officer or employee of a title insurance company or agent, the member's office becomes vacant.

(d) The commissioner shall appoint an individual to fill a vacancy on the board for the unexpired term.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2602.055. COMPENSATION OF BOARD MEMBERS. A board member may not receive compensation for the member's services but is entitled to reimbursement for actual expenses incurred in performing the member's duties.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2602.057. RIGHTS OF TITLE INSURANCE COMPANY WITH REPRESENTATIVE ON BOARD. (a) A title insurance company is not prohibited, because the company has an officer, director, or employee serving as a board member, from negotiating for or entering into a contract of reinsurance or assumption of liability or a contract of substitution to provide for liabilities for covered claims with the association, the commissioner, or the receiver or conservator of an impaired title insurance company or agent.

(b) A conflict of interest does not arise from entering into a contract described by this section.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 775 (H.B. 1614), Sec. 3, eff. September 1, 2019.

SUBCHAPTER C. GENERAL POWERS AND DUTIES OF ASSOCIATION

Sec. 2602.101. GENERAL POWERS AND DUTIES. (a) In addition to the other powers and duties provided by this chapter, the association may:

- (1) borrow money as necessary to implement this chapter according to the plan of operation;
- (2) lend money to the receiver, supervisor, or conservator of an impaired title insurance company or its agent;
- (3) sue and be sued, including taking any legal action necessary or proper to recover an unpaid assessment;
- (4) enter into contracts as necessary or proper to implement this chapter;
- (5) ensure payment of the policy obligations of an impaired title insurance company;
- (6) negotiate and contract with a rehabilitator, conservator, supervisor, receiver, ancillary receiver, or other third party to exercise the powers and perform the duties of the association;
- (7) guarantee, assume, or reinsure, or cause to be guaranteed, assumed, or reinsured, a policy or contract of an impaired title insurance company;
- (8) take legal action necessary to avoid the payment of improper claims or to settle claims or potential claims against an impaired title insurance company or agent, or the association;
- (9) assume control of and consolidate the escrow accounts transferred to the association by an impaired agent that has been placed in receivership, supervision, or conservatorship, and:
 - (A) pay covered claims from the consolidated escrow accounts to facilitate processing and payment of claims;
 - (B) maintain a separate accounting for each transferred escrow account; and
 - (C) return money not used to pay a covered claim to the owner of the money in accordance with the contract governing the escrow of the money; and
- (10) perform any other acts as necessary or proper to implement this chapter.

(b) The association has standing to appear before a court in this state with jurisdiction over an impaired title insurance company or agent concerning which the association is or may become obligated under this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.
Amended by:

Acts 2019, 86th Leg., R.S., Ch. 775 (H.B. 1614), Sec. 4, eff. September 1, 2019.

Sec. 2602.102. PLAN OF OPERATION. (a) The association shall perform its functions under a plan of operation. The plan of operation must contain provisions necessary or proper for the execution of the association's powers and duties. The plan of operation must, in addition to the other requirements of this chapter:

- (1) establish:
 - (A) procedures for handling the assets of the association;
 - (B) the amount and method of reimbursing board members;
 - (C) regular places and times for board meetings;
 - (D) procedures for maintaining records of all financial transactions of the association, its agents, and the board; and
 - (E) procedures for determining the amount of guaranty fees, for collecting those fees, and for assessments;
- (2) provide for the establishment of a claims filing procedure that includes:
 - (A) notice by the association to claimants;
 - (B) procedures for filing claims seeking recovery from the association; and
 - (C) a procedure for appealing the denial of claims by the association; and
- (3) contain additional provisions necessary or proper for the execution of the association's powers and duties.

(b) The association shall submit to the commissioner any amendment to the plan of operation necessary or suitable to ensure the fair, reasonable, and equitable administration of the association. The amendment takes effect on the commissioner's written approval or the 90th day after the date the amendment is

submitted unless disapproved by the commissioner.

(c) If the association does not submit a suitable amendment to the plan of operation, the commissioner after notice and hearing may adopt reasonable rules as necessary or advisable to implement this chapter. A rule continues in effect until modified by the commissioner or superseded by an amendment submitted by the association and approved by the commissioner.

(d) Each title insurance company shall comply with the plan of operation.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 775 (H.B. 1614), Sec. 5, eff. September 1, 2019.

Sec. 2602.103. EMPLOYEES AND EXPERTS. (a) The association may employ or retain persons to perform the functions necessary or proper under this chapter, including persons necessary to handle the association's financial transactions.

(b) On the commissioner's approval, the association shall reimburse the department out of the guaranty fee account for the cost, including reasonable and necessary expenses, to employ or retain one or more persons to:

(1) audit and review agent escrow and trust accounts, financial condition, and compliance with applicable statutes and rules;

(2) report to the commissioner on the accounts, condition, and compliance; or

(3) supervise a person employed or retained to perform audit and review under Subdivision (1).

(c) A person employed or retained under Subsection (b) acts solely under the direction of and as assigned by the commissioner but shall report the person's activity and expenses to the association on the request of the association.

(d) Repealed by Acts 2019, 86th Leg., R.S., Ch. 775 (H.B. 1614), Sec. 31, eff. September 1, 2019.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 775 (H.B. 1614), Sec. 6, eff.

September 1, 2019.

Acts 2019, 86th Leg., R.S., Ch. 775 (H.B. 1614), Sec. 31, eff. September 1, 2019.

Sec. 2602.104. ASSOCIATION RECORDS. (a) The association shall maintain a record of its activities in exercising its powers and performing its duties under this chapter.

(b) A record under Subsection (a) may be made public only on:

(1) termination of a liquidation, rehabilitation, or conservation proceeding involving the impaired or insolvent title insurance company;

(2) termination of the impairment or insolvency of the title insurance company; or

(3) order of a court.

(c) This section does not limit the association's duty to report on its activities under this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 775 (H.B. 1614), Sec. 7, eff. September 1, 2019.

Sec. 2602.105. MEETING BY CONFERENCE CALL. Notwithstanding Chapter 551, Government Code, the board may hold an open meeting by telephone conference call if immediate action is required and convening of a quorum of the board at a single location is not reasonable or practical. The meeting is subject to the notice requirements that apply to other meetings. The notice of the meeting must specify as the location of the meeting the location at which meetings of the board are usually held. Each part of the meeting that is required to be open to the public must be audible to the public at that location and must be recorded. The audio recording shall be retained and made available to the public for 30 days after the meeting date.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 775 (H.B. 1614), Sec. 8, eff. September 1, 2019.

Sec. 2602.106. ACCOUNTS. For purposes of administration and assessment, the board shall establish:

- (1) an administrative account;
- (2) a title account; and
- (3) a guaranty fee account.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2602.107. ADMINISTRATIVE EXPENSES. (a) The association may use money in the administrative account to pay administrative costs and other general expenses of the association.

(b) The association may transfer income from investment of the association's money in any account to the administrative account.

(c) The association shall assess title insurance companies as provided by Subchapter E for any additional money needed for the administrative account.

(d) The association shall pay from the guaranty fee account fees and reasonable and necessary expenses that the department incurs in an examination or audit of a title agent or direct operation under this chapter and Chapter 2651.

(e) The association may advance money from any account to the administrative account to pay the administrative expenses of the association.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.
Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1025 (H.B. [4338](#)), Sec. 5, eff. September 1, 2009.

Acts 2019, 86th Leg., R.S., Ch. 775 (H.B. [1614](#)), Sec. 9, eff. September 1, 2019.

Sec. 2602.108. DEPOSIT OF FEES AND ASSESSMENTS. The association may deposit fees and assessments it collects into the Texas Treasury Safekeeping Trust Company in accordance with procedures established by the comptroller. The comptroller shall account to the association for the deposited money separately from all other money.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2602.109. USE OF EXCESS MONEY IN ACCOUNTS. (a) The association shall reserve in the title account the amount of money the association determines reasonably necessary for efficient future administration under this chapter. The association shall return the excess money pro rata to the holders of participation receipts on which an outstanding balance exists after deducting any credits against premium taxes taken under Section 2602.210. The amount deducted for those credits shall be deposited with the comptroller for credit to the general revenue fund. The association shall transfer to the guaranty fee account any excess money remaining in the title account after the distribution and reservation of money for administration.

(b) If the association determines that money in the administrative account exceeds the amount reasonably necessary for efficient future operation under this chapter, the association shall transfer the excess money to the guaranty fee account.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.
Amended by:

Acts 2019, 86th Leg., R.S., Ch. 775 (H.B. [1614](#)), Sec. 10, eff. September 1, 2019.

Sec. 2602.110. EXPENSES OF ADMINISTERING IMPAIRED INSURER OR IMPAIRED AGENT. (a) The association may spend or advance money necessary to pay the expenses of administering the supervision, rehabilitation, receivership, conservatorship, or, as determined by a court of competent jurisdiction, other insolvency of an impaired title insurance company or impaired agent, on terms the association negotiates, if the company's or agent's assets are insufficient to pay those expenses.

(b) The association may file a claim in a receivership proceeding against an impaired title insurance company or impaired agent to recover the association's reasonable costs incurred in exercising the association's powers or performing the association's duties under this chapter with respect to the impaired title insurance company or impaired agent. Payment of a claim asserted by

the association under this section in a receivership proceeding in this state is governed by Section 443.301. Payment of a claim asserted by the association under this section in a receivership proceeding in another state is governed by the law governing priority of payment of distributions on unsecured claims by an insurance guaranty association in that state.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.
Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1025 (H.B. 4338), Sec. 6, eff. September 1, 2009.

Acts 2019, 86th Leg., R.S., Ch. 775 (H.B. 1614), Sec. 11, eff. September 1, 2019.

Sec. 2602.111. DELEGATION OF POWERS AND DUTIES. (a) The plan of operation may provide that, on approval of the board, a power or duty of the association may be delegated to a corporation or other organization that:

- (1) performs or will perform in two or more states functions similar to those of the association or its equivalent; and
- (2) provides protection not substantially less favorable and effective than that provided by this chapter.

(b) A power or duty under Section 2602.101(a)(1) or (4), 2602.107, 2602.201, 2602.202, 2602.203, or 2602.205 may not be delegated under this section.

(c) The corporation or other organization shall be:

- (1) reimbursed as a servicing facility would be reimbursed; and
- (2) paid for its performance of any other functions of the association.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.
Amended by:

Acts 2019, 86th Leg., R.S., Ch. 775 (H.B. 1614), Sec. 12, eff. September 1, 2019.

Sec. 2602.112. EXEMPTION FROM TAXATION. The association is exempt from payment of all fees and all taxes levied by this state or a subdivision of this state, except taxes levied on real or personal

property.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2602.113. DETECTION AND PREVENTION OF IMPAIRMENT. (a) The board may make recommendations to the commissioner for detecting and preventing title insurance company or agent impairments. The board shall advise and counsel with the commissioner on matters relating to the solvency of title insurance companies and agents.

(b) The board may report and make recommendations to the commissioner relating to any matter germane to the solvency, liquidation, rehabilitation, or conservation of a title insurance company or agent. A report or recommendation under this subsection is not a public document until a title insurance company is designated impaired.

(c) The board shall notify the commissioner of any information indicating that a title insurance company or agent may be unable or potentially unable to fulfill its contractual obligations and shall request a meeting with the commissioner. The board may request appropriate investigation and action by the commissioner. The commissioner may investigate and act as the commissioner considers appropriate.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2602.114. MEETING OF BOARD ON IMPAIRED TITLE INSURANCE COMPANY OR AGENT. (a) The commissioner:

(1) shall call a meeting of the board when the commissioner determines that a title insurance company or agent is insolvent or impaired; and

(2) may call a meeting of the board when the commissioner determines that a title insurance company or agent is in danger of becoming insolvent or impaired.

(b) The meeting is not open to the public. Only board members, association counsel and other association representatives, the commissioner, and persons the commissioner authorizes may attend the meeting.

(c) The commissioner may require an officer, director, or employee of the title insurance company or agent to appear before the

board for conference or to give testimony.

(d) At the meeting the commissioner may disclose to the board information that the commissioner possesses and may disclose department records, including an examination report or a preliminary report from an examiner that relates to the title insurance company or agent.

(e) A board member may not disclose information received in the meeting unless authorized by the commissioner or required as witness in court. A board member and the meeting are subject to the confidentiality standard imposed on an examiner under Sections 401.105 and 401.106, except that a bond is not required of a board member.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2I.006, eff. April 1, 2009.

Acts 2019, 86th Leg., R.S., Ch. 775 (H.B. 1614), Sec. 13, eff. September 1, 2019.

Sec. 2602.115. ASSOCIATION AND BOARD ADVICE AND ASSISTANCE.

(a) On the commissioner's request, the board shall attend hearings before the commissioner and meet with and advise the commissioner or the receiver or the conservator appointed by the commissioner on matters relating to:

- (1) the affairs of an impaired title insurance company or agent;
- (2) action that the commissioner, receiver, or conservator may take to best protect the interest of holders of covered claims against the company or agent; and
- (3) the marshalling of assets.

(b) On the commissioner's request, the association may assist and advise the commissioner concerning rehabilitation, payment of claims, continuation of coverage, or the performance of other contractual obligations of an impaired title insurance company or agent.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2602.116. BOARD ACCESS TO RECORDS. The receiver, supervisor, conservator, or other statutory successor of an impaired title insurance company or agent shall give the board or its representative:

(1) access to the company's or agent's records as necessary for the board to perform its functions under this chapter relating to covered claims; and

(2) copies of those records on the board's request and at the board's expense.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.
Amended by:

Acts 2019, 86th Leg., R.S., Ch. 775 (H.B. 1614), Sec. 14, eff. September 1, 2019.

Sec. 2602.117. BOARD REPORT AT CONCLUSION OF IMPAIRMENT. At the conclusion of a title insurance company or agent impairment in which the association exercised its powers or performed its duties under this chapter, the board shall prepare, from information available to the association, and submit to the commissioner a report on the history and causes of the impairment.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

SUBCHAPTER D. POLICY GUARANTY FEES

Sec. 2602.151. PAYMENT OF FEE. (a) An agent or, if there is no agent, the title insurance company shall pay the association a quarterly guaranty fee for each owner or mortgagee title insurance policy that the agent or company is required to report on its statistical report to the department.

(b) The fee is due:

(1) May 1, for the quarter ending March 31;

(2) August 1, for the quarter ending June 30;

(3) November 1, for the quarter ending September 30; and

(4) February 1, for the quarter ending December 31.

(c) The association shall deposit the fee in the guaranty fee account.

(d) Except as provided by Section 2602.109, money in the guaranty fee account shall be derived only from guaranty fees as

provided by this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2602.152. AMOUNT OF FEE. Annually or more frequently, the board shall determine the amount of the guaranty fee, considering the amount of money to be maintained in the guaranty fee account that is reasonably necessary for efficient future operation under this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1025 (H.B. 4338), Sec. 7, eff. September 1, 2009.

Sec. 2602.153. USE OF FEE. (a) The association shall collect, receive, retain, disburse, and advance the guaranty fees only as specifically provided by this chapter.

(b) The following claims shall be paid from guaranty fees only and may not be paid from assessments:

(1) covered claims against trust funds or an escrow account of an impaired agent under Section 2602.252;

(2) expenses incurred in complying with Subchapter J;

(3) conservator and receiver expenses under Section 2602.254; and

(4) administrative expenses with respect to the estate of an impaired agent under Section 2602.110.

(c) Repealed by Acts 2009, 81st Leg., R.S., Ch. 1025, Sec. 18, eff. September 1, 2009.

(d) Guaranty fees may be used only for payment of:

(1) claims described by Subsection (b); and

(2) expenses related to:

(A) an audit or an examination conducted by the department or the association under this chapter;

(B) the supervision and coordination of such an audit or examination; and

(C) an action under Section 2602.452.

(e) The association may advance money from the guaranty fee account as the association considers necessary to provide for the

payment of covered claims related to an impaired agent and administrative expenses related to the evaluation and payment of those claims. The advanced money shall be repaid to the guaranty fee account as soon as is practicable with money from guaranty fees or the estate of the impaired agent. No interest may accrue on the advanced money.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1025 (H.B. 4338), Sec. 8, eff. September 1, 2009.

Acts 2009, 81st Leg., R.S., Ch. 1025 (H.B. 4338), Sec. 18, eff. September 1, 2009.

Acts 2019, 86th Leg., R.S., Ch. 775 (H.B. 1614), Sec. 15, eff. September 1, 2019.

Sec. 2602.154. ENFORCEMENT OF FEE. (a) After notice and opportunity for hearing, the commissioner may suspend or revoke the certificate of authority or license to engage in business in this state of a title insurance company or agent that does not comply with this subchapter.

(b) The commissioner shall adopt rules that implement the program created under this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

SUBCHAPTER E. ASSESSMENTS

Sec. 2602.201. MAKING OF ASSESSMENT. (a) If the commissioner determines that a title insurance company has become impaired, the association shall promptly estimate the amount of additional money needed to supplement the assets of the impaired title insurance company to pay all covered claims and administrative expenses, including expenses related to processing and payment of the claims.

(b) The association shall assess title insurance companies in writing an amount as determined under Section 2602.202. A title insurance company does not incur real or contingent liability under this chapter until the association actually makes the written assessment.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.
Amended by:

Acts 2019, 86th Leg., R.S., Ch. 775 (H.B. 1614), Sec. 16, eff.
September 1, 2019.

Sec. 2602.202. AMOUNT OF ASSESSMENT; PRORATION OF PAYMENT.

(a) The association shall assess title insurance companies the amount necessary to pay:

(1) the association's obligations under this chapter and the expenses of handling covered claims subsequent to an impairment; and

(2) other expenses authorized by this chapter.

(b) The assessment of each title insurance company must be in the proportion that the net direct written premiums of that company in this state for the calendar year preceding the assessment bear to the net direct written premiums of all title insurance companies for that year. Assessments and supplemental assessments may be made in consecutive years until the association has collected an amount sufficient to pay the obligations and expenses described under Subsection (a). The association may make a supplemental assessment only against the same title insurance companies and in the same proportion for each company as the initial assessment.

(c) The total assessment of a title insurance company in a year may not exceed an amount equal to two percent of the company's net direct written premiums for the calendar year preceding the assessment. If the maximum assessment and the association's other assets are insufficient in any one year to make all necessary payments, the money available shall be prorated and the unpaid portion shall be paid as soon as money becomes available.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.
Amended by:

Acts 2019, 86th Leg., R.S., Ch. 775 (H.B. 1614), Sec. 17, eff.
September 1, 2019.

Sec. 2602.203. NOTICE AND PAYMENT. The association shall give each title insurance company to be assessed at least 90 days' written notice of the due date of the assessment.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.
Amended by:

Acts 2019, 86th Leg., R.S., Ch. 775 (H.B. 1614), Sec. 18, eff.
September 1, 2019.

Sec. 2602.204. EXEMPTION FOR IMPAIRED TITLE INSURANCE COMPANY.
A title insurance company is exempt from assessment during the period beginning on the date the commissioner designates the company as an impaired title insurance company and ending on the date the commissioner determines that the company is no longer an impaired title insurance company.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2602.205. DEFERMENT. (a) The association may defer in whole or in part an assessment of a title insurance company that would cause the company's financial statement to show amounts of capital or surplus less than the minimum amount required for a certificate of authority in any jurisdiction in which the company is authorized to engage in the business of insurance.

(b) The title insurance company shall pay the deferred assessment when payment will not reduce capital or surplus below required minimums. The payment shall be refunded to or credited against future assessments of any title insurance company receiving a larger assessment because of the deferment, as elected by that company.

(c) During a period of deferment, the title insurance company may not pay a dividend to shareholders or policyholders.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2602.206. PARTICIPATION RECEIPTS. (a) On receipt from a title insurance company of payment of an assessment or partial assessment, the association shall provide the company with a participation receipt. A participation receipt creates liability against the impaired title insurance company.

(b) The holder of the receipt is a general creditor of the impaired title insurance company, except that if the amount of

assessments the association receives exceeds the amount paid for covered claims and administrative expenses, the holders of participation receipts have preference over other general creditors to, and are entitled to share pro rata in, the excess.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.
Amended by:

Acts 2019, 86th Leg., R.S., Ch. 775 (H.B. 1614), Sec. 19, eff. September 1, 2019.

Sec. 2602.207. ACCOUNTING; REPORTS; REFUND. (a) The association shall adopt accounting procedures to show how money received from assessments or partial assessments is used.

(b) The association shall make interim accounting reports as the commissioner requires.

(c) The association shall make a final report to the commissioner showing how money received from assessments or partial assessments has been used, including a statement of any final balance of that money. As soon as practicable after completion of the final report, the association shall refund the remaining balance to the holders of participation receipts as required by Section 2602.206(b).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2602.208. USE OF ASSESSMENTS. (a) Money from assessments is considered to supplement the marshalling of an impaired title insurance company's assets to make payments of covered claims on the impaired title insurance company's behalf and to pay administrative expenses related to payment of covered claims. The association may assess title insurance companies or use money from assessments to pay covered claims before the receiver exhausts the impaired title insurance company's assets.

(b) The association may use money from assessments to negotiate and consummate contracts of reinsurance or assumption of liabilities or contracts of substitution to provide for outstanding liabilities of covered claims.

(c) Except as provided by Section 2602.109, money from assessments may not be used for the guaranty fee account.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.
Amended by:

Acts 2019, 86th Leg., R.S., Ch. 775 (H.B. 1614), Sec. 20, eff.
September 1, 2019.

Sec. 2602.209. FAILURE TO PAY; COLLECTION BY COMMISSIONER.

(a) The association shall promptly report to the commissioner a failure of a title insurance company to pay an assessment when due.

(b) On failure of a title insurance company to pay an assessment when due, the commissioner may either:

(1) suspend or revoke, after notice and hearing, the company's certificate of authority to engage in business in this state; or

(2) assess an administrative penalty as provided by Chapter 84 in an amount not to exceed the greater of five percent of the unpaid assessment each month or \$100 each month.

(c) A title insurance company whose certificate of authority is canceled or surrendered is liable for any unpaid assessments made before the date of the cancellation or surrender.

(d) The commissioner may collect an assessment on behalf of the association through a suit brought for that purpose.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2602.210. RECOVERY OF ASSESSMENT IN RATES; TAX CREDIT.

(a) A title insurance company is entitled to recover in its rates for the succeeding 12 months amounts paid in assessments not to exceed one percent of the company's net direct written premiums. In promulgating or establishing rates the commissioner shall consider assessments and refunds of assessments and shall adjust the rates to allow for recovery under this subsection.

(b) Unless the department determines that all amounts paid as assessments by each title insurance company have been recovered under Subsection (a), for any amount not recovered the title insurance company is entitled to a credit against its premium tax under Chapter 223. The credit may be taken at a rate of 20 percent each year for five successive years following the date of assessment and, if the title insurance company elects, may be taken over an additional

number of years.

(c) An amount of a tax credit allowed by this section that is unclaimed may be shown in the title insurance company's books and records as an admitted asset for all purposes, including an annual statement under Section 862.001.

(d) If the association receives money related to a title insurance company receivership from any source, including payment of a claim made by the association against the estate of the title insurance company, that is in excess of the amount title insurance companies have recovered or are entitled to recover under this section, the excess money shall be held by the association in its title account to offset the amounts required for future assessments or administrative expenses of the association.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 775 (H.B. [1614](#)), Sec. 21, eff. September 1, 2019.

SUBCHAPTER F. COVERED CLAIMS

Sec. 2602.251. COVERED CLAIMS IN GENERAL. An unpaid claim is a covered claim if:

(1) the claim is made by an insured under a title insurance policy to which this chapter applies;

(2) the claim arises out of the policy and is within the coverage and applicable limits of the policy, subject to all applicable policy provisions and defenses available under the policy and applicable law;

(3) the title insurance company that issued the policy or assumed the policy under an assumption certificate is an impaired title insurance company; and

(4) the insured real property or a lien on the property is located in this state.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 775 (H.B. [1614](#)), Sec. 22, eff. September 1, 2019.

Sec. 2602.252. CLAIM AGAINST TRUST FUNDS OR ESCROW ACCOUNT. An unpaid claim is a covered claim if the claim:

(1) is:

(A) against trust funds or an escrow account of an impaired title insurance company or agent; or

(B) for money received by an impaired title insurance company, the company's agent, or an authorized agent of the company's agent for deposit into a trust fund or an escrow account; and

(2) is unpaid because of a shortage of those funds or in that account, including a shortage that exists because the money was not deposited by the impaired title insurance company or the company's agent in the fund or account.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.
Amended by:

Acts 2019, 86th Leg., R.S., Ch. 775 (H.B. 1614), Sec. 23, eff. September 1, 2019.

Sec. 2602.253. CLAIM IN CONNECTION WITH FIDELITY OF AGENT. An unpaid claim is a covered claim if an impaired title insurance company is liable for the claim in connection with the fidelity of the company's agent as authorized by Subchapter A, Chapter 2702.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2602.254. CERTAIN CONSERVATOR AND RECEIVER EXPENSES COVERED. Reasonable and necessary administrative expenses incurred by a conservator appointed by the commissioner or a receiver appointed by a court for an unauthorized insurer operating in this state are covered claims if the commissioner has notified the association or the association has otherwise become aware that:

(1) the unauthorized insurer has insufficient liquid assets to pay those expenses; and

(2) insufficient money is available from:

(A) abandoned money under Section 443.304; and

(B) department appropriations for use in paying those expenses.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2I.007, eff. April 1, 2009.

Sec. 2602.255. CLAIMS NOT COVERED. The following are not covered claims:

(1) an amount due a reinsurer, title insurance company, insurance pool, or underwriting association as a subrogation recovery or otherwise;

(2) a supplementary payment obligation incurred before a determination is made under this chapter that a title insurance company or agent is impaired, including:

(A) adjustment fees or expenses;

(B) attorney's fees or expenses;

(C) court costs;

(D) interest;

(E) enhanced damages, sought as a recovery against the insured, the impaired title insurance company or agent, or the association, that arise under Chapter 541 of this code or Subchapter E, Chapter 17, Business & Commerce Code, or a similar law of another state; and

(F) bond premiums;

(3) a shortage of trust funds or in an escrow account resulting from the insolvency of a financial institution;

(4) exemplary, extracontractual, or bad faith damages awarded against an insured or title insurance company by a court judgment;

(5) a claim under Section 2602.252 by a claimant who has a lien against the real property that was the subject of the transaction from which the claim arises, unless the lien is held to be invalid as a matter of law;

(6) a claim under Section 2602.251, 2602.252, or 2602.253 by a claimant who caused or substantially contributed to the claimant's loss by the claimant's action or omission, as determined by the association or the association's agent; and

(7) a claim filed with the association after the claim filing deadline for an impaired title insurance company or agent.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 775 (H.B. 1614), Sec. 24, eff. September 1, 2019.

Sec. 2602.256. AMOUNT OF COVERED CLAIM; LIMIT. (a) A covered claim under Section 2602.251 or 2602.253 may not exceed the lesser of \$500,000 for each claimant or \$500,000 for each policy.

(b) A covered claim under Section 2602.252 may not exceed the lesser of \$500,000 for each claimant or the amount of money actually received by the impaired title insurance company or agent as trust funds or an escrow account for each claimant in a transaction from which the claim arises, except that the cumulative amount of covered claims arising from a single transaction may not exceed \$500,000.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 775 (H.B. 1614), Sec. 25, eff. September 1, 2019.

Sec. 2602.257. EXHAUSTION OF OTHER RIGHTS REQUIRED. (a) A person having a covered claim that is also a claim against a title insurance company under law or under an insurance policy other than a policy of an impaired title insurance company must exhaust the person's rights under law or the policy before asserting the covered claim under this chapter.

(b) The amount payable on the covered claim is reduced by the amount of any recovery under law or the policy.

(c) Notwithstanding any other provision, to avoid undue hardship to a claimant the association may authorize payment of a covered claim against an impaired agent without regard to the liability of any title insurance company or coverage under any insurance policy, subject to the approval of the receivership court or commissioner, as applicable. On payment, the association is in all respects subrogated to the rights and claims of the claimant.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2602.258. CERTAIN MONEY AUTHORIZED FOR USE IN PAYING

COVERED CLAIM; LIMIT. (a) Money from assessments or guaranty fees is liable only for the difference between the amount of covered claims and the amount of assets marshalled by a receiver or conservator for payment to holders of covered claims.

(b) In an ancillary receivership in this state, money from assessments is liable only for the difference between the amount of covered claims and the amount of assets marshalled by receivers in other states for payment of covered claims in this state.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2602.259. STAY OF PROCEEDINGS; CERTAIN DECISIONS NOT BINDING. (a) To permit the receiver or association to properly defend a pending cause of action, a proceeding in which an impaired title insurance company is a party or is obligated to defend a party in a court in this state, other than a proceeding directly related to the receivership or instituted by the receiver, is stayed for:

(1) a six-month period beginning on the later of the date of the designation of impairment or the date an ancillary proceeding is brought in this state; and

(2) any subsequent period as determined by the court.

(b) If a covered claim arises from a judgment, order, verdict, finding, or other decision based on the default of an impaired title insurance company or its failure to defend an insured, the association on its own behalf or on behalf of the insured may apply to the court or administrator that made the decision to have the decision set aside and may defend the claim on its merits.

(c) In a proceeding considering a covered claim, a judgment against an insured taken after the date the delinquency proceeding or supervision begins or a conservator is appointed is not evidence of liability or of the amount of damages, and a default or consent judgment against an insured or the impaired title insurance company or a settlement, release, or judgment entered into by the insured or the impaired title insurance company does not bind the association and is not evidence of liability or of the amount of damages in connection with a claim brought against the association or another party under this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.
Amended by:

Acts 2019, 86th Leg., R.S., Ch. 775 (H.B. 1614), Sec. 26, eff. September 1, 2019.

Sec. 2602.260. ADMISSIBILITY OF PAYMENT. In a lawsuit brought by a conservator, supervisor, or receiver of an impaired title insurance company or agent to recover assets of the company or agent, the fact that a claim against the company or agent has been or will be paid under this chapter is not admissible and may not be placed before a jury by evidence, argument, or reference.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.
Amended by:

Acts 2019, 86th Leg., R.S., Ch. 775 (H.B. 1614), Sec. 27, eff. September 1, 2019.

Sec. 2602.261. APPEAL OF CLAIM DETERMINATION. A claimant's right of appeal with respect to a claim determination by the association is governed by the association's plan of operation. A claimant must bring an action, including an action for declaratory relief, challenging denial of a claim not later than one year after the date the claim was denied.

Added by Acts 2019, 86th Leg., R.S., Ch. 775 (H.B. 1614), Sec. 28, eff. September 1, 2019.

SUBCHAPTER G. ASSOCIATION POWERS AND DUTIES RELATING TO COVERED CLAIMS

Sec. 2602.301. GENERAL POWERS AND DUTIES OF ASSOCIATION IN CONNECTION WITH PAYMENT OF COVERED CLAIMS. (a) The association shall:

(1) investigate a claim brought against the association, the commissioner, or a special deputy receiver appointed under Chapter 443 if the claim involves or may involve the association's rights and obligations under this chapter; and

(2) adjust, compromise, settle, and pay a covered claim to the extent of the association's obligation, and deny all other claims.

(b) The association may review a settlement, release, or

judgment to which an impaired title insurance company or agent or its insured was a party to determine the extent to which the settlement, release, or judgment is contested.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2I.008, eff. April 1, 2009.

Sec. 2602.302. PAYMENT OF COVERED CLAIMS. (a) The association shall pay covered claims:

(1) existing before the determination of impairment; or

(2) arising on or before:

(A) the date of cancellation of the impaired title insurance company's policies or the claim deadline for claims against the impaired title insurance company, as applicable; or

(B) the claim deadline for covered claims against an impaired agent, which is the first anniversary of the date of determination of impairment.

(b) A court in this state in which receivership proceedings of an impaired title insurance company are pending shall set, as applicable:

(1) the date of cancellation of the policies, which may not be later than the fifth anniversary of the date of determination of impairment; or

(2) the claim deadline, which may not be later than the first anniversary of the date of determination of impairment.

(b-1) If an impaired title insurance company is in receivership proceedings outside of this state, the claim deadline is the first anniversary of the date of determination of impairment.

(c) Subject to the approval of the commissioner, the association shall establish:

(1) procedures for filing claims with the association; and

(2) acceptable forms of proof of covered claims.

(d) The association shall pay claims in the order the association considers reasonable, including payment as claims are received from the claimants or in groups or categories of claims.

(e) The association may not pay a claimant an amount exceeding the amount of the claimant's covered claim.

(f) On payment of the last timely filed covered claim, the association is discharged from the association's obligations under this chapter. This subsection does not discharge the association of obligations related to pending litigation.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.
Amended by:

Acts 2019, 86th Leg., R.S., Ch. 775 (H.B. 1614), Sec. 29, eff. September 1, 2019.

Sec. 2602.303. SERVICING FACILITY. (a) The association may handle claims through its employees or through one or more title insurance companies or other persons designated, subject to the approval of the commissioner, as a servicing facility.

(b) A title insurance company may decline designation as a servicing facility.

(c) The association shall reimburse a servicing facility for:

(1) obligations of the association paid by the facility;

and

(2) expenses incurred by the facility in handling claims for the association.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2602.304. ADVANCE AS LOAN. Money advanced by the association under this chapter is considered a special fund loan to the impaired title insurance company or agent for payment of covered claims and does not become an asset of the title insurance company or agent. The loan is repayable to the extent money from the title insurance company or agent is available.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2602.305. ASSOCIATION IN PLACE OF IMPAIRED TITLE INSURANCE COMPANY OR AGENT. (a) To the extent of the association's obligation on a covered claim, the association stands in the place of the impaired title insurance company or agent and has all the rights, duties, and obligations of the company or agent as if the company or

agent were not impaired.

(b) In performing its obligations under this chapter, the association is not considered:

- (1) to be engaged in the business of insurance;
- (2) to have assumed or succeeded to a liability of the impaired title insurance company or agent; or
- (3) to otherwise stand in the place of the impaired title insurance company or agent, including as to whether the association is subject to personal jurisdiction of the courts of another state.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2602.306. ASSIGNMENT OF CLAIMANT'S RIGHTS. (a) Any cause of action or other right of the holder of a covered claim arising from the occurrence on which the claim is based is assigned to the association on the holder's acceptance of:

- (1) the association's payment of the claim; or
- (2) a benefit of a contract by the association providing for reinsurance or assumption of liabilities or for substitution.

(b) Rights are assigned to the association under Subsection (a) to the extent of the amount accepted or the value of the benefit provided.

(c) The association may assign the rights acquired under this section to the title insurance company executing the reinsurance, assumption, or substitution agreement.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2602.307. SETTLEMENT BY ASSOCIATION BINDING; PRIORITY OF CLAIM AND EXPENSES. (a) The settlement of a covered claim by the association binds the receiver or statutory successor of an impaired title insurance company.

(b) The court shall give the covered claim the same priority against assets of the impaired title insurance company that the claim would have had in the absence of this chapter.

(c) The association's expenses in handling claims have the same priority as the receiver's expenses.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2602.308. REPORT TO RECEIVER. The association shall periodically file with the receiver of an impaired title insurance company a statement of covered claims paid by the association and an estimate of claims anticipated against the association. The statement preserves the rights of the association against the assets of the company.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

SUBCHAPTER H. CONSERVATOR OR RECEIVER POWERS AND DUTIES RELATING TO COVERED CLAIMS

Sec. 2602.351. DETERMINATION OF CONSERVATOR CONCERNING REINSURANCE, ASSUMPTION, OR SUBSTITUTION. A conservator appointed to handle the affairs of an impaired title insurance company or agent shall determine whether covered claims should or can be provided for in whole or in part by reinsurance, assumption, or substitution.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2602.352. NOTICE OF DETERMINATION CONCERNING ACTUAL PAYMENT. (a) On determination by the conservator that covered claims should be actually paid, the conservator shall give notice of the determination to holders of covered claims.

(b) The conservator shall mail the notice to each holder of a covered claim at the most recent address shown in the impaired title insurance company's or agent's records, except that if those records do not show the claimant's address the conservator may give notice by publication in a newspaper of general circulation.

(c) The notice must state a date, not earlier than the 91st day after the date of the mailing or publication of the notice, before which the claimant must file a claim with the conservator.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2602.353. FILING OF COVERED CLAIM. The conservator may require in whole or in part that claimants file:

- (1) sworn claim forms; and
- (2) additional information or evidence reasonably necessary for the conservator to determine the legality of or amount due under a covered claim.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2602.354. CLAIM BY PERSON WITH CAUSE OF ACTION AGAINST INSURED. (a) On determination by the conservator that covered claims should be actually paid or on order of the court to the receiver to give notice for the filing of claims, a person having a cause of action that constitutes a covered claim against an insured of the impaired title insurance company under a title insurance policy issued or assumed by the company may file the claim with the receiver or conservator, regardless of whether the claim is unliquidated or undetermined.

(b) A claim under this section may be approved as a covered claim if:

(1) it may be reasonably inferred from the proof presented that the claimant would be able to obtain a judgment on the cause of action against the insured;

(2) the claimant provides suitable proof that no valid claim exists against the impaired title insurance company arising from the cause of action other than claims already made; and

(3) the total liability of the impaired title insurance company to all claimants under the same title insurance policy does not exceed the amount of the company's total liability if the company were not in liquidation, rehabilitation, or conservation.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2602.355. REPORT TO ASSOCIATION. (a) A receiver of an impaired title insurance company or agent shall periodically submit a list of claims to the association or a similar organization in another state.

(b) Notice of a claim to the receiver is considered notice to the association.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

SUBCHAPTER I. OPERATION OF IMPAIRED TITLE INSURANCE COMPANY OR AGENT

Sec. 2602.401. ISSUANCE OR RENEWAL OF POLICIES. (a) If an assessment has been made under this chapter for an impaired title insurance company or association funds have been provided for the company, the company, on release from the supervision, rehabilitation, conservatorship, receivership, or other proceeding in which the company was found by a court of competent jurisdiction to be insolvent or otherwise unable to pay obligations as they come due, may not issue a new or renewal insurance policy until the company:

(1) has repaid pro rata in full to each holder of a participation receipt the assessment amount paid by the receipt holder or its assignee; and

(2) has repaid in full the amount of guaranty fees paid by the association.

(b) If an assessment has been made under this chapter for an impaired agent or guaranty fees have been provided for the impaired agent, the agent, on release from the supervision, conservatorship, rehabilitation, receivership, or other proceeding in which the agent was found by a court of competent jurisdiction to be insolvent or otherwise unable to pay obligations as they come due, subject to dischargeability, may not act as an agent until the agent has repaid in full the amount of guaranty fees paid by the association.

(c) Notwithstanding Subsections (a) and (b), on application of the association and after hearing, the commissioner may permit the impaired title insurance company or agent to issue new policies as provided by a plan of operation for repayment. In approving the plan, the commissioner may restrict the issuance of new or renewal policies as the commissioner considers necessary to implement the plan.

(d) Not later than the 11th day before the date of a hearing under Subsection (c), the commissioner shall give notice of the hearing to the association. The commissioner shall give 10 days' notice of the hearing to title insurance companies to whom participation receipts were issued for an assessment made for the benefit of the released title insurance company. The association and title insurance companies are entitled to appear at and participate in the hearing.

(e) Money recovered against an impaired title insurance company under this section shall be repaid to the title insurance companies that paid assessments in relation to the impaired title insurance company on return of the participation receipt.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.
Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1025 (H.B. 4338), Sec. 9, eff. September 1, 2009.

Sec. 2602.402. DISTRIBUTIONS TO SHAREHOLDERS AND AFFILIATES.

(a) An impaired or insolvent title insurance company may not make a distribution to shareholders until the association has recovered the total amount of valid claims for money spent in exercising the association's powers and performing the association's duties under this chapter with respect to that company, plus interest on that amount.

(b) Except as otherwise provided by this section, the receiver appointed under an order of receivership of a title insurance company domiciled in this state may recover on behalf of the company from an affiliate that controlled the company the amount of a distribution, other than a stock dividend the company paid on its capital stock, made during the five years preceding the date of the petition for liquidation or rehabilitation.

(c) A person who was an affiliate that controlled the title insurance company when the distribution described by Subsection (b) was paid is liable for the amount of the distribution received. A person who was an affiliate that controlled the title insurance company when the distribution was declared is liable for the amount of the distribution the affiliate would have received if the distribution had been paid immediately. Two or more persons liable for the same distribution are jointly and severally liable. If a person liable under this subsection is insolvent, all of the affiliates that controlled the insolvent person when the distribution was paid are jointly and severally liable for any resulting deficiency in the amount recovered from the insolvent person.

(d) The maximum amount recoverable under Subsections (b) and (c) is the amount needed in excess of all other available assets of the insolvent title insurance company to pay the company's

contractual obligations.

(e) The receiver may not recover a distribution under Subsection (b) if the title insurance company shows that:

(1) the distribution was lawful and reasonable on the date of payment; and

(2) the company did not know and could not reasonably have known that the distribution might adversely affect the ability of the company to fulfill its contractual obligations.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.079, eff. September 1, 2005.

Sec. 2602.403. ASSETS ATTRIBUTABLE TO COVERED POLICIES. (a) For the purposes of this section, assets attributable to covered policies are the proportion of the assets that the reserves that should have been established for the covered policies bear to the reserves that should have been established for all insurance policies written by the impaired or insolvent title insurance company.

(b) To perform its obligations under this chapter, the association is considered a creditor of the impaired or insolvent title insurance company to the extent of assets attributable to covered policies, less any amount that the association recovers as a subrogee under this chapter.

(c) Assets of the impaired or insolvent title insurance company attributable to covered policies shall be used to continue all covered policies and pay all contractual obligations of the impaired or insolvent company as required by this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

SUBCHAPTER J. ADDITIONAL DUTIES OF ASSOCIATION

Sec. 2602.451. APPLICABILITY. This subchapter applies, at the commissioner's discretion and regardless of whether there are covered claims against an agent, to any agent that is designated by the commissioner as an impaired agent.

Added by Acts 2009, 81st Leg., R.S., Ch. 1025 (H.B. 4338), Sec. 10,

eff. September 1, 2009.

Sec. 2602.452. ACTIONS FOR CERTAIN AGENTS. (a) The commissioner may direct the association, at the association's expense and on behalf of an impaired agent, to:

- (1) close real estate transactions;
- (2) disburse escrow funds;
- (3) record documents; and
- (4) issue final title insurance policies.

(b) The association may employ or retain a person or persons to perform any action required under Subsection (a), in accordance with Section 2602.103(a).

Added by Acts 2009, 81st Leg., R.S., Ch. 1025 (H.B. 4338), Sec. 10, eff. September 1, 2009.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 775 (H.B. 1614), Sec. 30, eff. September 1, 2019.

Sec. 2602.453. AUTHORITY OF ASSOCIATION; COOPERATION OF OFFICERS, OWNERS, AND EMPLOYEES. (a) On the direction of the commissioner under Section 2602.452, the association may implement any direction made by the commissioner and may access all books, records, accounts, networks, and electronic document storage and management systems as necessary to implement the commissioner's direction.

(b) Any present or former officer, manager, director, trustee, owner, employee, or agent of the agent, or any other person with authority over or in charge of any segment of the agent's affairs, shall cooperate with the association. For purposes of this subsection:

(1) "Person" includes a person who exercised or exercises control directly or indirectly over activities of the agent through a holding company or other affiliate of the agent.

(2) "Cooperate" means:

(A) replying promptly in writing to any request for information from the association within the period established in the request; and

(B) making available to the association any books, accounts, documents, or other records or information of, or relating to, the agent within the period set in the request.

(c) A person who fails to cooperate as required under Subsection (b) is subject to sanctions under Chapter 82, in addition to all other sanctions available under law.

Added by Acts 2009, 81st Leg., R.S., Ch. 1025 (H.B. 4338), Sec. 10, eff. September 1, 2009.

SUBTITLE D. TITLE INSURANCE PROFESSIONALS

CHAPTER 2651. TITLE INSURANCE AGENTS AND DIRECT OPERATIONS

SUBCHAPTER A. TITLE INSURANCE AGENT'S LICENSE

Sec. 2651.001. LICENSE AND BOND OR DEPOSIT REQUIRED. (a) An individual, firm, association, or corporation may not act in this state as a title insurance agent for a title insurance company unless the individual or entity:

(1) holds a license as an agent issued by the department; and

(2) maintains a surety bond or deposit required under Subchapter C.

(b) A title insurance company may not allow or permit an individual, firm, association, or corporation to act as its agent in this state unless the individual or entity complies with this section.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2651.002. LICENSE APPLICATION. (a) Before an initial license is issued to an individual, firm, association, or corporation to act as an agent in this state for a title insurance company, the company must file an application for an agent's license with the department on forms provided by the department.

(b) The application must be:

(1) accompanied by a nonrefundable license fee; and

(2) signed and sworn to by the title insurance company and by the proposed agent.

(c) The completed application must state that:

(1) the proposed agent is:

(A) an individual who is a bona fide resident of this state;

(B) an association or firm composed only of Texas residents; or

(C) a Texas corporation or a foreign corporation authorized to engage in business in this state;

(2) the proposed agent has unencumbered assets in excess of liabilities, exclusive of the value of abstract plants, as required by Section 2651.012;

(3) the proposed agent, including a corporation's managerial personnel, if applicable, has reasonable experience or instruction in the field of title insurance;

(4) the title insurance company:

(A) knows that the proposed agent has a good business reputation and is worthy of the public trust; and

(B) is unaware of any fact or condition that disqualifies the proposed agent from receiving a license; and

(5) the proposed agent qualifies as a title insurance agent under this chapter.

(d) Except as provided by Section 2651.0021(e), an agent applying for an initial license under this subchapter must provide evidence that the agent and its management personnel have successfully completed a professional training program that complies with Section 2651.0021. The program must have been completed within one year preceding the date of application.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.
Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1025 (H.B. 4338), Sec. 11, eff. September 1, 2009.

Sec. 2651.0021. PROFESSIONAL TRAINING PROGRAM. (a) The commissioner shall adopt by rule a professional training program for a title insurance agent and the management personnel of the title insurance agent.

(b) The professional training program must be designed to provide information regarding:

(1) the basic principles and coverages related to title insurance;

(2) recent and prospective changes in those principles and coverages;

(3) applicable rules and laws;

(4) proper conduct of the license holder's title insurance business;

(5) accounting principles and practices and financial responsibilities and practices relevant to title insurance; and

(6) the duties and responsibilities of a title insurance agent.

(c) Professional training program hours may be used to satisfy the continuing education requirements established under Section 2651.204.

(d) A professional training program course must be offered by:

(1) a statewide title insurance association, statewide title agents' association or professional association, or local chapter of a statewide title insurance or title agents' association or professional association;

(2) an accredited college or university;

(3) a career school or college as defined by Section 132.001, Education Code;

(4) the State Bar of Texas;

(5) an educational publisher;

(6) a title insurance company authorized to engage in business in this state;

(7) a company that owns one or more title insurance companies authorized to engage in business in this state;

(8) a public school system in this state; or

(9) an individual accredited as an instructor by an entity described by Subdivisions (1)-(8).

(e) An individual is exempt from the professional training requirement of this section if the individual has held in this state for at least five years a position as management personnel with a title insurance agent, or a comparable position, as determined under rules adopted by the commissioner.

Added by Acts 2009, 81st Leg., R.S., Ch. 1025 (H.B. 4338), Sec. 12, eff. September 1, 2009.

Sec. 2651.003. LICENSE AND RENEWAL FEES. (a) The department

shall prescribe the license fee in an amount not to exceed \$50.

(b) License fees, and renewal fees collected under this subchapter, shall be deposited to the credit of the Texas Department of Insurance operating account to be used by the department to enforce this chapter and any other law of this state that regulates title insurance agents.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2651.004. LICENSE ISSUANCE. The department shall issue a license if the department determines, based on the application and the department's investigation, that the requirements of Section 2651.002 are satisfied.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2651.005. DUPLICATE LICENSE. (a) The department shall collect in advance a fee from a title insurance agent who requests a duplicate license.

(b) The department shall prescribe the fee in an amount not to exceed \$20.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2651.006. LICENSE TERM. Unless a system of staggered license renewal is adopted under Section 4003.002, a license issued under this subchapter expires on June 1 after the second anniversary of the date of issuance.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2651.007. LICENSE RENEWAL. (a) A title insurance agent may renew a license by:

(1) filing a completed license renewal application form with the department; and

(2) paying the nonrefundable license renewal fee to the department.

(b) The department shall prescribe the license renewal application form.

(c) The department shall prescribe the license renewal fee in an amount not to exceed \$50.

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

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

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

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

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.
Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 1011 (H.B. 2408), Sec. 3, eff. September 1, 2011.

Sec. 2651.008. RECORDS OF AGENTS. The department shall maintain a record of the name and address of each title insurance agent licensed by the department in a manner that ensures that the agents appointed by any company authorized to engage in the business of title insurance in this state may be conveniently ascertained and inspected by any person on request.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2651.009. MULTIPLE APPOINTMENTS. (a) A licensed title insurance agent may be appointed to represent additional title insurance companies.

(b) Any additional title insurance company must notify the department of the appointment in the manner prescribed by the

department. The agent must include with the notice a nonrefundable fee for each additional appointment. The department shall prescribe the fee in an amount not to exceed \$16.

(c) Not later than the 20th business day after the date the department receives a notice under Subsection (b), the department shall notify the title insurance agent and appointing title insurance company in writing of any deficiencies in the notice that render the notice incomplete. A notice under Subsection (b) is considered complete on the date the department receives the notice, unless the department provides notice of the deficiencies under this section.

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

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

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

(d) A title insurance company may not permit an agent appointed by the company to write, sign, or deliver title insurance until the agent's appointment is effective.

(e) The appointment remains effective, without the necessity of renewal, until the appointment:

(1) is terminated by the title insurance company as provided by this section; or

(2) is otherwise terminated under this subchapter.

(f) A renewal license issued to an agent authorizes the agent to represent and act for the title insurance companies for which the agent holds appointments until the appointments are terminated, and the agent is considered to be the agent of the appointing companies for purposes of this subchapter.

(g) When a title insurance company terminates the appointment of an agent, the company shall immediately file with the department a

statement that contains:

(1) the facts relating to the termination of the appointment; and

(2) the effective date and reason for the termination.

(h) On receipt of the statement, the department shall terminate the appointment of the agent to represent that title insurance company in this state.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 1011 (H.B. 2408), Sec. 4, eff. September 1, 2011.

Sec. 2651.010. SUSPENSION OF LICENSE. The department shall suspend the license of a title insurance agent during any period in which the agent does not have a valid appointment. The department shall end the suspension when the department receives an acceptable notice of a valid appointment.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2651.011. PRIVILEGED COMMUNICATIONS; FINANCIAL INFORMATION. (a) Any information, including a document, record, or statement, and including information provided to or received from the commissioner under Subsection (b) or (c), or any other information required or permitted to be made or disclosed to or by the department under this subchapter, other than Section 2651.001, is not public information subject to Chapter 552, Government Code, except to the extent described by Subsection (b), and is a privileged communication and may not be disclosed to the public except as evidence in an administrative hearing or proceeding. This subsection does not apply to a document, record, or statement required to be made or disclosed to the department under Chapter 36.

(b) A title insurance company may provide information to the commissioner about a financial matter that would reasonably call into question the solvency of a title agent that the title insurance company appointed. Each title insurance company shall provide annually to the department a list of officers authorized to provide to the department the information under this subsection. Information

provided under this subsection is not subject to Chapter 552, Government Code, except that the commissioner may release information that the commissioner received under this subsection to a title insurance company that has appointed, or that is considering appointing, the title agent. The commissioner may also release information that the commissioner received under this subsection to a title agent under Section 2651.206, Insurance Code, if the information is evidence on which an audit report or examination report relies. A title insurance company that receives information under this subsection may not release the information except under a subpoena issued by a court of competent jurisdiction.

(c) Each title insurance agent shall provide the department, on a quarterly basis, with a copy of the agent's quarterly withholding tax report furnished by the agent to the United States Internal Revenue Service. The title insurance agent must also provide to the department proof of the payment of the tax. An agent that does not have employees shall certify to the department on a quarterly basis that there has not been a material change in the agent's financial condition.

(d) The commissioner by rule may prescribe the types of information under Subsections (b) and (c) that are privileged under Subsection (a).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.
Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1025 (H.B. 4338), Sec. 13, eff. September 1, 2009.

For contingent effect of this section, see Subsection (j).

For expiration of Subsections (g) and (i), see Subsection (i).

Sec. 2651.012. UNENCUMBERED ASSETS. (a) In this section:

(1) "Principal office" means a principal office of the business organization, unincorporated association, sole proprietorship, or partnership in this state in which the decision makers for the organization conduct the daily affairs of the organization. The presence of an agency or representative does not establish a principal office.

(2) "Unencumbered assets" means:

(A) cash or cash equivalents;

- (B) liquid assets that have a readily determinable market value and that do not have any lien against them;
- (C) real estate, in excess of any encumbrances;
- (D) investments, such as mutual funds, certificates of deposit, and stocks and bonds;
- (E) a surety bond, the form and content of which shall be prescribed by the commissioner in accordance with this code;
- (F) a deposit made in accordance with Section 2651.102;
- (G) a letter of credit that meets the requirements of Section 493.104(b)(2)(C); and
- (H) a solvency account that meets the requirements of Section 2651.0121.

(b) The unencumbered assets required under this section are reserves for contingencies. The reserves must be deducted from premiums for purposes of proceedings conducted under Subchapter D, Chapter 2703. The reserves may only be spent or released:

- (1) as permitted by the commissioner if the agent is declared impaired;
- (2) if the agent merges or consolidates with another agent who maintains the amount of unencumbered assets that would be required for the survivor of the merger or consolidation;
- (3) if the agent surrenders the agent's license under Section 2651.201;
- (4) if the agent is liquidated; or
- (5) if the agent's license is revoked.

(c) Except as provided by Subsection (d), an agent must maintain unencumbered assets with a market value in excess of liabilities, exclusive of the value of abstract plants, in the following amounts unless the commissioner establishes lesser amounts by rule:

- (1) if the agent maintains its principal office in a county with a population of 10,000 or more but less than 50,000: \$25,000;
- (2) if the agent maintains its principal office in a county with a population of 50,000 or more but less than 200,000: \$50,000;
- (3) if the agent maintains its principal office in a county with a population of 200,000 or more but less than one million: \$100,000; and
- (4) if the agent maintains its principal office in a county with a population of one million or more: \$150,000.

(d) Except as provided by the commissioner by rule, an agent

that maintains its principal office in a county with a population of less than 10,000 is exempt from this section.

(e) An agent that maintains a principal office in more than one county must meet the asset standards for the largest county for which the agent will hold a license.

(f) An agent may elect to:

(1) maintain unencumbered assets as required by this section; or

(2) place a deposit with the department as authorized by Section 2652.102.

(g) An agent that holds a license on September 1, 2009, and that has held the license for at least three years as of that date is not required to comply with Subsection (c) on September 1, 2009, but shall increase the unencumbered assets held by the agent, or make and increase the required deposit, until the agent is in compliance with the required capitalization amounts in accordance with the schedule established under this subsection. The agent must hold unencumbered assets, or make a deposit in an amount, such that:

(1) if the agent has been licensed at least three years but less than four years:

(A) the agent has at least 33 percent of the required capitalization amount on September 1, 2010;

(B) the agent has at least 66 percent of the required capitalization amount on September 1, 2011; and

(C) the agent has at least 100 percent of the required capitalization amount on September 1, 2012;

(2) if the agent has been licensed at least four years but less than five years:

(A) the agent has at least 25 percent of the required capitalization amount on September 1, 2010;

(B) the agent has at least 50 percent of the required capitalization amount on September 1, 2011;

(C) the agent has at least 75 percent of the required capitalization amount on September 1, 2012; and

(D) the agent has at least 100 percent of the required capitalization amount on September 1, 2013;

(3) if the agent has been licensed at least five years but less than six years:

(A) the agent has at least 20 percent of the required capitalization amount on September 1, 2010;

(B) the agent has at least 40 percent of the required capitalization amount on September 1, 2011;

(C) the agent has at least 60 percent of the required capitalization amount on September 1, 2012;

(D) the agent has at least 80 percent of the required capitalization amount on September 1, 2013; and

(E) the agent has at least 100 percent of the required capitalization amount on September 1, 2014;

(4) if the agent has been licensed at least six years but less than seven years:

(A) the agent has at least 16.66 percent of the required capitalization amount on September 1, 2010;

(B) the agent has at least 33.32 percent of the required capitalization amount on September 1, 2011;

(C) the agent has at least 49.98 percent of the required capitalization amount on September 1, 2012;

(D) the agent has at least 66.64 percent of the required capitalization amount on September 1, 2013;

(E) the agent has at least 83.3 percent of the required capitalization amount on September 1, 2014; and

(F) the agent has at least 100 percent of the required capitalization amount on September 1, 2015;

(5) if the agent has been licensed at least seven years but less than eight years:

(A) the agent has at least 14.29 percent of the required capitalization amount on September 1, 2010;

(B) the agent has at least 28.58 percent of the required capitalization amount on September 1, 2011;

(C) the agent has at least 42.87 percent of the required capitalization amount on September 1, 2012;

(D) the agent has at least 57.16 percent of the required capitalization amount on September 1, 2013;

(E) the agent has at least 71.45 percent of the required capitalization amount on September 1, 2014;

(F) the agent has at least 85.74 percent of the required capitalization amount on September 1, 2015; and

(G) the agent has at least 100 percent of the required capitalization amount on September 1, 2016;

(6) if the agent has been licensed at least eight years but less than nine years:

(A) the agent has at least 12.5 percent of the required capitalization amount on September 1, 2010;

(B) the agent has at least 25 percent of the required capitalization amount on September 1, 2011;

(C) the agent has at least 37.5 percent of the required capitalization amount on September 1, 2012;

(D) the agent has at least 50 percent of the required capitalization amount on September 1, 2013;

(E) the agent has at least 62.5 percent of the required capitalization amount on September 1, 2014;

(F) the agent has at least 75 percent of the required capitalization amount on September 1, 2015;

(G) the agent has at least 87.5 percent of the required capitalization amount on September 1, 2016; and

(H) the agent has at least 100 percent of the required capitalization amount on September 1, 2017; and

(7) if the agent has been licensed at least nine years:

(A) the agent has at least 11.11 percent of the required capitalization amount on September 1, 2010;

(B) the agent has at least 22.22 percent of the required capitalization amount on September 1, 2011;

(C) the agent has at least 33.33 percent of the required capitalization amount on September 1, 2012;

(D) the agent has at least 44.44 percent of the required capitalization amount on September 1, 2013;

(E) the agent has at least 55.55 percent of the required capitalization amount on September 1, 2014;

(F) the agent has at least 66.66 percent of the required capitalization amount on September 1, 2015;

(G) the agent has at least 77.77 percent of the required capitalization amount on September 1, 2016;

(H) the agent has at least 88.88 percent of the required capitalization amount on September 1, 2017; and

(I) the agent has at least 100 percent of the required capitalization amount on September 1, 2018.

(h) If the agent has been licensed less than three years as of September 1, 2009, the agent must have:

(1) at least 50 percent of the required capitalization amount required under Subsection (c) on September 1, 2010; and

(2) 100 percent of that required capitalization amount on

September 1, 2011.

(i) This subsection and Subsection (g) expire September 2, 2018.

(j) Notwithstanding any other provision of this section, this section takes effect only after the commissioner adopts the form, content, and procedures for use of the surety bond authorized under Subsection (a). The commissioner by rule shall establish the procedures for making, filing, using, and paying for the surety bond. Notwithstanding Subsections (g) and (h), the commissioner by rule may extend the dates established under those subsections as necessary to comply with this subsection.

Added by Acts 2009, 81st Leg., R.S., Ch. 1025 (H.B. 4338), Sec. 14, eff. September 1, 2009.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 536 (H.B. 2604), Sec. 1, eff. June 17, 2011.

Acts 2011, 82nd Leg., R.S., Ch. 536 (H.B. 2604), Sec. 2, eff. June 17, 2011.

Sec. 2651.0121. SOLVENCY ACCOUNT. (a) An agent may maintain a solvency account to accrue and hold unencumbered assets as provided by this section.

(b) An account under this section must be:

(1) in a financial institution in this state that is insured by an agency of the United States;

(2) accessible only to the department, on order of the commissioner; and

(3) audited in the same manner provided for trust funds by Section 2651.151.

(c) Subject to Subsection (d), an account under this section may be established by an initial deposit in an amount less than the amount provided by Section 2651.012(c).

(d) An account established by an initial deposit of an amount less than the amount provided by Section 2651.012(c) must be funded with a minimum deposit in the amount for each policy of title insurance issued by the agent that is equal to the greater of \$5 or one percent of the agent's portion of the retained premium received by the agent rounded to the nearest whole dollar.

(e) Deposits to the account must be made at least quarterly and must be made from and based on the agent's portion of retained premiums collected during the calendar quarter during which premiums were collected.

(f) Interest that accrues in an account the principal balance of which is less than the amount provided by Section 2651.012(c) must be retained in the account. Interest that accrues in an account the principal balance of which is greater than the amount provided by Section 2651.012(c) shall be paid to the agent maintaining the account.

(g) The commissioner may issue an order to access or release funds held in an account under this section if any of the events described by Section 2651.012(b) occur.

(h) The commissioner by rule shall adopt procedures and requirements for the release, transfer, or expenditure of the funds held in an account. The rules must establish the procedures and requirements by which the department shall account for any expenditures that the department makes from an account or funds transferred by the department to a third party.

(i) If an agent or an agent's principal office voluntarily ceases to engage in business, surrenders the agent's license, and liquidates the agent's assets, the agent may apply to the department in a form prescribed by the commissioner by rule for the release of the agent's solvency account.

(j) Not later than the 60th day after the date the department receives an application under Subsection (i), provided that the title agent complied with all applicable rules adopted under Subsection (h), the commissioner shall enter an order authorizing the financial institution in which the solvency account is held to release all or part of the account balance to the agent or the agent's principal office. If the commissioner does not enter the order within that 60-day period, the application is denied.

(k) An agent may appeal an order of the commissioner or denial of an application without an order by filing a petition in a district court of Travis County to seek injunctive or other relief against the commissioner.

(l) An account established, funded, and maintained as provided by this section complies with the requirement for maintenance of unencumbered assets under Section 2651.012(c), regardless of whether the amount required by that section is fully accrued. The amount

required by Section 2651.012(c) may be accrued in an account as provided by this section according to the schedule established by Section 2651.012(g) or as provided by the commissioner by rule under Section 2651.012(j).

(m) In a home office issue transaction in which a title insurance company issues a policy of title insurance, an agent who closes the transaction and remits premium to the title insurance company shall make the deposit required by this section. An agent who otherwise participates in a home office issue transaction but does not close the transaction is not required to make a deposit under this section.

Added by Acts 2011, 82nd Leg., R.S., Ch. 536 (H.B. 2604), Sec. 3, eff. June 17, 2011.

Sec. 2651.013. DIVISION OF PREMIUM HELD IN TRUST; RULES. (a) The funds held by a title insurance agent that are owed to a title insurance company, another title insurance agent, or a direct operation arising from a division of premium, whether as determined under rules adopted by the commissioner or by agreement among the parties, are considered to be held in trust for the title insurance company, other title insurance agent, or direct operation.

(b) This section does not require, and the commissioner may not require by rule, that funds described by Subsection (a) be held in a separate account subject to an external audit. This section does not affect the department's or association's authority to examine or audit a title agent or direct operation.

Added by Acts 2009, 81st Leg., R.S., Ch. 1025 (H.B. 4338), Sec. 14, eff. September 1, 2009.

SUBCHAPTER B. DIRECT OPERATION LICENSE

Sec. 2651.051. LICENSE REQUIRED. (a) A title insurance company may not own or lease and operate an abstract plant or participate in a bona fide joint abstract plant operation in a county in this state unless the company holds a license as a direct operation issued by the department for that county.

(b) A title insurance company may not write, sign, or deliver title insurance in a county in which the company operates an abstract

plant until the department has issued a direct operation license to the company.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2651.052. LICENSE APPLICATION. (a) Before a direct operation license is issued to a title insurance company, the company must file an application for a direct operation license on forms provided by the department.

(b) The application must be:

- (1) accompanied by a nonrefundable license fee; and
- (2) signed and sworn to by the title insurance company.

(c) The completed application must state that:

(1) the title insurance company is a Texas corporation or a foreign corporation holding a certificate of authority to insure titles to real property in this state and meets the requirements of this title; and

(2) the abstract plant to be licensed:

- (A) complies with department requirements relating to abstract plants; and
- (B) has been approved by the department.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2651.053. LICENSE AND RENEWAL FEES. (a) The department shall prescribe the license fee in an amount not to exceed \$50.

(b) License fees, and renewal fees collected under this subchapter, shall be deposited to the credit of the Texas Department of Insurance operating account to be used by the department to enforce this chapter and the laws of this state that regulate title insurance agents and title insurance companies.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2651.054. LICENSE TERM. Unless a system of staggered license renewal is adopted, a license issued under this subchapter expires on the second June 1 following the date of issuance.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2651.055. LICENSE RENEWAL. (a) On or before the expiration date of a license issued under this subchapter, a title insurance company may renew the license by:

(1) certifying to the department each county and address at which the company operates the abstract plant for each license to be renewed;

(2) filing a completed renewal application; and

(3) paying a nonrefundable license renewal fee for each license.

(b) The department shall provide the forms used under this section.

(c) The department shall prescribe the license renewal fee in an amount not to exceed \$50.

(d) If a license has been expired for 90 days or less, the license holder may renew the license by paying to the department the required nonrefundable renewal fee and a nonrefundable fee equal to one-half of the original license fee.

(e) If a license has been expired for more than 90 days, the license may not be renewed.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2651.056. CEASING OPERATION OF ABSTRACT PLANT; REQUEST FOR LICENSE CANCELLATION. If a title insurance company ceases to operate a licensed abstract plant, the company shall immediately notify the department in writing and request cancellation of the license.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2651.057. AUTOMATIC TERMINATION OF LICENSES. If a title insurance company surrenders the company's certificate of authority or if the certificate of authority is revoked by the department, all licenses of the company's abstract plants automatically terminate.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2651.058. RECORDS OF DIRECT OPERATIONS. The department shall maintain a record of the county and address of each location at which a title insurance company operates an abstract plant in a manner that ensures that the abstract plants may be conveniently ascertained and inspected by any person on request.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2651.059. USE OF AGENTS NOT PROHIBITED. This subchapter does not prohibit a title insurance company from issuing title insurance through a licensed title insurance agent.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

SUBCHAPTER C. BOND AND DEPOSIT REQUIREMENTS

Sec. 2651.101. BOND REQUIRED. (a) Each licensed title insurance agent and direct operation shall make, file, and pay for a surety bond payable to the department and issued by a corporate surety company authorized to write surety bonds in this state. The bond shall obligate the principal and surety to pay for any pecuniary loss sustained by:

(1) any participant in an insured real property transaction through an act of fraud, dishonesty, theft, embezzlement, or wilful misapplication by a title insurance agent or direct operation; or

(2) the department as a result of any administrative expense incurred in a receivership of a title insurance agent or direct operation.

(b) The amount of the bond must be the greater of:

(1) \$10,000; or

(2) an amount equal to 10 percent of the gross premium written by the title insurance agent or direct operation in accordance with the latest statistical report to the department but not to exceed \$100,000.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2651.102. ALTERNATIVE TO BOND. (a) Instead of the bond required by Section 2651.101, a title insurance agent or direct operation may deposit with the department:

(1) cash;

(2) irrevocable letters of credit issued by a financial institution in this state that is insured by an agency of the United States; or

(3) securities approved by the department.

(b) The cash, letters of credit, or securities deposited under this section are subject to the conditions required for a bond under Section 2651.101.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2651.103. EXAMINATION OF LOSS COVERED BY BOND OR DEPOSIT.

(a) At any time it appears that a loss covered by a bond or deposit has occurred, the department may require the title insurance agent or direct operation to appear in Travis County, with records the department determines to be proper, for an examination.

(b) The department shall specify a date for the examination that is not earlier than the 10th day or later than the 15th day after the date of service of notice of the requirement to appear.

(c) If after the examination the department determines that a loss covered by the bond or deposit has occurred, the department shall immediately notify the surety on the bond, if applicable, and prepare a written statement of the facts of the loss and deliver the statement to the attorney general.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2651.104. INVESTIGATION BY ATTORNEY GENERAL. (a) On receipt of a written statement under Section 2651.103, the attorney general shall investigate the charges and, on determining that a loss covered by the bond or deposit has occurred, shall enforce the liability by collecting against the deposited cash or securities or by filing suit on the bond.

(b) A suit brought under this section shall be filed in the name of the department in Travis County for the benefit of all parties who have suffered any loss covered by the bond or deposit.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

SUBCHAPTER D. ANNUAL AUDIT

Sec. 2651.151. ANNUAL AUDIT OF TRUST FUND ACCOUNTS: TITLE INSURANCE AGENTS AND DIRECT OPERATIONS. (a) Each title insurance agent and direct operation shall have an annual audit made of trust fund accounts. The agent or direct operation shall pay for the audit.

(b) Not later than the 90th day after the date of the end of the agent's or direct operation's fiscal year, the agent or direct operation shall file with the department one copy of the audit report with a transmittal letter. The agent shall also send a copy of the audit report and transmittal letter to each title insurance company that the agent represents.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.
Amended by:

Acts 2023, 88th Leg., R.S., Ch. 429 (H.B. 1901), Sec. 1, eff. September 1, 2023.

Sec. 2651.152. ANNUAL AUDIT OF TRUST FUND ACCOUNTS: TITLE INSURANCE COMPANIES. (a) Each title insurance company shall have an annual audit made of trust fund accounts for each county in which it operates in its own name. The company shall pay for the audit.

(b) Not later than the 90th day after the date of the end of the title insurance company's fiscal year, the company shall file with the department one copy of the audit report.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.
Amended by:

Acts 2023, 88th Leg., R.S., Ch. 429 (H.B. 1901), Sec. 2, eff. September 1, 2023.

Sec. 2651.153. RULES. The commissioner by rule shall adopt:

- (1) the standards for an audit; and
- (2) the form of the required audit report.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2651.154. PERFORMANCE OF AUDIT BY PUBLIC ACCOUNTANT. An audit required under this subchapter must be performed by an independent certified public accountant or licensed public accountant, or a firm composed of either.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2651.155. CONFIDENTIALITY OF AUDIT. The commissioner may classify an audit report that is filed with the department by a title insurance company under this subchapter as confidential and privileged.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2651.156. FAILURE TO RECEIVE AUDIT REPORT FROM AGENTS OR DIRECT OPERATIONS. If a title insurance company fails to receive an audit report from any of the company's agents or direct operations in the specified period required by Section 2651.151, the company shall report that failure to the department not later than the 30th day after the expiration of the specified period.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2651.157. ENFORCEMENT; HEARING. (a) After notice and hearing, the department may revoke the license or certificate of authority of a title insurance agent, direct operation, or title insurance company that:

(1) fails to furnish an audit report in the time required;
or

(2) furnishes an audit report that reveals any irregularity, including a shortage, or any practice not in keeping with sound, honest business practices.

(b) The notice must be provided to the agent, the direct operation, or each title insurance company involved.

(c) At a hearing under this section, the agent, direct operation, or title insurance company may offer evidence explaining

or excusing a failure or irregularity.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2651.158. CERTIFICATION OF UNENCUMBERED ASSETS. (a) Unless the agent has elected to make a deposit with the department under Section 2651.012(f), the annual audit of escrow accounts must be accompanied by a certification by the title insurance agent or direct operation that the title insurance agent has the appropriate unencumbered assets in excess of liabilities, exclusive of the value of its abstract plants, as required by Section 2651.012.

(b) The commissioner by rule shall establish the method by which the certification required by this section must be made, which shall not include an audit of operating accounts or a certification by a certified public accountant.

Added by Acts 2009, 81st Leg., R.S., Ch. 1025 (H.B. 4338), Sec. 15, eff. September 1, 2009.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 536 (H.B. 2604), Sec. 4, eff. June 17, 2011.

SUBCHAPTER E. GENERAL REGULATION OF TITLE INSURANCE AGENTS AND DIRECT OPERATIONS

Sec. 2651.201. LICENSE SURRENDER OR FORFEITURE. (a) A title insurance agent or direct operation may voluntarily surrender at any time a license issued under this chapter by giving notice to:

- (1) the department; and
- (2) the affected title insurance company.

(b) A title insurance agent or direct operation that terminates the agency contract with a title insurance company automatically forfeits the license under that company.

(c) A surrender or forfeiture of a license under this section does not affect the culpability of the license holder for conduct committed before the effective date of the surrender or forfeiture. The department may institute a disciplinary proceeding against the former license holder for conduct committed before the effective date of the surrender or forfeiture.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2651.202. TRUST FUND ACCOUNT DISBURSEMENTS. (a) A title insurance company, title insurance agent, or direct operation may not disburse funds from a trust fund account until good funds related to the transaction have been received and deposited in the account in amounts sufficient to fund any disbursements from the transaction.

(b) A title insurance company, title insurance agent, or direct operation is not liable for a violation of this section if the violation:

(1) was not intentional; and

(2) resulted from a bona fide error despite the maintenance of procedures reasonably adopted to avoid the error.

(c) The commissioner shall adopt rules and definitions to implement this section.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2651.203. DISCLOSURE OF OWNERSHIP AND PREMIUM INFORMATION.

(a) A title insurance agent who receives a portion of a premium shall disclose to each purchaser of a title insurance policy or other title insurance form the following:

(1) each shareholder, owner, or partner owning or controlling at least one percent of the agent;

(2) each shareholder, owner, or partner owning or controlling at least 10 percent of an entity that owns or controls at least one percent of the agent;

(3) each person who is not a full-time employee of the agent and who receives a portion of the premium for services performed on behalf of the agent in connection with the issuance of a title insurance form; and

(4) the amount of premium that a person disclosed in Subdivision (3) receives.

(b) The department shall prescribe the form of the disclosure required by this section.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2651.204. CONTINUING EDUCATION. (a) To protect the public and to preserve and improve the competence of license holders, the department shall require as a condition of holding a title insurance agent license that the license holder enroll in and attend or teach continuing education consisting of class instruction, lectures, seminars, or other forms of education approved by the department for title insurance agents.

(b) The department shall prescribe the required number of hours of continuing education, not to exceed 15 hours in each two-year license period.

(c) Continuing education instruction must be designed to refresh the license holder's understanding of:

- (1) basic principles and coverages relating to title insurance;
- (2) recent and prospective changes in those principles and coverages;
- (3) applicable rules of the commissioner and laws;
- (4) the proper conduct of the license holder's business;

and

- (5) the duties and responsibilities of the license holder.

(d) The department may permit a license holder to complete an equivalent course of study and instruction by mail if, because of the remote location of the license holder's residence or business, the license holder is unable to attend educational sessions with reasonable convenience.

(e) On written request by the license holder, the department may extend the time for the license holder to comply with the requirements of this section or may exempt the license holder from all or part of the requirements for a license period if the department determines that the license holder is unable to comply with the requirements because of illness, medical disability, or another extenuating circumstance beyond the control of the license holder. The commissioner shall prescribe the criteria for an extension or exemption by rule.

(f) The commissioner shall adopt rules to administer this section.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2651.205. TITLE AGENT RECORDS. (a) A landlord or storage facility, including electronic storage, that accepts possession of an agent's guaranty file or other records takes possession subject to:

(1) the right of access of the title insurance company involved in the transaction that the file documents, during customary business hours, for the purpose of copying the guaranty file; and

(2) the obligation to maintain the confidentiality of nonpublic information in the title insurance agent's records according to state and federal laws that govern the title insurance agent.

(b) If the title insurance agent has been designated impaired, the Texas Title Insurance Guaranty Association has the right to access the guaranty files and other records of the title insurance agent, including electronic records, for 60 days from the date of impairment, during customary business hours, for purposes of copying those records.

(c) Except for the right of access granted under Subsections (a) and (b), a lien created in favor of the landlord by contract or otherwise is not impaired.

(d) For purposes of this section, "title insurance agent" includes an agent owned wholly or partly by a title insurance company and includes a direct operation.

Added by Acts 2009, 81st Leg., R.S., Ch. 1025 (H.B. 4338), Sec. 16, eff. September 1, 2009.

Sec. 2651.206. EXAMINATION REPORTS. (a) An audit, review, or examination conducted under this chapter or Chapter 2602 must be conducted in accordance with rules adopted by the commissioner. The rules must provide:

(1) that before a report from an examination, review, or audit becomes final, the department will furnish to the title agent or direct operation a copy of the report and any evidence on which the report relies;

(2) a reasonable period of not less than 10 days after the title agent or direct operation receives the report and evidence from the department for the title agent or direct operation to respond;

(3) an opportunity for an appeal under a process similar to the process under Title 28, Part 1, Chapter 7, Subchapter A, Texas

Administrative Code; and

(4) procedures to ensure that the report and any evidence regarding the report remain confidential and are transmitted only to designated representatives of the title agent or direct operation.

(b) The commissioner shall furnish the title agent or direct operation with a draft of the report and a copy of any evidence not later than the 10th day before the scheduled date of a meeting requested by the department regarding a report.

(c) This section does not require the department to turn over work papers. For purposes of this subsection, work papers are the records of an auditor or examiner of the procedures followed, the tests performed, the information obtained, and the conclusions reached that are pertinent to the audit or examination. Work papers include work programs, analyses, memoranda, letters of confirmation and representation, abstracts of company documents and schedules, and commentaries prepared or obtained by the auditor or examiner that support the opinions of the auditor or examiner.

Added by Acts 2009, 81st Leg., R.S., Ch. 1025 (H.B. 4338), Sec. 16, eff. September 1, 2009.

**SUBCHAPTER F. TITLE INSURANCE COMPANY POWERS AND DUTIES REGARDING
TITLE INSURANCE AGENTS**

Sec. 2651.251. EXAMINATION OF TRUST FUND ACCOUNTS BY TITLE INSURANCE COMPANY. (a) A title insurance company may examine, at any time, the trust fund accounts and related records of the company's title insurance agents through the company's examiners or auditors or through independent certified public accountants commissioned by the company.

(b) The title insurance company shall pay for each examination.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2651.252. SPECIAL REPORTS. A title insurance company may require special reports from the company's title insurance agents regarding any of its transactions.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2651.253. AUDIT OF UNUSED FORMS. (a) A title insurance company shall periodically audit the unused forms in the possession of each of the company's title insurance agents to determine that all used forms have been reported to the company.

(b) A title insurance company shall conduct an audit required by this section at least once every two years.

(c) A report of each audit conducted under this section shall be made to the department.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

SUBCHAPTER G. LICENSE DENIAL AND DISCIPLINARY ACTION

Sec. 2651.301. GROUNDS FOR LICENSE DENIAL OR DISCIPLINARY ACTION. The department may deny an application for a license or discipline a title insurance agent or direct operation under Sections 4005.102, 4005.103, and 4005.104 if the department determines that the applicant or license holder has:

- (1) wilfully violated this title;
- (2) intentionally made a material misstatement in the license application;
- (3) obtained or attempted to obtain the license by fraud or misrepresentation;
- (4) misappropriated or converted to the applicant's or license holder's own use or illegally withheld money belonging to a title insurance company, an insured, or another person;
- (5) been guilty of fraudulent or dishonest practices;
- (6) materially misrepresented the terms and conditions of a title insurance policy or contract; or
- (7) failed to maintain:
 - (A) a separate and distinct accounting of escrow funds; and
 - (B) an escrow bank account or accounts separate and apart from all other accounts.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2651.3015. PROHIBITED GROUNDS FOR REJECTION, DELAY, OR DENIAL. (a) Except as provided by Subsection (b) or (c), the department may not reject, delay, or deny a notice of appointment

under Section 2651.009 based wholly or partly on a pending department audit or complaint investigation or a pending disciplinary action against a title insurance agent or appointing title insurance company that has not been finally closed or resolved by a final order issued by the commissioner on or before the date on which the notice is received by the department.

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

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

(1) the title insurance agent or the appointing title insurance company is the subject of a criminal investigation or prosecution; or

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

(d) Except as provided by Subsection (e) or (f), the department may not delay or deny a renewal application under Section 2651.007 based wholly or partly on a department audit or complaint investigation of, or disciplinary or enforcement action against, an applicant or license holder that is pending and has not been finally closed or resolved by a final order issued by the commissioner on or before the date on which the application is complete.

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

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

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

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

Added by Acts 2011, 82nd Leg., R.S., Ch. 1011 (H.B. 2408), Sec. 5, eff. September 1, 2011.

Sec. 2651.302. LICENSE APPLICATION AFTER DENIAL, REFUSAL, OR REVOCATION. (a) An applicant whose license application has been denied or refused or a license holder whose license has been revoked under this subchapter may not file another application for a license as a title insurance agent or direct operation before the first anniversary of:

(1) the effective date of the denial, refusal, or revocation; or

(2) the date of a final court order affirming the denial, refusal, or revocation if judicial review is sought.

(b) A license application filed after the time required by this section may be denied by the department unless the applicant shows good cause why the denial, refusal, or revocation should not be a bar to the issuance of a license.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

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

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

(2) about which the deputy commissioner of the title division of the department makes a good faith determination that there is a credible suspicion that there are ongoing or continuing acts of fraud by a person who is the subject of the action.

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

(c) A disciplinary or enforcement action is automatically dismissed with prejudice, unless the department serves a notice of

hearing on the license holder not later than the 60th business day after the date the department receives a hearing request from the license holder.

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

Added by Acts 2011, 82nd Leg., R.S., Ch. 1011 (H.B. 2408), Sec. 5, eff. September 1, 2011.

CHAPTER 2652. ESCROW OFFICERS
SUBCHAPTER A. GENERAL PROVISIONS

Sec. 2652.001. LICENSE AND BOND OR DEPOSIT REQUIRED. An individual may not act as an escrow officer unless the individual:

- (1) holds a license issued by the department;
- (2) is covered by a surety bond or deposit required under Subchapter C; and
- (3) is appointed under Section 2652.1511 as an escrow officer by a title insurance agent or direct operation.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.
Amended by:

Acts 2015, 84th Leg., R.S., Ch. 232 (H.B. 2491), Sec. 1, eff. September 1, 2015.

Sec. 2652.002. EMPLOYMENT OF ESCROW OFFICER. (a) A title insurance agent or direct operation may not employ an individual as an escrow officer unless the individual:

- (1) holds a license issued by the department;
- (2) is covered by a surety bond or deposit as required under Subchapter C; and
- (3) is appointed under Section 2652.1511 as an escrow officer by the title insurance agent or direct operation.

(b) A title insurance agent or direct operation may not permit an individual to act as an escrow officer in this state before the agent or direct operation has complied with Sections 2652.151 and 2652.1511 with respect to the individual.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.
Amended by:

Acts 2015, 84th Leg., R.S., Ch. 232 (H.B. 2491), Sec. 1, eff.
September 1, 2015.

Sec. 2652.003. ATTORNEY ACTING AS ESCROW OFFICER. (a)
Notwithstanding Section 2652.001, an attorney is not required to be
licensed as an escrow officer to perform the duties of an escrow
officer as defined by Section 2501.003.

(b) An attorney may hold a license to act as an escrow officer.
An employee of an attorney licensed as an escrow officer also may
hold a license to act as an escrow officer. An attorney licensed as
an escrow officer shall comply with the provisions of this code that
apply to escrow officers and trust funds as if the attorney were a
title insurance agent.

(c) Notwithstanding any other provision of this chapter, a
title insurance company or title insurance agent may not permit an
attorney to conduct the attorney's business in the name of the
company or agent unless the attorney and the attorney's bona fide
employees who close transactions are licensed escrow officers.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2652.004. TRUST FUND ACCOUNT DISBURSEMENTS. (a) An
escrow officer may not disburse funds from a trust fund account until
good funds related to the transaction have been received and
deposited in the account in amounts sufficient to fund any
disbursements from the transaction.

(b) An escrow officer is not liable for a violation of this
section if the violation:

(1) was not intentional; and

(2) resulted from a bona fide error despite the maintenance
of procedures reasonably adopted to avoid the error.

(c) The commissioner shall adopt rules and definitions to
implement this section.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2652.005. ESCROW ACCOUNT AUDIT. Each escrow account used by a licensed escrow officer for closing a transaction is subject to the audit requirements of Subchapter D, Chapter 2651.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2652.006. RECORD OF ESCROW OFFICERS; PUBLIC INFORMATION.

(a) The department shall maintain a record of each escrow officer licensed by the department in a manner that ensures that the escrow officers employed and appointed under Section 2652.1511 by any title insurance agent or direct operation in this state may be conveniently determined.

(b) The department shall make available to the public from the records maintained under Subsection (a) or from other records of the department each escrow officer's name, license number, continuing education compliance status, and appointment history.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 232 (H.B. [2491](#)), Sec. 1, eff. September 1, 2015.

SUBCHAPTER B. LICENSE APPLICATION AND RENEWAL

Sec. 2652.051. LICENSE APPLICATION. (a) Before an initial license is issued to an individual to act as an escrow officer in this state for a title insurance agent or direct operation, the individual must file an application for an escrow officer's license with the department on forms provided by the department and the title insurance agent or direct operation must file an appointment of the escrow officer under Section 2652.1511.

(b) The application must be:

- (1) accompanied by a nonrefundable license fee; and
- (2) signed and sworn to by the title insurance agent or direct operation and by the proposed escrow officer.

(c) The completed application must state that:

(1) the proposed escrow officer is an individual who is a bona fide resident of:

- (A) this state; or
- (B) a state adjacent to this state;

(2) the proposed escrow officer is an attorney or is a bona fide employee of:

(A) an attorney licensed as an escrow officer; or

(B) a title insurance agent or direct operation;

(3) the proposed escrow officer has reasonable experience or instruction in the field of title insurance;

(4) the title insurance agent or direct operation does not know of any fact or condition that disqualifies the proposed escrow officer from receiving a license; and

(5) the proposed escrow officer is a bona fide employee of a title insurance agent or direct operation with an office in this state.

(d) Notwithstanding Sections 406.004 and 406.020, Government Code, a person qualified under this section as an escrow officer may hold a license and operate as a notary public under Chapter 406, Government Code.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.
Amended by:

Acts 2009, 81st Leg., R.S., Ch. 155 (H.B. 652), Sec. 1, eff. September 1, 2009.

Acts 2015, 84th Leg., R.S., Ch. 232 (H.B. 2491), Sec. 2, eff. September 1, 2015.

Sec. 2652.052. LICENSE AND RENEWAL FEES. (a) The department shall prescribe the license fee in an amount not to exceed \$50.

(b) License and renewal fees collected under this chapter and appointment fees collected under Section 2652.1511 shall be deposited to the credit of the Texas Department of Insurance operating account to be used by the department to enforce this chapter and any other law of this state that regulates escrow officers for title insurance agents or direct operations.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.
Amended by:

Acts 2015, 84th Leg., R.S., Ch. 232 (H.B. 2491), Sec. 3, eff. September 1, 2015.

Sec. 2652.053. LICENSE ISSUANCE. The department shall issue a

license if the department determines, based on the application and the department's investigation, that the requirements of Section 2652.051 are satisfied.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2652.054. DUPLICATE LICENSE. (a) The department shall collect in advance a fee from a title insurance agent or direct operation that requests a duplicate license.

(b) The department shall prescribe the fee in an amount not to exceed \$20.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2652.055. LICENSE TERM. Unless a system of staggered license renewal is adopted or required under Chapter 4003, a license expires on the second June 1 following the date of issuance.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 232 (H.B. [2491](#)), Sec. 4, eff. September 1, 2015.

Sec. 2652.056. PROCEDURE FOR LICENSE RENEWAL. An individual may renew an unexpired escrow officer license by:

(1) submitting to the department on a form provided by the department a completed application, signed and sworn by the individual, stating that the applicant is an individual who is a bona fide resident of this state or a state adjacent to this state; and

(2) paying to the department a renewal fee in an amount set by the department.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 232 (H.B. [2491](#)), Sec. 4, eff. September 1, 2015.

Sec. 2652.057. LICENSE SURRENDER OR FORFEITURE. (a) An escrow officer may voluntarily surrender the escrow officer's license at any time by giving notice to the department.

(b) Repealed by Acts 2015, 84th Leg., R.S., Ch. 232 , Sec. 11, eff. September 1, 2015.

(c) A surrender or forfeiture of a license under this section does not affect the culpability of the license holder for conduct committed before the effective date of the surrender or forfeiture. The department may institute a disciplinary proceeding against the former license holder for conduct committed before the effective date of the surrender or forfeiture.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 232 (H.B. [2491](#)), Sec. 11, eff. September 1, 2015.

Sec. 2652.058. CONTINUING EDUCATION. (a) To protect the public and to preserve and improve the competence of license holders, the department shall require as a condition of holding an escrow officer license that the license holder enroll in and attend or teach continuing education consisting of class instruction, lectures, seminars, or other forms of education approved by the department for escrow officers.

(b) The department shall prescribe the required number of hours of continuing education, not to exceed 15 hours in each two-year license period.

(c) Continuing education instruction must be designed to refresh the license holder's understanding of:

(1) basic principles and coverages relating to title insurance;

(2) recent and prospective changes in those principles and coverages;

(3) applicable rules of the commissioner and laws;

(4) the proper conduct of the license holder's business;

and

(5) the duties and responsibilities of the license holder.

(d) The department may permit a license holder to complete an equivalent course of study and instruction by mail if, because of the

remote location of the license holder's residence or business, the license holder is unable to attend educational sessions with reasonable convenience.

(e) On written request by the license holder, the department may extend the time for the license holder to comply with the requirements of this section or may exempt the license holder from all or part of the requirements for a license period if the department determines that the license holder is unable to comply with the requirements because of illness, medical disability, or another extenuating circumstance beyond the control of the license holder. The commissioner shall prescribe the criteria for an extension or exemption by rule.

(f) The commissioner shall adopt rules to administer this section.

(g) Continuing education programs to satisfy the requirements of this section must be certified under Subchapter C, Chapter 4004. The department may enter into an agreement with an independent contractor as authorized by Section 4004.104 to certify and register the programs and providers of those programs.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.
Amended by:

Acts 2015, 84th Leg., R.S., Ch. 232 (H.B. 2491), Sec. 5, eff. September 1, 2015.

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

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

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

proposes to deny the application.

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

Added by Acts 2011, 82nd Leg., R.S., Ch. 1011 (H.B. 2408), Sec. 6, eff. September 1, 2011.

SUBCHAPTER C. BOND AND DEPOSIT REQUIREMENTS

Sec. 2652.101. BOND REQUIRED. (a) A title insurance agent or direct operation shall obtain, at its own expense, a bond for its escrow officers appointed under Section 2652.1511 payable to the department. The bond shall obligate the principal and surety to pay for any pecuniary loss sustained by the title insurance agent or direct operation through an act of fraud, dishonesty, forgery, theft, embezzlement, or wilful misapplication by an escrow officer, either directly and alone or in conspiracy with another person.

(b) The bond must be:

(1) of a type approved by the department; and

(2) issued by a surety licensed by the department to do business in this state.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.
Amended by:

Acts 2015, 84th Leg., R.S., Ch. 232 (H.B. 2491), Sec. 6, eff. September 1, 2015.

Sec. 2652.102. ALTERNATIVE TO BOND. (a) Instead of the bond required by Section 2652.101, a title insurance agent or direct operation may deposit with the department:

(1) cash;

(2) irrevocable letters of credit issued by a financial institution insured by an agency of the United States; or

(3) securities approved by the department.

(b) The cash, letters of credit, or securities deposited under this section are subject to the conditions required for a bond under Section 2652.101.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2652.103. AMOUNT OF BOND OR DEPOSIT. (a) The amount of the bond or deposit required under this subchapter is determined by multiplying the number of escrow officers employed by the title insurance agent or direct operation by:

(1) \$5,000 for an application of an individual who is a bona fide resident of this state; or

(2) \$10,000 for an application of an individual who is a bona fide resident of a state adjacent to this state.

(b) Notwithstanding Subsection (a), the maximum amount of the bond or deposit required under this subchapter is \$50,000.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.
Amended by:

Acts 2009, 81st Leg., R.S., Ch. 155 (H.B. 652), Sec. 2, eff. September 1, 2009.

Sec. 2652.104. EXAMINATION OF LOSS COVERED BY BOND OR DEPOSIT.

(a) At any time it appears that a loss covered by a bond or deposit has occurred, the department may require the escrow officer to appear in Travis County, with records the department determines to be proper, for an examination.

(b) The department shall specify a date for the examination that is not earlier than the 10th day or later than the 15th day after the date of service of notice of the requirement to appear. Copies of the notice shall be sent to any title insurance agent or direct operation concerned.

(c) If after the examination the department determines that a loss covered by the bond or deposit has occurred, the department shall immediately notify the appropriate title insurance agent or direct operation and the surety on the bond, if applicable, and prepare a written statement of the facts of the loss and deliver the statement to the attorney general.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2652.105. INVESTIGATION BY ATTORNEY GENERAL. (a) On receipt of a written statement under Section 2652.104, the attorney general shall investigate the charges and, on determining that a loss covered by the bond or deposit has occurred, shall enforce the

liability by collecting against the deposited cash or securities or by filing suit on the bond.

(b) A suit brought under this section shall be filed in the name of the department in Travis County for the benefit of all parties who have suffered any loss covered by the bond or deposit.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

**SUBCHAPTER D. DUTIES OF TITLE INSURANCE AGENTS AND DIRECT OPERATIONS
REGARDING ESCROW OFFICERS**

Sec. 2652.151. LIST OF ESCROW OFFICERS. (a) A title insurance agent or direct operation shall certify to the department, not later than the expiration date of the title insurance agent's or direct operation's license, the name and address of each individual employed and appointed under Section 2652.1511 by the title insurance agent or direct operation to serve as an escrow officer in this state.

(b) The certification required by this section must be on a form provided by the department.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 232 (H.B. [2491](#)), Sec. 7, eff. September 1, 2015.

Sec. 2652.1511. APPOINTMENT OF ESCROW OFFICER. (a) An escrow officer may be employed and appointed by more than one title insurance agent or direct operation.

(b) Before an escrow officer may act in that capacity for a title insurance agent or direct operation, the title insurance agent or direct operation must appoint the escrow officer and file the escrow officer's appointment with the department on the electronic or nonelectronic form provided by the department.

(c) The appointment form must:

(1) be accompanied by a nonrefundable appointment fee;

(2) certify that:

(A) the escrow officer is a bona fide employee of the title insurance agent or direct operation making the appointment; and

(B) the title insurance agent or direct operation has an office in this state;

(3) be signed and sworn to by the title insurance agent or direct operation and by the escrow officer; and

(4) acknowledge that the escrow officer is covered by a surety bond or deposit required under Subchapter C.

(d) The appointment of the escrow officer expires on the revocation, termination, or nonrenewal of the escrow officer's license or termination of the escrow officer's employment with the title insurance agent or direct operation that made the appointment.

(e) Unless otherwise notified by the department, the escrow officer may act as an escrow officer for the appointing title insurance agent or direct operation after:

(1) the second business day after the date the appointment is submitted to the department electronically; or

(2) the eighth business day after the date the appointment is submitted to the department on a nonelectronic form.

Added by Acts 2015, 84th Leg., R.S., Ch. 232 (H.B. [2491](#)), Sec. 8, eff. September 1, 2015.

Sec. 2652.153. NOTICE OF TERMINATION. A title insurance agent or direct operation that terminates the employment of a licensed escrow officer shall:

(1) immediately notify the department in writing of the termination and request cancellation of the appointment under Section 2652.1511; and

(2) notify the escrow officer of the action by the title insurance agent or direct operation.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.
Amended by:

Acts 2015, 84th Leg., R.S., Ch. 232 (H.B. [2491](#)), Sec. 9, eff. September 1, 2015.

SUBCHAPTER E. LICENSE DENIAL AND DISCIPLINARY ACTION

Sec. 2652.201. GROUNDS FOR LICENSE DENIAL OR DISCIPLINARY ACTION. (a) The department may deny an application for a license or discipline an escrow officer under Sections 4005.102, 4005.103, and 4005.104 if the department determines that the applicant or license holder has:

- (1) wilfully violated this title;
- (2) intentionally made a material misstatement in the license application;
- (3) obtained or attempted to obtain the license by fraud or misrepresentation;
- (4) misappropriated or converted to the escrow officer's own use or illegally withheld money belonging to a title insurance agent, direct operation, or another person;
- (5) been guilty of fraudulent or dishonest practices;
- (6) materially misrepresented the terms and conditions of a title insurance policy or contract; or
- (7) failed to complete all educational requirements.

(b) The department may not deny an application for a license or discipline an escrow officer under Section 4005.102, 4005.103, or 4005.104 solely because the individual resides in an adjacent state and acts as an escrow officer in this state as a bona fide employee of a title insurance agent or direct operation in this state.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 155 (H.B. 652), Sec. 3, eff. September 1, 2009.

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

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

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

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

Added by Acts 2011, 82nd Leg., R.S., Ch. 1011 (H.B. 2408), Sec. 7, eff. September 1, 2011.

Sec. 2652.202. LICENSE APPLICATION AFTER DENIAL, REFUSAL, OR REVOCATION. (a) An applicant whose license application has been denied or refused or a license holder whose license has been revoked under this subchapter may not file another application for a license as an escrow officer before the first anniversary of:

(1) the effective date of the denial, refusal, or revocation; or

(2) the date of a final court order affirming the denial, refusal, or revocation if judicial review is sought.

(b) A license application filed after the time required by this section may be denied by the department unless the applicant shows good cause why the denial, refusal, or revocation should not be a bar to the issuance of a license.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2652.203. NOTICE OF DISCIPLINARY OR ENFORCEMENT ACTION; AUTOMATIC DISMISSAL. (a) The department shall notify a license holder of a disciplinary action or enforcement action against the license holder not later than the 30th business day after the date the department assigns a file number to the action, except that this subsection does not apply to a file or action:

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

(2) about which the department makes a good faith determination that there is a credible suspicion that there are ongoing or continuing acts of fraud by a person who is the subject of the action.

(b) A notice required by Subsection (a) must provide a license

holder fair notice of the alleged facts known by the department on the date of the notice that constitute grounds for the action.

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

(d) The department may provide information about an enforcement action, including a copy of a notice issued under this section, to each title insurance agent or direct operation with which an escrow officer has, or proposes to obtain, an appointment under Section 2652.1511.

(e) Except as prohibited by Chapter 552, Government Code, or any other law, on the date an enforcement action against an escrow officer becomes final, the department shall provide information about the action, including a copy of a commissioner's order or department warning issued under this section, to each title insurance agent or direct operation for which the escrow officer holds appointment under Section 2652.1511.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1011 (H.B. 2408), Sec. 7, eff. September 1, 2011.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 232 (H.B. 2491), Sec. 10, eff. September 1, 2015.

SUBTITLE E. THE BUSINESS OF TITLE INSURANCE

CHAPTER 2701. GENERAL PROVISIONS

Sec. 2701.001. ABSTRACT OF TITLE DISTINGUISHED; PROHIBITION ON REGULATION OF ABSTRACT OF TITLE. (a) In this section, "commitment for title insurance" means a title insurance form under which a title insurance company offers to issue a title insurance policy subject to stated exceptions, requirements, and terms. The term includes a mortgagee title policy binder on an interim construction loan.

(b) A commitment for title insurance constitutes a statement of the terms and conditions on which a title insurance company is willing to issue its policy. A title insurance policy or other title insurance form constitutes a statement of the terms and conditions of the indemnity under the policy or form.

(c) An abstract of title prepared from an abstract plant for a chain of title to real property described in the abstract of title is not title insurance, a commitment for title insurance, or any other title insurance form. A commitment for title insurance, title insurance policy, or other title insurance form is not an abstract of title.

(d) The commissioner may not adopt rules relating to abstracts of title.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2701.002. CONSTRUCTION OF CHAPTER 601, BUSINESS & COMMERCE CODE. Chapter 601, Business & Commerce Code, is a consumer protection law when construed in connection with a title insurance policy issued in this state.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 885 (H.B. 2278), Sec. 2.22, eff. April 1, 2009.

CHAPTER 2702. CLOSING AND SETTLEMENT

SUBCHAPTER A. INSURED CLOSING AND SETTLEMENT LETTERS

Sec. 2702.001. INSURED CLOSING AND SETTLEMENT LETTER: LOANS.

(a) On request, a title insurance company may issue insured closing and settlement letters in connection with the closing and settlement by a title insurance agent or direct operation of loans relating to real property located in this state.

(b) Insured closing and settlement letters must be issued in the form prescribed by the commissioner.

(c) A title insurance company may not impose a charge for issuing insured closing and settlement letters under this section.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2702.002. INSURED CLOSING AND SETTLEMENT LETTER: CERTAIN BUYERS OR SELLERS. (a) On written request, a title insurance company may issue to the buyer or seller of real property located in

this state, the sales price of which exceeds the maximum covered claim specified by Chapter 2602, an insured closing and settlement letter in connection with the closing and settlement of the transaction by a title insurance agent or direct operation. Only the title insurance company that is to issue an owner title insurance policy in connection with the transaction may issue the insured closing and settlement letter.

(b) An insured closing and settlement letter must be issued:

- (1) at or before closing; and
- (2) in the form and manner prescribed by the commissioner.

(c) The commissioner may adopt a charge for the issuance of an insured closing and settlement letter under this section and prescribe the form and manner in which the charge must be made.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2702.003. EFFECT OF FAILURE TO ISSUE INSURED CLOSING AND SETTLEMENT LETTER. The failure of a title insurance company to issue an insured closing and settlement letter does not affect the company's liability under an issued title insurance policy.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

SUBCHAPTER B. UNIFORM CLOSING AND SETTLEMENT STATEMENTS

Sec. 2702.051. APPLICABILITY. This subchapter does not apply to the closing or settlement of:

(1) a residential real property transaction regulated by the Real Estate Settlement Procedures Act of 1974 (Pub. L. No. 93-533); or

(2) a real property transaction if the closing or settlement is not actually handled by:

(A) a title insurance company, a title insurance agent, or an attorney for a title insurance company or title insurance agent; or

(B) a representative of a title insurance company, a title insurance agent, or an attorney for a title insurance company or title insurance agent.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2702.052. DUTY TO PRESCRIBE UNIFORM CLOSING AND SETTLEMENT STATEMENT FORMS. (a) The department, after notice and hearing, shall prescribe uniform closing and settlement statement forms to be used in connection with the closing and settlement of a transaction involving:

- (1) the conveyance or mortgage of real property; and
- (2) the issuance of a title insurance policy by a title insurance company or title insurance agent.

(b) The department may prescribe separate forms under this section for transactions involving improved residential real property and for all other real property transactions.

(c) The department shall design the forms under this section to enable each party to the transaction to be provided with a dual or separate form identifying only the charges made to that party.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2702.053. CONTENT OF CLOSING AND SETTLEMENT STATEMENT.

(a) Each closing and settlement statement provided to a party to a transaction described by Section 2702.052(a) must state the name of any person receiving any amount from that party.

(b) Notwithstanding Subsection (a), the title insurance company or title insurance agent is required to include in the closing and settlement statement only those items of disbursement that are actually disbursed by the company or agent.

(c) If an attorney, other than a full-time employee of the title insurance company or title insurance agent, examines a title or provides any closing or settlement services, the closing and settlement statement must include:

- (1) the amount of the fee for the services, shown as included in the premium; and
- (2) the name of the attorney or, if applicable, the name of the firm to which the fee was paid.

(d) The closing and settlement statement must conspicuously and clearly itemize the charges imposed on the party in connection with the closing and settlement.

(e) If a charge for title insurance is made to the party, the

closing and settlement statement must state whether the title insurance premium included in the charge covers the mortgagee's interest in the real property, the borrower's interest, or both.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2702.054. USE OF ALTERNATE SETTLEMENT STATEMENT FORM PERMITTED. A title insurance company or title insurance agent may use the uniform settlement statement form prepared under the Real Estate Settlement Procedures Act of 1974 (Pub. L. No. 93-533) instead of the uniform closing and settlement statement form prescribed by the department under this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

SUBCHAPTER C. ADVANCE DISCLOSURE OF CLOSING AND SETTLEMENT COSTS IN TRANSACTIONS INVOLVING RESIDENTIAL REAL PROPERTY

Sec. 2702.101. APPLICABILITY. This subchapter does not apply to the closing or settlement of a real property transaction if the closing or settlement is not actually handled by:

(1) a title insurance company, a title insurance agent, or an attorney for a title insurance company or title insurance agent; or

(2) a representative of a title insurance company, a title insurance agent, or an attorney for a title insurance company or title insurance agent.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2702.102. DUTY TO PROVIDE ADVANCE DISCLOSURE OF CLOSING AND SETTLEMENT COSTS. (a) Except as provided by Subsection (c), on the written request of the buyer, seller, or borrower before the closing and settlement of a transaction involving improved residential real property, a title insurance company or title insurance agent shall, in connection with the issuance of any kind of title insurance policy guaranteeing a lien on or the title to the property, provide to the requesting party an itemized disclosure of each charge to be made to that party that arises in connection with

the closing and settlement.

(b) The itemized disclosure must be provided on a closing and settlement statement form prescribed or permitted under Subchapter B.

(c) The title insurance company or title insurance agent is required to provide the itemized disclosure only to the extent that information is available concerning each charge to be made to the party. If information concerning a charge is not available, the title insurance company or title insurance agent shall:

(1) make a notation that the charge is to be made but that the information is not available or that the amount shown is an estimate of the charge; and

(2) advise the party in writing as to the identity of the person or organization responsible for the charge.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2702.103. TITLE INSURANCE COMPANY OR TITLE INSURANCE AGENT NOT SUBJECT TO REQUIREMENTS APPLICABLE TO LENDERS. (a)

Notwithstanding Section 2702.102, a title insurance company or title insurance agent is not required to disclose a cost or charge that a lender is required by law to disclose to a party.

(b) Section 2702.102 does not impose on a title insurance company or title insurance agent any obligation imposed on a lender by the Real Estate Settlement Procedures Act of 1974 (Pub. L. No. 93-533).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

CHAPTER 2703. POLICY FORMS AND PREMIUM RATES

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 2703.001. COMPLIANCE WITH TITLE AND RULES. (a) This section applies to a corporation organized under this title, a foreign corporation, and, to the extent that the corporation is engaged in the business of title insurance, a corporation organized under another law, including:

(1) Subdivision 57, Article 1302, Revised Statutes, before repeal of that statute; and

(2) Chapter 861.

(b) A corporation operates in this state under the control and

supervision of the commissioner and under uniform rules adopted by the commissioner relating to:

- (1) forms of policies and underwriting contracts;
- (2) premiums for those policies and contracts; and
- (3) underwriting standards and practices.

(c) With respect to real property located in this state, a corporation may not issue any kind of title insurance coverage, any kind of guarantee, or reinsurance of a risk assumed under a title insurance policy, except as provided by Section 2551.305 or 2551.3055, unless the corporation is authorized to engage in the business of title insurance under this title and otherwise complies with this title. In engaging in the business of title insurance with respect to real property located in this state, the corporation shall comply with this title and rules described by Subsection (b), including when:

- (1) issuing any kind of title insurance policy or an underwriting contract;
- (2) reinsuring any portion of a risk assumed under a title insurance policy; and
- (3) deleting a title insurance policy exclusion.

(d) Title insurance coverage, reinsurance, or a guarantee issued in violation of Subsection (c) is invalid.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.
Amended by:

Acts 2015, 84th Leg., R.S., Ch. 38 (S.B. 572), Sec. 4, eff. September 1, 2015.

Sec. 2703.002. USE OF FORMS IN GENERAL. A title insurance company or title insurance agent may not use a form required under this title to be prescribed or approved until the commissioner has prescribed or approved the form.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2703.003. PAYMENT OF PREMIUMS. The premium for a title insurance policy or for another form prescribed or approved by the commissioner shall be paid in the due and ordinary course of business.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

SUBCHAPTER B. POLICY PROVISIONS

Sec. 2703.051. CERTAIN PROVISIONS REQUIRED. A title insurance policy delivered or issued for delivery in this state to insure an owner of real property must include certain provisions, the form and content of which shall be prescribed by the commissioner, in accordance with this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

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

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

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

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

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

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

lignite, oil, gas, or another mineral;

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

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

Added by Acts 2011, 82nd Leg., R.S., Ch. 1011 (H.B. 2408), Sec. 8, eff. September 1, 2011.

Sec. 2703.052. DUTY OF TITLE INSURANCE COMPANY. (a) On a report to a title insurance company made by an insured after a title insurance policy has been issued that a lien, encumbrance, or title defect exists that is not excepted under the policy or otherwise excluded from coverage, the company shall promptly investigate to determine whether the lien or encumbrance is valid and not barred by statute or other law.

(b) A title insurance company that concludes that a valid lien or encumbrance that is not barred by statute or other law exists or that a title defect exists shall:

(1) institute all necessary legal proceedings to clear the title to the property;

(2) indemnify the insured according to the terms of the policy;

(3) reinsure at current value the title to the property without making exception to the lien, encumbrance, or defect or indemnify another insurer for reinsuring the title without making exception to the lien, encumbrance, or defect;

(4) secure a release of the lien, encumbrance, or defect;

or

(5) take a combination of the actions described by this subsection.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2703.053. ESTABLISHMENT OF STANDARDS AND SCHEDULES. The commissioner by rule shall establish standards and time schedules for implementing and handling claims by title insurance companies in accordance with this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2703.054. AUTHORITY OF COMMISSIONER IN IMPLEMENTING SUBCHAPTER. (a) The commissioner may adopt, by amendment to an owner title insurance policy or by separate endorsement to an owner title insurance policy, language to implement this subchapter in a manner consistent with the terms, provisions, conditions, and stipulations of the policy or the exceptions to coverage contained in the schedules to the policy.

(b) This subchapter does not prohibit the commissioner from adopting for use in this state one or more policies in a simplified, generally more understandable, and usable form.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

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

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

(2) provide insurance as to ownership of minerals.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1011 (H.B. 2408), Sec. 9, eff. September 1, 2011.

Sec. 2703.056. EXCEPTIONS; MINERAL AND GEOTHERMAL ENERGY INTERESTS. (a) Subject to the underwriting standards of the title insurance company, a title insurance company may in a commitment for title insurance or a title insurance policy include a general exception or a special exception to except from coverage:

(1) a mineral estate or the geothermal energy and associated resources below the surface of the land; or

(2) an instrument that purports to reserve or transfer all or part of a mineral estate or the geothermal energy and associated resources below the surface of the land.

(b) A reduction to, or credit on a premium charge for, a policy

of title insurance or other insuring form may not be directly or indirectly based on an exclusion of, or general or special exception to, a mineral estate or the geothermal energy and associated resources below the surface of the land in the title insurance policy.

(c) 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 or the geothermal energy and associated resources below the surface of the land.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1011 (H.B. 2408), Sec. 9, eff. September 1, 2011.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 1108 (S.B. 785), Sec. 1, eff. June 18, 2023.

SUBCHAPTER C. POLICY FORMS FOR RESIDENTIAL REAL PROPERTY

Sec. 2703.101. POLICY FORMS FOR RESIDENTIAL REAL PROPERTY. (a) The commissioner shall prescribe an owner title insurance policy form to be issued in connection with a transaction involving residential real property in this state.

(b) A title insurance company or title insurance agent shall use the form prescribed by the commissioner in issuing to an individual an owner title insurance policy relating to residential real property in this state.

(c) Unless authorized by rule adopted by the commissioner, an insurer may not enter into a contract or other agreement concerning an individual title insurance policy if the contract or other agreement is not expressed in the policy. A contract or agreement prohibited by this subsection is void.

(d) An endorsement prescribed by the commissioner may be attached to the title insurance policy form as authorized by rule adopted by the commissioner.

(e) The commissioner may not prescribe an owner title insurance policy form for residential real property or an endorsement to the policy if the policy form or endorsement is not written in plain language. For purposes of this subsection, a policy form or endorsement is written in plain language if it achieves the minimum

score established by the commissioner on the Flesch reading ease test or an equivalent test selected by the commissioner or, at the commissioner's option, if it conforms to the language requirements in a National Association of Insurance Commissioners model act relating to plain language. This subsection does not apply to policy language required by state or federal law.

(f) For an owner title insurance policy on residential real property that is issued to an individual, the commissioner may adopt coverages that insure against ad valorem taxes, including penalties and interest, to be paid with respect to the property for a previous tax year:

(1) that are delinquent on the effective date of the policy because of sale, diversion, or change of use, unless excluded because the insured has actual knowledge of the delinquent taxes; or

(2) that result from an exemption granted to a previous owner of the property under Section 11.13, Tax Code, or from an improvement not assessed for a previous tax year, unless excluded because the insured has actual knowledge of the taxes.

(g) For an owner's title insurance policy on residential real property that is issued to an individual, the commissioner shall adopt terms that provide for continuation of coverage subject to rights and defenses against the original named insured for:

(1) a person who inherits the original named insured's title on the original named insured's death;

(2) the original named insured's spouse who receives title in a dissolution of marriage with the original named insured;

(3) the trustee or successor of a trust established by the original named insured to whom the original named insured transfers title after the date of policy; or

(4) the beneficiaries of a trust described by Subdivision (3) on the death of the original named insured.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.
Amended by:

Acts 2009, 81st Leg., R.S., Ch. 985 (H.B. 3768), Sec. 1, eff. September 1, 2009.

SUBCHAPTER D. FIXING AND PROMULGATING PREMIUM RATES

Sec. 2703.151. FIXING AND PROMULGATING PREMIUM RATES. (a)

Except as provided by Subsection (b), the commissioner shall fix and promulgate the premium rates to be charged by a title insurance company or by a title insurance agent for title insurance policies or for other forms prescribed or approved by the commissioner.

(b) The commissioner may not fix or promulgate the premium rates for reinsurance between title insurance companies. Title insurance companies may establish the premium rates in amounts to which the companies agree.

(c) Except for a premium charged for reinsurance, a premium may not be charged for a title insurance policy or for another prescribed or approved form at a rate different than the rate fixed and promulgated by the commissioner.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2703.152. FACTORS CONSIDERED IN FIXING PREMIUM RATES. (a) In fixing premium rates, the commissioner shall consider all relevant income and expenses of title insurance companies and title insurance agents attributable to engaging in the business of title insurance in this state.

(b) The premium rates fixed by the commissioner must be:

(1) reasonable as to the public; and

(2) nonconfiscatory as to title insurance companies and title insurance agents.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2703.153. COLLECTION OF DATA FOR FIXING PREMIUM RATES; ANNUAL STATISTICAL REPORT. (a) Each title insurance company and title insurance agent engaged in the business of title insurance in this state shall annually submit to the department, as required by the department to collect data to use to fix premium rates, a statistical report containing information relating to:

(1) loss experience;

(2) expense of operation; and

(3) other material matters.

(b) The information must be submitted in the form prescribed by the department.

(c) Not less frequently than once every five years, the

commissioner shall evaluate the information required under this section to determine whether the department needs additional or different information or no longer needs certain information to promulgate rates. If the department requires a title insurance company or title insurance agent to include new or different information in the statistical report, that information may be considered by the commissioner in fixing premium rates if the information collected is reasonably credible for the purposes for which the information is to be used.

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

(1) is unduly burdensome; or

(2) is not a request for information material to fixing and promulgating premium rates or another matter that may be the subject of the periodic hearing and is not a request reasonably designed to lead to the discovery of that information.

(e) On filing of a suit under Subsection (d), the requirement that the title insurance company or title insurance agent bringing the suit comply with the request for the information is abated as to that title insurance company or title insurance agent. The district court may enter an order requiring the title insurance company or title insurance agent to comply with the request for information subject to the limitations, if any, imposed by the court.

(f) A title insurance company or title insurance agent must bring suit under Subsection (d) not later than the 30th day after the date the company or agent receives the request for information from the department.

(g) This section may not be construed to limit the department's authority to request information under Section 38.001 or other applicable provisions of this code.

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

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

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 930 (H.B. 3271), Sec. 1, eff. September 1, 2007.

Acts 2011, 82nd Leg., R.S., Ch. 1011 (H.B. 2408), Sec. 10, eff. September 1, 2011.

Acts 2011, 82nd Leg., R.S., Ch. 1147 (H.B. 1951), Sec. 5.001, eff. September 1, 2011.

**SUBCHAPTER E. PROCEDURES REGARDING PREMIUM RATES, POLICY FORMS, AND
OTHER RELATED MATTERS**

Sec. 2703.201. HEARING REQUIRED FOR FIXING PREMIUM RATE.

Before a premium rate may be fixed and a premium charged, the department must provide reasonable notice and a hearing must be afforded to title insurance companies, title insurance agents, and the public.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2703.202. HEARING REQUIRED FOR CHANGE IN PREMIUM RATE.

(a) A premium rate previously fixed by the commissioner may not be changed until after the commissioner holds a public hearing.

(b) The commissioner shall order a public hearing to consider changing a premium rate, including fixing a new premium rate, in response to a written request of:

(1) a title insurance company;

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

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

(4) the office of public insurance counsel.

(b-1) An interested person by a written request to the commissioner may request a public hearing to consider changing a premium rate, including fixing a new premium rate. For the purposes of this subsection, "interested person" means:

(1) a resident of this state;

(2) a business entity doing business in this state;

(3) a political subdivision located in this state; or

(4) a public or private organization, other than a state agency, that is located in this state.

(b-2) Not later than the 60th day after the date of submission of a request under Subsection (b-1), the commissioner shall:

(1) deny the request in writing, stating the reasons for the denial; or

(2) initiate a hearing under Subsection (a).

(c) Except as provided by Subsection (d), a public hearing held under Subsection (a) or under Section 2703.206 shall be conducted by the commissioner as a rulemaking hearing under Subchapter B, Chapter 2001, Government Code.

(d) Notwithstanding Subsection (c), a person or entity described by Subsection (b) or an interested person described by, and subject to, Subsection (b-1) may petition the commissioner in writing that a public hearing held under Subsection (a) or under Section 2703.206 be conducted by the commissioner as a contested case hearing under Subchapters C through H and Subchapter Z, Chapter 2001, Government Code. The petition must state the grounds for the petitioner's request.

(d-1) Not later than the 30th day after the date the commissioner receives a petition under Subsection (d), the commissioner shall hold a public hearing on the petition to determine whether:

(1) the petition is made in good faith; and

(2) the grounds stated in the petition otherwise justify conducting the proceeding as a contested case hearing.

(d-2) Not later than the 60th day after the date a petition under Subsection (d) is submitted, the commissioner shall:

(1) deny the petition in writing, stating the reasons for the denial; or

(2) grant the petition to initiate a hearing under Subsections (a) and (h) as a contested hearing.

(e) Information received or requested by the commissioner as part of an individual audit or examination under Chapters 2602 and 2651 may not be used for rate setting under Subchapter D, Chapter 2703. Nothing in this section prohibits a party from conducting discovery in a ratemaking or other proceeding or producing other information requested by the department, or verifying the data reported under a statistical plan or report promulgated by the commissioner.

(f) Subsections (c) through (e) apply only to a public hearing held on or after January 1, 2009.

(g) If a hearing held under Subsection (a) is not conducted as a contested case hearing, the commissioner shall render a decision and issue a final order not later than the 120th day after the date the commissioner receives a written request under Subsection (b) or (b-1).

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

(1) not later than the 30th day after the date the commissioner rules on a petition for a public hearing under Subsection (d-2), 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 the public hearing not later than the 30th day after the date responses to the notice of call are required under Subdivision (2);

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

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

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

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

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

(k) A party described by Subsection (b) or (b-1) may petition a district court in Travis County to enter an order requiring the commissioner to comply with the deadlines described by this section if the commissioner fails to meet a requirement in Subsection (g) or (h).

(l) Subject to Subsection (m), if the commissioner fails to comply with the requirements under Subsection (g) or (h)(6), a

combination of at least three associations, persons, or entities listed in Subsection (b) or (b-1) may jointly petition a district court of Travis County to adopt a rate based on the record made in the hearing before the commissioner under this section.

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

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

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

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1025 (H.B. 4338), Sec. 17, eff. September 1, 2009.

Acts 2011, 82nd Leg., R.S., Ch. 1011 (H.B. 2408), Sec. 11, eff. September 1, 2011.

Acts 2019, 86th Leg., R.S., Ch. 884 (H.B. 3228), Sec. 1, eff. September 1, 2019.

Sec. 2703.203. PERIODIC HEARING. The commissioner shall hold a public hearing not earlier than July 1 after the fifth anniversary of the closing of a hearing held under this chapter to consider adoption of premium rates and other matters relating to regulating the business of title insurance that an interested person, association, title insurance company, title insurance agent, or entity under Section 2703.204 requests to be considered or that the commissioner determines necessary to consider.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 930 (H.B. 3271), Sec. 1, eff. September 1, 2007.

Acts 2011, 82nd Leg., R.S., Ch. 1011 (H.B. 2408), Sec. 12, eff. September 1, 2011.

Acts 2019, 86th Leg., R.S., Ch. 884 (H.B. 3228), Sec. 2, eff.

September 1, 2019.

Sec. 2703.204. ADMISSION AS PARTY TO HEARING. (a) Subject to this section, the following persons, associations, and entities shall be admitted as parties to a contested case hearing under Section 2703.202, the periodic hearing under Section 2703.203, or a hearing under Section 2703.206:

(1) 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;

(2) an association, person, or entity described by Section 2703.202(b);

(3) an interested person described by Section 2703.202(b-1); or

(4) department staff.

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

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 930 (H.B. 3271), Sec. 2, eff. September 1, 2007.

Acts 2011, 82nd Leg., R.S., Ch. 1011 (H.B. 2408), Sec. 13, eff. September 1, 2011.

Acts 2019, 86th Leg., R.S., Ch. 884 (H.B. 3228), Sec. 3, eff. September 1, 2019.

Sec. 2703.206. COMMISSIONER AUTHORITY TO HOLD HEARINGS AS NECESSARY. At any time, the commissioner may order a public hearing to consider adoption of premium rates and other matters relating to regulating the business of title insurance as the commissioner determines necessary or proper.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

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

(1) sent directly to all parties to the previous hearing conducted under Section 2703.202, 2703.203, or 2703.206, if the hearing was conducted as a contested case hearing; and

(2) published in the Texas Register and on the department's Internet website.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.
Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 1011 (H.B. 2408), Sec. 14, eff. September 1, 2011.

Sec. 2703.208. ADDITIONS OR AMENDMENTS TO MANUAL. (a) An addition or amendment to the Basic Manual of Rules, Rates, and Forms for the Writing of Title Insurance in the State of Texas may be proposed and adopted by reference by publishing notice of the proposal or adoption by reference in the Texas Register.

(b) Notice under this section must include:

(1) a brief summary of the substance of the matter to be added or amended; and

(2) a statement that the full text of the matter is available for review in the office of the chief clerk of the department.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

CHAPTER 2704. ISSUANCE OF POLICY OR CONTRACT; DETERMINATION OF INSURABILITY

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 2704.001. ISSUANCE OF POLICY OR CONTRACT. A title insurance policy or contract may not be written unless:

(1) Sections 2502.053, 2502.054, and 2502.055 have been complied with;

(2) the policy or contract is based on an examination of title made from title evidence prepared from an abstract plant owned, or leased and operated by a title insurance agent or direct operation

for the county in which the real property is located, except as provided by Section 2704.002;

(3) insurability of title has been determined in accordance with sound title underwriting practices; and

(4) evidence thereof is preserved and retained in the files of the title insurance company, title insurance agent, or direct operation for a period of not less than 15 years after the date of issuance of the policy or contract.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2704.002. DIRECT ISSUANCE OF POLICY OR CONTRACT. A title insurance company may directly issue a title insurance policy or contract based on the best title evidence available if:

(1) a title insurance agent or direct operation does not exist for the county in which the real property is located; or

(2) each title insurance agent and direct operation for that county refuses to provide title evidence:

(A) in a reasonable period as determined by the department; and

(B) in compliance with Section 2502.053(1).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2704.003. COPY OF POLICY OR CONTRACT TO AGENT OR DIRECT OPERATION. In a reasonable period as determined by the department, a copy of each title insurance policy or contract issued in a real property transaction shall be provided to each title insurance agent or direct operation providing the title evidence on which the policy or contract is issued.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2704.004. EXCEPTIONS TO APPLICABILITY OF CHAPTER. This chapter does not apply to a company that:

(1) does not assume primary liability in a reinsurance contract; or

(2) acts as coinsurer, if at least one of the other

coinsurers has complied with this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

**SUBCHAPTER B. ISSUANCE OF OWNER AND MORTGAGEE POLICIES FOR
RESIDENTIAL REAL PROPERTY**

Sec. 2704.051. ISSUANCE OF OWNER POLICY REQUIRED IN CONNECTION WITH ISSUANCE OF MORTGAGEE POLICY. (a) In this section, "mortgagee title insurance policy" means a mortgagee policy of title insurance or another agreement or the equivalent that constitutes the business of title insurance.

(b) Except as provided by Section 2704.052, a title insurance company or title insurance agent that issues a mortgagee title insurance policy in connection with a lien on improved residential real property in this state that is sold shall also issue an owner title insurance policy to the owner of the property.

(c) The title insurance company or title insurance agent issuing the owner title insurance policy shall charge the required premium promulgated by the commissioner.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2704.052. REJECTION OF ISSUANCE OF OWNER POLICY. At or before closing and settlement, the person acquiring title may reject the issuance of the owner title insurance policy required under Section 2704.051 by executing a written and acknowledged rejection in the form prescribed, after notice and hearing, by the commissioner.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

SUBCHAPTER C. TITLE INSURANCE COVERING AREAS AND BOUNDARIES

Sec. 2704.101. DEFINITION. In this subchapter, "area and boundary coverage" means title insurance coverage relating to discrepancies, conflicts, or shortages in area or boundary lines, or any encroachments or protrusions, or any overlapping of improvements.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2704.102. RULES AUTHORIZING ACCEPTANCE OF EXISTING SURVEY.

(a) The commissioner by rule may authorize a title insurance company providing area and boundary coverage to accept an existing real property survey as provided by this section.

(b) A title insurance company may accept an existing real property survey rather than requiring a new survey if, notwithstanding the age of the survey or the identity of the person for whom the survey was prepared, the company is willing to accept:

(1) evidence of the existing survey; and

(2) an affidavit prescribed by the commissioner that verifies the existing survey.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2704.103. CERTAIN DISCRIMINATION PROHIBITED. A title insurance company may not discriminate in providing area and boundary coverage in connection with residential real property solely because:

(1) the real property is platted or unplatted; or

(2) a municipality did not accept a subdivision plat relating to the real property before September 1, 1975.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

Sec. 2704.104. INDEMNITY PROHIBITED. A title insurance company may not require an indemnity from a seller, buyer, borrower, or lender to provide area and boundary coverage.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 6, eff. April 1, 2005.

**SUBTITLE F. TITLE INSURANCE FOR CERTAIN
PERSONAL PROPERTY INTERESTS
CHAPTER 2751. TITLE INSURANCE FOR PERSONAL
PROPERTY INTERESTS
SUBCHAPTER A. GENERAL PROVISIONS**

Sec. 2751.001. GENERAL DEFINITIONS. (a) The definitions under Sections 2501.003(2)-(5), (7), (10), and (12)-(14) apply to the regulation of title insurance under this chapter.

(b) In this subtitle, a term not defined under Subsection (a)

that is used in Chapter 9, Business & Commerce Code, has the meaning assigned by that code.

Added by Acts 2007, 80th Leg., R.S., Ch. 543 (S.B. 1153), Sec. 1, eff. September 1, 2007.

Sec. 2751.002. DEFINITIONS OF PERSONAL PROPERTY AND PERSONAL PROPERTY TITLE INSURANCE. In this subtitle:

(1) "Personal property" has the meaning assigned by Section 1.04, Tax Code.

(2) "Personal property title insurance" means coverage that insures:

(A) whether affirming or negating, one or more of the elements of attachment, perfection, or priority of a security interest in personal property or fixtures;

(B) the results, as to correctness, completeness, or other criteria, of a search of:

(i) the filing office of the financing statement record of a debtor; or

(ii) any other database, whether publicly or privately maintained, such as court dockets, tax records, motor vehicle department records, or the records of the Federal Aviation Administration as to aircraft, the United States Coast Guard as to vessels, or the United States Department of Transportation;

(C) the status of ownership of, rights in, powers to transfer rights in, or title with respect to personal property or fixtures;

(D) the effectiveness of the filing of a financing statement with a filing office, or any other record with any publicly maintained database or registry;

(E) the lien status of personal property or fixtures, or compliance with Title 1, Business & Commerce Code, the Uniform Commercial Code, international conventions such as the United Nations Commission on International Trade Law (UNCITRAL), or similar laws or regulations; or

(F) any of the matters covered by Paragraphs (A)-(E) with respect to the laws of any other domestic or foreign jurisdiction.

Added by Acts 2007, 80th Leg., R.S., Ch. 543 (S.B. 1153), Sec. 1, eff.

September 1, 2007.

Sec. 2751.003. APPLICABILITY OF OTHER LAWS. (a) Except as provided by Subsection (b), this code, other than this chapter, does not apply to the business of personal property title insurance.

(b) The following laws apply to the business of personal property title insurance:

(1) Section 2501.005, other than Subsections (a)(2)(A)-(C) of that section;

(2) Section 2501.007;

(3) Section 2502.001;

(4) Sections 2502.051, 2502.053, and 2502.055;

(5) Chapter 2551;

(6) Chapter 2553;

(7) Chapter 2601;

(8) Chapter 2651;

(9) Chapter 2652;

(10) Section 2701.002;

(11) Chapter 2703, except to the extent of any conflict with Subchapter B of this chapter;

(12) Section 2704.001, other than Subdivisions (1) and (2) of that section;

(13) Section 2704.002; and

(14) Section 2704.004.

Added by Acts 2007, 80th Leg., R.S., Ch. 543 (S.B. [1153](#)), Sec. 1, eff. September 1, 2007.

Sec. 2751.004. GENERAL RULES. The commissioner, in the manner prescribed by Subchapter A, Chapter 36, shall adopt rules as necessary to implement and enforce this chapter.

Added by Acts 2007, 80th Leg., R.S., Ch. 543 (S.B. [1153](#)), Sec. 1, eff. September 1, 2007.

SUBCHAPTER B. RATES AND FORMS

Sec. 2751.051. FIXING AND PROMULGATING PREMIUM RATES AND FORMS.

(a) The commissioner shall, in the manner prescribed by this

subchapter:

(1) fix and promulgate the premium rates to be charged by a title insurance company or by a title insurance agent for personal property title insurance policies under this chapter; and

(2) prescribe the forms to be used in connection with those policies.

(b) A premium may not be charged for a personal property title insurance policy or for another prescribed or approved form at a rate different than the rate fixed and promulgated by the commissioner.

(c) The commissioner may not limit the number of forms for personal property title insurance if the forms meet the requirements of this title.

Added by Acts 2007, 80th Leg., R.S., Ch. 543 (S.B. 1153), Sec. 1, eff. September 1, 2007.

Sec. 2751.052. FACTORS CONSIDERED IN FIXING PREMIUM RATES. (a) In fixing premium rates, the commissioner shall consider all relevant income and expenses of title insurance companies and title insurance agents attributable to engaging in the business of personal property title insurance in this state.

(b) The premium rates fixed by the commissioner must be reasonable, adequate, not unfairly discriminatory, nonconfiscatory, and not excessive.

Added by Acts 2007, 80th Leg., R.S., Ch. 543 (S.B. 1153), Sec. 1, eff. September 1, 2007.

Sec. 2751.053. HEARING REQUIRED. (a) Before a premium rate may be fixed and forms adopted for personal property title insurance under this chapter, the department must provide reasonable notice and a hearing must be afforded to title insurance companies, title insurance agents, and the public.

(b) A hearing under this section is subject to Subchapter B, Chapter 40, and is handled as a contested case under Chapter 2001, Government Code, in the manner prescribed by that subchapter.

Added by Acts 2007, 80th Leg., R.S., Ch. 543 (S.B. 1153), Sec. 1, eff. September 1, 2007.

Sec. 2751.054. COMMISSIONER ORDER. (a) Not later than the 90th day after the date of a hearing under Section 2751.053, the commissioner shall issue an order prescribing the rates and forms to be used in connection with personal property title insurance policies under this chapter.

(b) The commissioner's order promulgating rates must be based on the evidence adduced at the hearing.

Added by Acts 2007, 80th Leg., R.S., Ch. 543 (S.B. 1153), Sec. 1, eff. September 1, 2007.

Sec. 2751.055. REVISIONS TO RATES AND FORMS; HEARING. (a) A title insurance company may apply to the department in the manner prescribed by the commissioner for approval of a new or revised personal property title insurance form or a change in a rate associated with such a form. The commissioner may approve or disapprove an application after a hearing conducted in the manner prescribed by Section 2751.053.

(b) A hearing under this section must be conducted not later than the 60th day after the date on which the department receives the application.

(c) The commissioner shall approve or disapprove the application not later than the 90th day after the date of the hearing under Subsection (a).

Added by Acts 2007, 80th Leg., R.S., Ch. 543 (S.B. 1153), Sec. 1, eff. September 1, 2007.

SUBCHAPTER C. POWERS AND DUTIES OF INSURERS AND AGENTS

Sec. 2751.101. ISSUANCE OF POLICIES. A title insurance company may issue a personal property title insurance policy in this state if the policy covers personal property or fixtures, or a secured party or other insured, or a debtor, located in this state.

Added by Acts 2007, 80th Leg., R.S., Ch. 543 (S.B. 1153), Sec. 1, eff. September 1, 2007.

Sec. 2751.102. USE OF FORMS. (a) A title insurance company or title insurance agent shall use the forms prescribed by the commissioner in issuing a personal property title insurance policy.

(b) Unless authorized by rule adopted by the commissioner, an insurer may not enter into a contract or other agreement concerning a personal property title insurance policy if the contract or other agreement is not expressed in the policy. A contract or agreement prohibited by this subsection is void.

Added by Acts 2007, 80th Leg., R.S., Ch. 543 (S.B. 1153), Sec. 1, eff. September 1, 2007.

Sec. 2751.103. AGENTS. A title insurance agent or direct operation may accept orders for insurance products authorized under this chapter. The agent or direct operation shall act according to the authority granted to the agent or direct operation by the title insurance company issuing the product.

Added by Acts 2007, 80th Leg., R.S., Ch. 543 (S.B. 1153), Sec. 1, eff. September 1, 2007.

Sec. 2751.104. AGENT COMPENSATION. (a) The title insurance company that issues a personal property title insurance policy shall pay the title insurance agent that places the order for the policy a total commission equal to 30 percent of the premium charged for the personal property title insurance or personal property title insurance product authorized under this chapter.

(b) Notwithstanding Subsection (a), a title insurance company may not pay a commission to a title insurance agent for an application for coverage that is placed with the title insurance company directly.

(c) A commission paid under Subsection (a) does not constitute a violation of Section 2502.051.

Added by Acts 2007, 80th Leg., R.S., Ch. 543 (S.B. 1153), Sec. 1, eff. September 1, 2007.

TITLE 12. OTHER COVERAGE

CHAPTER 3501. CREDIT INVOLUNTARY UNEMPLOYMENT INSURANCE

Sec. 3501.001. DEFINITION. In this chapter, "credit involuntary unemployment insurance" means insurance that indemnifies a debtor for installment or other periodic payments on an indebtedness while the debtor is involuntarily unemployed. The term includes policy forms and endorsements that define involuntary unemployment to provide coverage and a premium charge for interruption or reduction of a debtor's income during periods of leave, whether paid or unpaid, authorized by the federal Family and Medical Leave Act of 1993 (29 U.S.C. Section 2601 et seq.), as amended, or other state or federal law.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 3, eff. April 1, 2007.

Sec. 3501.002. AUTHORIZATION. (a) Any insurer authorized to write any form of casualty insurance in this state may also write group or individual credit involuntary unemployment insurance.

(b) Credit involuntary unemployment insurance may be written alone or in conjunction with credit life insurance, credit accident and health insurance, or both, in a policy issued by an authorized insurer.

(c) Credit involuntary unemployment insurance may not be written in contravention of Chapter 15, Business & Commerce Code.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 3, eff. April 1, 2007.

Sec. 3501.003. RATES AND FORMS. Rates and forms for credit involuntary unemployment insurance must be set and filed in accordance with Chapters 2251 and 2301 and Article 5.13-2.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 3, eff. April 1, 2007.

CHAPTER 3502. MORTGAGE GUARANTY INSURANCE**SUBCHAPTER A. GENERAL PROVISIONS**

Sec. 3502.001. APPLICABILITY OF CHAPTER. This chapter applies

only to mortgage guaranty insurance and does not affect any other provision of this code.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 3, eff. April 1, 2007.

Sec. 3502.002. APPLICABILITY OF OTHER LAW. (a) This code and other state laws apply to the business of mortgage guaranty insurance.

(b) This chapter controls to the extent of any conflict with another provision of this code or other state law.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 3, eff. April 1, 2007.

Sec. 3502.003. MORTGAGE GUARANTY INSURANCE DEFINED. In this chapter, "mortgage guaranty insurance" means insurance against:

(1) financial loss because of nonpayment of principal, interest, and other amounts agreed to be paid under the terms of a note, bond, or other evidence of indebtedness that is secured by an authorized real estate security, provided the improvement on the real estate is:

(A) one or more residential buildings designed to be occupied by not more than four families;

(B) a condominium unit; or

(C) one or more buildings designed to be occupied by five or more families or for industrial or commercial purposes; or

(2) financial loss because of nonpayment of rent and other amounts agreed to be paid under the terms of a written lease for the possession, use, or occupancy of real estate, provided the improvement on the real estate is one or more buildings designed to be occupied for industrial or commercial purposes.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 3, eff. April 1, 2007.

Sec. 3502.004. AUTHORIZED REAL ESTATE SECURITY DEFINED. (a) In this chapter, "authorized real estate security" means:

(1) a proprietary lease and a stock membership certificate issued to a tenant stockholder or resident member of a fee simple cooperative housing corporation as defined in Section 216, Internal Revenue Code of 1986; or

(2) a mortgage, deed of trust, wraparound mortgage, or other instrument that constitutes a first lien or charge on real estate or is considered to be the equivalent of a first lien or charge on real estate by the Federal National Mortgage Association, the Federal Home Loan Mortgage Corporation, the Federal Housing Finance Board, a successor of one of those entities, an agency of this state, or a federal agency, provided:

(A) the improvement on the real estate is a building or buildings designed to be occupied as specified by Section 3502.003(1); and

(B) the real estate loan is a type of loan that is:

(i) authorized to be made by a bank, savings and loan association, credit union, or insurer that is supervised and regulated by a department of this state or a federal agency;

(ii) authorized to be made by a mortgage banker that is an approved seller-servicer of the Federal National Mortgage Association, the Federal Home Loan Mortgage Corporation, or a successor of one of those entities; or

(iii) approved by the federal secretary of housing and urban development for participation in a mortgage insurance program.

(b) The lien on real estate described by Subsection (a)(2) may be subject and subordinate to:

(1) the lien of a public bond, assessment, or tax if there is not a delinquent installment, call, or payment of or under the bond, assessment, or tax;

(2) an outstanding mineral, oil, or timber right, right-of-way, easement or right-of-way support, sewer right, building restriction, other restriction or covenant, or other condition or regulation of use; or

(3) an outstanding lease on the real estate under which rents or profits are reserved to the owner.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 3, eff. April 1, 2007.

SUBCHAPTER B. MORTGAGE GUARANTY INSURERS

Sec. 3502.051. GENERAL ELIGIBILITY TO WRITE MORTGAGE GUARANTY INSURANCE. (a) An insurer that writes anywhere any class of insurance other than mortgage guaranty insurance may not be issued or continue to hold a certificate of authority to write mortgage guaranty insurance in this state.

(b) A mortgage guaranty insurer that writes anywhere the class of mortgage guaranty insurance described by Section 3502.003(1)(C) or (2) may not be issued or continue to hold a certificate of authority to write in this state the class of mortgage guaranty insurance described by Section 3502.003(1)(A) or (B).

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 3, eff. April 1, 2007.

Sec. 3502.052. ELIGIBILITY OF FOREIGN OR ALIEN INSURER TO WRITE MORTGAGE GUARANTY INSURANCE. The department may not issue a certificate of authority to a foreign or alien insurer writing mortgage guaranty insurance unless the insurer demonstrates a satisfactory operating experience in the insurer's state of domicile.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 3, eff. April 1, 2007.

Sec. 3502.053. DISCRIMINATION PROHIBITED. In extending or issuing mortgage guaranty insurance, a mortgage guaranty insurer may not discriminate on the basis of the applicant's sex, marital status, race, color, creed, national origin, disability, or age or solely on the basis of the geographic location of the property to be insured unless:

(1) the discrimination related to geographic location is for a business purpose that is not a mere pretext for unfair discrimination; or

(2) the refusal, cancellation, or limitation of the insurance is required by law or regulatory mandate.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 3, eff. April 1, 2007.

SUBCHAPTER C. FORMS AND RATES

Sec. 3502.101. RATE FILINGS. (a) Not later than the 15th day before the date a mortgage guaranty insurer uses a rate or supplementary rate information in this state, the insurer must file the rate and supplementary rate information, and any changes to the rate or supplementary rate information, with the department.

(b) The rate filing must include adequate supporting data, including:

- (1) information on:
 - (A) past and prospective loss experience in this state and outside the state;
 - (B) catastrophe hazards;
 - (C) expenses of operation; and
 - (D) a reasonable margin for profit and contingencies;
- (2) an explanation of the insurer's interpretation of any statistical data on which the insurer relied;
- (3) an explanation and description of the methods used in making the rates; and
- (4) certification by an appropriate official of the insurer relating to the appropriateness of the charges, rates, or rating plans based on reasonable assumptions and accompanied by adequate supporting information.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 3, eff. April 1, 2007.

Sec. 3502.102. RATE STANDARDS. (a) A mortgage guaranty insurance rate, rating plan, or charge may not be excessive, inadequate, or unfairly discriminatory and must be reasonable with respect to the benefits provided.

(b) This chapter does not require the department to:

- (1) establish standard and absolute rates or a single and uniform rate for each risk or risks; or
- (2) compel all insurers to adhere to rates previously filed by other insurers.

(c) The department may accept different rates for different insurers for the same risk or risks on mortgage guaranty insurance. The department may accept different rates for different insurers as filed by any authorized insurer unless the department finds that the

filing does not meet the requirements of this chapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 3, eff. April 1, 2007.

Sec. 3502.103. RECORDING AND REPORTING OF LOSS AND EXPENSE EXPERIENCE AND OTHER DATA. (a) The commissioner shall adopt reasonable rules and statistical plans for the recording and reporting of loss experience and other required data by a mortgage guaranty insurer. The rules and plans must ensure that each insurer's total loss and expense experience is made available in the form and with the detail the commissioner considers necessary.

(b) Each mortgage guaranty insurer shall use the statistical plans adopted under this section to record and report loss experience and other required data in accordance with the rules adopted by the commissioner.

(c) The commissioner may modify statistical plans adopted under this section.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 3, eff. April 1, 2007.

Sec. 3502.104. POLICY FORM FILINGS. (a) Except as provided by Subsection (b), not later than the 15th day before the date a mortgage guaranty insurer uses a policy form, related form, classification, or rule in this state, the insurer must file the form, classification, or rule with the department.

(b) This subsection applies only to a policy form, related form, classification, or rule a mortgage guaranty insurer uses in this state for a policy that provides coverage for a pool or group of loans in connection with the issuance of mortgage-backed securities or bonds. Not later than the 15th day after the date the insurer uses the form, classification, or rule, the insurer shall file the form, classification, or rule with the department.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 3, eff. April 1, 2007.

Sec. 3502.105. POLICY FORM STANDARDS. The commissioner shall disapprove a mortgage guaranty insurance policy form if the form:

- (1) violates this code or rules adopted by the commissioner; or
- (2) contains a provision that encourages misrepresentation or is unjust, unfair, inequitable, misleading, deceptive, or contrary to law or to the public policy of this state.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 3, eff. April 1, 2007.

Sec. 3502.106. CLAIM AGAINST RESIDENTIAL BORROWER. A mortgage guaranty insurance policy may not contain a provision that allows subrogation rights or any other claim by the insurer against the borrower for a deficiency arising from a foreclosure sale of a single-family dwelling that is occupied by the borrower as the borrower's principal residence.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 3, eff. April 1, 2007.

Sec. 3502.107. EXEMPTION; WITHDRAWAL OF APPROVAL. (a) A policy form, related form, classification, or rule a mortgage guaranty insurer uses in this state, including for a policy described by Section 3502.104(b), is exempt from department approval.

(b) If the commissioner finds, after notice and hearing, that the filing of a policy form, related form, classification, or rule is no longer in the best interest of the public, the commissioner may issue an order:

- (1) suspending the exemption under Subsection (a) with respect to one or more insurers that filed the form, classification, or rule; and

- (2) requiring each affected insurer to cease and desist using the form, classification, or rule, as the commissioner specifies.

(c) If the commissioner finds, after notice and hearing, that a filed policy form or rate no longer meets the requirements of this code, the commissioner may issue an order withdrawing approval of the form or rate. The order must specify the reasons the form or rate no

longer meets the requirements. An order under this subsection may not take effect until the 30th day after the date the commissioner issues the order.

(d) The commissioner must provide to each insurer that filed a form, classification, rule, or rate that is the subject of a hearing under this section notice of the hearing not later than the 20th day before the date of the hearing. The notice must specify the matters to be considered at the hearing.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 3, eff. April 1, 2007.

Sec. 3502.108. RULES. (a) The commissioner may, after notice and hearing, adopt reasonable rules:

(1) relating to the minimum standards for coverage under policy forms consistent with the purpose of this chapter and the public policy of this state; and

(2) necessary to establish guidelines, procedures, methods, standards, and criteria by which the types of forms and documents submitted to the department are to be reviewed and acted on by the department.

(b) The department may establish requirements for data and information filed under this chapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 3, eff. April 1, 2007.

SUBCHAPTER D. FINANCIAL REQUIREMENTS

Sec. 3502.151. DEFINITION. In this subchapter, "contingency reserve" means an additional premium reserve established to protect policyholders against the effect of adverse economic cycles or losses.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 3, eff. April 1, 2007.

Sec. 3502.152. CAPITAL AND SURPLUS REQUIREMENTS. An insurer may not write mortgage guaranty insurance unless the insurer has the

minimum capital and surplus required by Chapter 861 for a general casualty company.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 3, eff. April 1, 2007.

Sec. 3502.153. UNEARNED PREMIUM RESERVE. (a) Except as provided by Subsection (b), the unearned premium reserve on mortgage guaranty insurance must be computed in accordance with this code.

(b) For a policy covering a risk period of more than one year, the unearned premium reserve must be computed in accordance with standards adopted by the commissioner after appropriate hearings.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 3, eff. April 1, 2007.

Sec. 3502.154. LOSS RESERVE. A mortgage guaranty insurer shall determine the loss reserve using the case basis method. The loss reserve must include a reserve for claims incurred but not reported.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 3, eff. April 1, 2007.

Sec. 3502.155. CONTINGENCY RESERVE. (a) In addition to the capital, surplus, and reserves required by Sections 3502.152, 3502.153, and 3502.154, a mortgage guaranty insurer shall establish a contingency reserve and report the contingency reserve as a liability in the insurer's financial statements.

(b) To establish and maintain the contingency reserve, the mortgage guaranty insurer shall annually contribute to the contingency reserve 50 percent of the earned premiums on the insurer's mortgage guaranty insurance business. The reserved earned premiums may be released to the insurer's surplus annually after the premiums have been maintained for 120 months.

(c) In addition, the mortgage guaranty insurer may withdraw premiums from the contingency reserve in any year for which the insurer can demonstrate to the department that the incurred losses for that year exceed 35 percent of the corresponding earned premiums

for that year. The insurer shall reduce any subsequent annual release to surplus from the established contingency reserve by an amount equal to the amount withdrawn and released for the losses. The insurer shall deduct from subsequent annual releases any balance that exceeds the normal annual release from the contingency reserve.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 3, eff. April 1, 2007.

Sec. 3502.156. OUTSTANDING TOTAL LIABILITY. (a) Except as provided by Subsection (d), a mortgage guaranty insurer may not at any time have outstanding under the insurer's aggregate mortgage guaranty insurance policies a total liability, net of reinsurance, that exceeds the sum of the insurer's capital, surplus, and contingency reserve, multiplied by 25.

(b) An insurer shall compute the insurer's liability for leases on the basis of the insurer's liability as determined by the department.

(c) Except as provided by Subsection (d), a mortgage guaranty insurer that has outstanding total liability that exceeds the amount computed under Subsection (a) may not write new mortgage guaranty insurance business until the insurer's total liability no longer exceeds that amount.

(d) The commissioner may waive the limit imposed by Subsection (a) at the written request of a mortgage guaranty insurer on a finding by the commissioner that the sum of the insurer's capital, surplus, and contingency reserve is reasonable in relationship to the insurer's aggregate insured risk and adequate to the insurer's financial needs. The request must be made in writing on or before the 90th day before the date the insurer expects to exceed the limit imposed by Subsection (a) and shall, at a minimum, address the factors listed in Subsection (e).

(e) In determining whether a mortgage guaranty insurer's capital, surplus, and contingency reserve is reasonable in relation to the insurer's aggregate insured risk and adequate to the insurer's financial needs, the commissioner, in the commissioner's sole discretion, may consider relevant factors including:

(1) the insurer's size as measured by the insurer's assets, capital and surplus, reserves, premium writings, insurance in force,

and other appropriate criteria;

(2) the extent to which the insurer's business is diversified across time, geography, credit quality, origination, and distribution channels;

(3) the nature and extent of the insurer's reinsurance program;

(4) the quality, diversification, and liquidity of the insurer's investment portfolio;

(5) the historical and forecasted trend in the size of the insurer's capital, surplus, and contingency reserve;

(6) the capital, surplus, and contingency reserve maintained by other comparable mortgage guaranty insurers in relation to the nature of the insurers' respective insured risks;

(7) the reasonableness of the insurer's reserves;

(8) the quality and liquidity of the insurer's investments in affiliates; and

(9) the quality of the insurer's earnings and the extent to which the insurer's reported earnings include extraordinary items.

(f) With respect to the factors listed in Subsection (e)(8), the commissioner may treat an investment in an affiliate as a nonadmitted asset for purposes of determining the adequacy of surplus as regards policyholders.

(g) The commissioner may retain accountants, actuaries, or other experts to assist the commissioner in the review of a request made by a mortgage guaranty insurer under Subsection (d). The insurer shall pay the commissioner's cost of retaining those persons.

(h) A waiver granted under Subsection (d) must be for a specified period that does not exceed two years and is subject to any terms and conditions the commissioner considers best suited to restoring the mortgage guaranty insurer's capital, surplus, and contingency reserve to the level required by Subsection (a). The mortgage guaranty insurer may apply to extend the waiver on or before the 90th day before the date the waiver period expires.

(i) The commissioner may not under any circumstances allow the mortgage guaranty insurer to have outstanding under the insurer's aggregate mortgage guaranty insurance policies a total liability, net of reinsurance, that exceeds the sum of the insurer's capital, surplus, and contingency reserve, multiplied by 50.

(j) An insurer may not be allowed a waiver under Subsections (d) and (h) for a continuous period of more than six years.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 3, eff. April 1, 2007.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 41 (S.B. 416), Sec. 1, eff. May 10, 2011.

Acts 2013, 83rd Leg., R.S., Ch. 734 (S.B. 147), Sec. 1, eff. June 14, 2013.

Sec. 3502.157. LIMIT ON INSURANCE OF CERTAIN LOANS. (a) In this section, "contiguous" means not separated by more than one-half mile.

(b) A mortgage guaranty insurer may not insure loans secured by properties in a single housing tract or a contiguous tract in an amount that exceeds 10 percent of the insurer's capital, surplus, and contingency reserve.

(c) In determining the amount of risk under this section, a mortgage guaranty insurer shall deduct from the total direct risk insured any applicable reinsurance in an assuming insurer authorized to engage in the business of mortgage guaranty insurance in this state.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 3, eff. April 1, 2007.

SUBCHAPTER E. LENDER POWERS AND DUTIES

Sec. 3502.201. DEFINITION. In this subchapter, "lender" has the meaning assigned by Section 549.001.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 3, eff. April 1, 2007.

Sec. 3502.202. NOTICE OF BORROWER'S RIGHT TO CANCEL. (a) A lender that requires a borrower to purchase mortgage guaranty insurance shall provide annually to the borrower a copy of the following written notice printed in at least 10-point boldfaced type:

"NOTICE OF RIGHT TO CANCEL PRIVATE MORTGAGE INSURANCE: If you currently pay private mortgage insurance premiums, you may have the right to cancel the insurance and cease paying premiums. This would

permit you to make a lower total monthly mortgage payment and to possibly receive a refund of any unearned premiums on the policy. In most cases, you have the right to cancel private mortgage insurance if the principal balance of your loan is 80 percent or less of the current fair market appraised value of your home. If you want to learn whether you are eligible to cancel this insurance, please contact us at (address and telephone number of lender) or the Texas Department of Insurance consumer help line at (the appropriate toll-free telephone number)."

(b) If federal law requires a lender to provide a borrower with a written notice containing substantially the same information required by Subsection (a), a lender that provides the notice required by federal law within the period prescribed by federal law satisfies the notice requirement of Subsection (a).

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 3, eff. April 1, 2007.

Sec. 3502.203. REFUND OF PREMIUM. A lender that receives a refund of an unearned mortgage guaranty insurance premium paid by a borrower shall remit the refund to the borrower not later than the 10th business day after the date the lender receives the refund.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 3, eff. April 1, 2007.

Sec. 3502.204. ADVERTISING OF "INSURED LOANS." A bank, savings and loan association, insurer, or approved seller-servicer of the Federal National Mortgage Association, any of whose authorized real estate securities are insured by a mortgage guaranty insurer, may not state in a brochure, pamphlet, or report or any form of advertising that the real estate loans of the bank, savings and loan association, insurer, or seller-servicer are "insured loans" unless:

(1) the brochure, pamphlet, report, or advertising also:

(A) clearly states that the loans are insured by private insurers; and

(B) lists the names of the private insurers; and

(2) the insurance on the real estate loans is written by an insurer authorized to write that insurance in this state.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 3, eff. April 1, 2007.

CHAPTER 3503. SURETY BONDS AND RELATED INSTRUMENTS

SUBCHAPTER A. CERTAIN REQUIRED OR PERMITTED OBLIGATIONS

Sec. 3503.001. DEFINITION. In this subchapter, "obligation" means a bond, undertaking, recognizance, guaranty, or other obligation that is by law or by a charter, ordinance, or rule of a municipality, board, body, organization, court, or public officer required or permitted to be made, given, tendered, or filed to guarantee the performance of an act, duty, or obligation or the refraining from an act.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 3, eff. April 1, 2007.

Sec. 3503.002. EXECUTION OF OBLIGATION BY SURETY COMPANY. (a) A surety company authorized to engage in business in this state may execute an obligation.

(b) Except as provided by Section 3503.004 or 3503.005, the execution of an obligation by a surety company under Subsection (a) is in full compliance with each law, charter, ordinance, or rule that requires:

(1) the obligation to be executed by one or more sureties;
or

(2) the executing sureties to possess any qualification, including the requirement that a surety be a resident, householder, or freeholder.

(c) Each municipality, board, body, organization, court, public officer, and head of department shall accept and treat an obligation executed by a surety company under Subsection (a) as fully complying with each law, charter, ordinance, or rule described by Subsection (b).

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 3, eff. April 1, 2007.

Sec. 3503.003. DESIGNATION OF AGENT BY CORPORATE SURETY

REQUIRED. Notwithstanding Section 3503.002, in specifications by a municipality for work or supplies for which sealed bids are required, the municipality may require that a corporate surety tender designate, in a manner satisfactory to the municipality, an agent:

- (1) who is a resident of the county in which the municipality is located; and
- (2) to whom any required notices may be delivered and on whom process may be served in matters arising out of the suretyship.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 3, eff. April 1, 2007.

Sec. 3503.004. WRITTEN CERTIFICATION OF REINSURANCE AS CONDITION OF ACCEPTANCE OF OBLIGATION. (a) If an obligation is in an amount that exceeds 10 percent of the surety company's capital and surplus, the municipality, board, body, organization, court, or public officer may require, as a condition of accepting the obligation, written certification that the surety company has reinsured the portion of the risk that exceeds 10 percent of the surety company's capital and surplus with one or more reinsurers who are authorized, accredited, or trusted to engage in business in this state.

(b) Repealed by Acts 2011, 82nd Leg., R.S., Ch. 1147, Sec. 14.002, eff. September 1, 2011.

(c) On request, the department shall provide the amount of the allowed capital and surplus, as of the date of the last annual statutory financial statement, for a surety company or reinsurer authorized to engage in business in this state.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 3, eff. April 1, 2007.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 1147 (H.B. 1951), Sec. 14.002, eff. September 1, 2011.

Sec. 3503.005. ADDITIONAL REQUIREMENTS FOR CERTAIN BONDS. (a) A bond that is made, given, tendered, or filed under Chapter 53, Property Code, or Chapter 2253, Government Code, may be executed only by a surety company that is authorized to write surety bonds in this

state. If the amount of the bond exceeds \$100,000, the surety company must also:

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

(2) have obtained reinsurance for any liability in excess of \$1 million from a reinsurer that:

(A) is an authorized reinsurer in this state; or

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

(b) To determine whether the surety on the bond or the reinsurer holds a certificate of authority from the United States secretary of the treasury, a party may conclusively rely on the list published in the Federal Register by the United States Department of the Treasury, covering the date on which the bond was executed, of the companies holding certificates of authority as acceptable sureties on federal bonds and as acceptable reinsuring companies. A purchaser, insurer of title, or lender acquiring or insuring an interest in or title to real property may also conclusively rely on, and is protected by, a statement on a recorded bond or a sworn, recorded statement by the surety that refers to the specific recorded bond and states that, at the time the bond was executed, the surety complied with Subsection (a)(1) or (2).

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 3, eff. April 1, 2007.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 1147 (H.B. 1951), Sec. 14.001, eff. September 1, 2011.

SUBCHAPTER B. PROMPT PAYMENT OF CONSTRUCTION PAYMENT BONDS

Sec. 3503.051. DEFINITIONS. In this subchapter:

(1) "Claimant" means a person directly entitled to payment under a construction payment bond.

(2) "Construction payment bond" means a surety agreement or obligation issued to guarantee or assure payment by a principal obligor for work performed or materials supplied or specially fabricated for a public or private construction project.

(3) "Notice of claim" means a written notification by a claimant who makes a claim for payment from the surety company. The term does not include a routine statutory notice required by Section 53.056 or 53.057, Property Code, or Section 2253.047, Government Code.

(4) "Surety company" means an authorized surety or guaranty company that executes and delivers a construction payment bond as a surety for a principal obligor.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 3, eff. April 1, 2007.

Amended by:

Acts 2021, 87th Leg., R.S., Ch. 690 (H.B. 2237), Sec. 1, eff. January 1, 2022.

Sec. 3503.052. CONSTRUCTION OF SUBCHAPTER. (a) This subchapter shall be construed to encourage prompt payment of just claims made under construction payment bonds of surety companies. This subchapter does not foreclose any other remedy available to a claimant by law or contract.

(b) This subchapter may not be construed to:

- (1) create a private cause of action;
- (2) be a precondition to judicially enforcing an obligation under a construction payment bond;
- (3) diminish any other obligation of a surety company that exists by law; or
- (4) prohibit a surety company from asserting a defense against a construction payment bond claim in a proceeding to enforce a claim.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 3, eff. April 1, 2007.

Sec. 3503.053. CERTAIN TERMS VOID. A term contained in a construction payment bond that is inconsistent with this subchapter is void.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 3, eff. April 1, 2007.

Sec. 3503.054. NOTICE OF CLAIM; ACKNOWLEDGMENT AND INVESTIGATION. (a) A surety company that issues a construction payment bond shall, not later than the 15th day after the date of receipt of notice of claim under the bond:

- (1) acknowledge receipt of the claim;
- (2) begin any review or investigation necessary to determine whether the surety company is obligated to satisfy the claim under the bond; and
- (3) request from the claimant each document, item of information, accounting, statement, or form that the surety company reasonably believes, at that time, will be required from the claimant.

(b) If a construction payment bond provides an address to which a notice of claim under the bond should be submitted, the notice is effective on the date the notice is received at that address.

(c) This subchapter does not exempt a claimant from complying with any applicable statutory or contractual notice requirement.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 3, eff. April 1, 2007.

Sec. 3503.055. NOTICE OF ACCEPTANCE OR REJECTION OF CLAIM. (a) Except as provided by Subsection (c), a surety company shall notify a claimant in writing of the acceptance or rejection of a claim not later than the 30th day after the date the company receives all documents, items of information, accountings, statements, and forms requested by the company under Section 3503.054.

(b) If the surety company rejects all or part of the claim, the notice required by Subsection (a) must state in specific terms the reasons for the rejection that are known by the company at the time of the rejection.

(c) If the surety company is unable to accept or reject the claim within the period specified by Subsection (a), the company, in that same period, shall notify the claimant in writing that the company is unable to accept or reject the claim. The notice provided under this subsection must:

- (1) state the reasons for which the company needs

additional time to accept or reject the claim; and

(2) include a request for any additional information the company reasonably needs to process the claim.

(d) Not later than the 30th day after the date a surety company notifies a claimant under Subsection (c), the company shall notify the claimant in writing of the acceptance or rejection of the claim. If the company rejects all or part of the claim, the company shall state in specific terms the reasons for the rejection that are known by the company at the time of the rejection.

(e) In addition to any other contractual or statutory basis for denying a claim, the surety company may reject all or part of a claim:

(1) that is the subject of a legitimate dispute between the principal obligor and the claimant; or

(2) for which the claimant has failed to provide supporting documents or information the company reasonably requested.

(f) The time limits provided by this section and Section 3503.054 may be varied by any statute requiring a construction payment bond.

(g) This section does not preclude a surety company from asserting any defense in an action brought by a claimant on a construction payment bond if the company makes a good faith effort to inform the claimant in accordance with this section of the reasons for rejecting all or part of the claim.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 3, eff. April 1, 2007.

Sec. 3503.056. PAYMENT OF CLAIM. (a) If a surety company notifies a claimant under Section 3503.055 that the company accepts a claim or part of a claim, the company shall pay the claim not later than the 15th day after the date of the notice.

(b) If payment of the claim or part of the claim is conditioned on the execution of a document or performance of an act by the claimant, the surety company shall pay the claim not later than the seventh day after the date the company receives the executed document or evidence that the act has been performed.

(c) For purposes of this section, payment of a claim occurs when the surety company places the company's check or draft in the

United States mail properly addressed to the claimant or the claimant's representative.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 3, eff. April 1, 2007.

Sec. 3503.057. RULES. The commissioner may adopt rules enforcing this subchapter in cases in which a surety company violates this subchapter as a general business practice.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 3, eff. April 1, 2007.

SUBCHAPTER C. OTHER BONDS

Sec. 3503.101. BAIL BOND CERTIFICATES. (a) In any year, an insurance company authorized to engage in fidelity and surety insurance business in this state may become surety in an amount not to exceed \$200 with respect to each bail bond certificate issued in that year by:

(1) an automobile club authorized to transact business in this state; or

(2) a truck and bus association incorporated in this state.

(b) The bail bond certificate must be a printed card or other certificate that:

(1) is issued by:

(A) an automobile club authorized to transact business within this state; or

(B) a truck and bus association incorporated in this state;

(2) is issued to a member of the club or association and signed by the member of the club or association; and

(3) contains a printed statement that:

(A) a fidelity and surety company authorized to engage in business in this state guarantees the appearance of the member whose signature appears on the card or certificate; and

(B) if the member fails to appear in court at the time of trial, the fidelity and surety company will pay any fine or forfeiture imposed on the member in an amount not to exceed \$200.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 3, eff. April 1, 2007.

SUBCHAPTER D. SUIT ON CERTAIN BONDS OR OTHER OBLIGATIONS

Sec. 3503.151. VENUE OF SUIT ON CERTAIN BONDS OR OTHER OBLIGATIONS. (a) This section applies to:

(1) a bond or other obligation of an insurance company authorized to engage in business in this state and to act as surety and guarantor of the fidelity of employees, trustees, executors, administrators, guardians, or others appointed to, or assuming the performance of, any public or private trust under appointment of a court or tribunal, or under contract between private individuals or corporations; or

(2) a bond that may be required:

(A) to be filed in a judicial proceeding;

(B) to guarantee a contract or undertaking between:

(i) individuals;

(ii) private corporations;

(iii) individuals and corporations; or

(iv) individuals or private corporations and the state, a municipal corporation, or a county; or

(C) of a state, county, municipal, or district official, including a school district official.

(b) A proper court in the county in which a bond or other obligation described by Subsection (a) is filed has jurisdiction of a suit instituted on the bond or obligation.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 3, eff. April 1, 2007.

Sec. 3503.152. RESIDENCE OF INSURANCE COMPANY. An insurance company described by Section 3503.151 is a resident of a county in which the company engages in business.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 3, eff. April 1, 2007.

Sec. 3503.153. SERVICE OF PROCESS. In a suit described by

Section 3503.151, process shall be served in accordance with Sections 804.003, 804.101, 804.102, 804.103, 804.201, 804.202, 804.203(a), (c), and (d), and 804.204, as applicable.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 3, eff. April 1, 2007.

Sec. 3503.154. ACCEPTANCE OF SUBCHAPTER. The doing or performance of any business in any county is considered an acceptance of the provisions of this subchapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 3, eff. April 1, 2007.

SUBCHAPTER E. REGULATION OF SURETY COMPANY

Sec. 3503.201. MERGER OR CONSOLIDATION OF CERTAIN COMPANIES. When two or more companies authorized to write fidelity, guaranty, and surety insurance in this state merge or consolidate and, incident to the merger or consolidation, enter into a total reinsurance contract under which the merged or ceding company is dissolved and that company's assets are acquired and liabilities are assumed by the new or surviving company, the commissioner, on finding that the contracting companies have on deposit with the comptroller two or more deposits made for the same or similar purposes under former Article 7.03, repealed by Chapter 388, Acts of the 55th Legislature, Regular Session, 1957, or under Section 861.252, shall authorize the comptroller to:

(1) retain for a single purpose only the deposit of the greatest amount and value; and

(2) permit the new or surviving company, on proper showing that there is duplication of deposits and that the new or surviving company is the owner of those deposits, to withdraw a duplicate or excessive deposit.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 3, eff. April 1, 2007.

Sec. 3503.202. UNEARNED PREMIUM RESERVE FOR BAIL BOND NOT

REQUIRED. A surety company is not required to maintain an unearned premium reserve for a bail bond, as defined by Section 1704.001, Occupations Code, executed or delivered by the company.

Added by Acts 2013, 83rd Leg., R.S., Ch. 896 (H.B. 1047), Sec. 2, eff. September 1, 2013.

Sec. 3503.203. DIRECT WRITTEN PREMIUM CALCULATION. Direct written premium reported by a surety company in a financial statement filed with the department may be calculated excluding any premiums or service fees retained by a bail bond surety licensed under Chapter 1704, Occupations Code, or by a property and casualty agent in connection with the execution or delivery of a bail bond as defined by Section 1704.001, Occupations Code.

Added by Acts 2013, 83rd Leg., R.S., Ch. 896 (H.B. 1047), Sec. 2, eff. September 1, 2013.

Sec. 3503.204. DISCLOSURE REQUIREMENTS. A surety company that executes or delivers in this state a bail bond as defined by Section 1704.001, Occupations Code, shall disclose in the company's financial statement filed with the department the aggregate amount of:

- (1) gross premium for bail bond business reported in the company's surety line of business;
- (2) premium or service fees retained by the bail bond surety or agent; and
- (3) premium for bail bond business received by the company, net of amounts retained by the bail bond surety or agent.

Added by Acts 2013, 83rd Leg., R.S., Ch. 896 (H.B. 1047), Sec. 2, eff. September 1, 2013.

CHAPTER 3504. TRAVEL INSURANCE

Sec. 3504.0001. DEFINITIONS. In this chapter:

- (1) "Aggregator site" means an Internet website that provides access to information regarding insurance products from more than one insurer, including product and insurer information, for use in comparison shopping.

(2) "Blanket travel insurance" means a policy of travel insurance issued to an eligible group that provides coverage for specific classes of persons with coverage provided to each member of the eligible group defined in the policy without a separate charge to individual members of the eligible group.

(3) "Cancellation fee waiver" means a contractual agreement between a supplier of travel services and the supplier's customer to waive some or all of the nonrefundable cancellation fee provisions of the supplier's underlying travel contract with or without regard to the reason for the cancellation or form of reimbursement. A cancellation fee waiver is not insurance.

(4) "Eligible group" means two or more persons who are engaged in a common enterprise or have an economic, educational, or social affinity or relationship, including any of the following:

(A) an entity engaged in the business of providing travel or travel services, including a tour operator, a lodging provider, a vacation property owner, a hotel or resort, a travel club, a travel agency, a property manager, a cultural exchange program, and a common carrier or the operator, owner, or lessor of a means of transportation of passengers, including an airline, a cruise line, a railroad, a steamship company, and a public bus carrier, wherein with regard to any particular travel or type of travel or travelers, all members or customers of the group must have a common exposure to risk attendant to the travel;

(B) a college, school, or other institution of learning covering students, teachers, employees, or volunteers;

(C) an employer covering a board of directors or a group of employees, volunteers, contractors, dependents, or guests;

(D) a sports team or camp or sponsor of a team or camp covering participants, members, campers, employees, officials, supervisors, or volunteers;

(E) a religious, charitable, recreational, educational, or civic organization or branch of the organization covering members, participants, or volunteers;

(F) a financial institution or financial institution vendor or a parent holding company, trustee, or agent or designee of a financial institution or financial institution vendor covering persons, including account holders, credit card holders, debtors, guarantors, or purchasers;

(G) an incorporated or unincorporated association,

including a labor union that has a common interest, constitution, and bylaws, organized and maintained in good faith for a purpose other than obtaining insurance for the association's members or participants;

(H) a trust, or the trustees of a fund, established, created, or maintained for the benefit of and covering members, employees, or customers of one or more associations meeting the requirements of Paragraph (G), subject to the commissioner's approval and the state premium tax provisions of Section 3504.0004;

(I) an entertainment production company covering a group of participants, volunteers, audience members, contestants, or workers;

(J) a volunteer fire department or an ambulance, rescue, police, court, first aid, or civil defense volunteer group or other similar volunteer group;

(K) a preschool, a day-care facility for children or adults, or a senior citizen club;

(L) an automobile or truck rental or leasing company covering a group of individuals who may become renters, lessees, or passengers defined by the individual's status on the rented or leased vehicles, in which circumstance the common carrier, the operator, owner, or lessor of a means of transportation, or the automobile or truck rental or leasing company is the policyholder; or

(M) any other group with respect to which the commissioner has determined:

(i) the members are engaged in a common enterprise or have an economic, educational, or social affinity or relationship; and

(ii) issuance of the policy is not contrary to the public interest.

(5) "Fulfillment materials" means documentation sent to the purchaser of a travel protection plan that confirms the purchase and provides the travel protection plan's coverage and assistance details.

(6) "Group travel insurance" means travel insurance issued to an eligible group.

(7) "Planned trip" or "planned travel" means any journey or travel arranged through the services of a travel agency.

(8) "Primary certificate holder," specific to Section 3504.0004, means an individual who elects and purchases travel

insurance under a group policy.

(9) "Primary policyholder," specific to Section 3504.0004, means an individual who elects and purchases individual travel insurance.

(10) "Travel assistance services" means noninsurance services that do not indemnify the consumer based on a fortuitous event or result in the transfer or shifting of risk constituting the business of insurance. Travel assistance services include security advisories, destination information, vaccination and immunization information services, travel reservation services, entertainment, activity and event planning, translation assistance, emergency messaging, international legal and medical referrals, medical case monitoring, coordination of transportation arrangements, emergency cash transfer assistance, medical prescription replacement assistance, passport and travel document replacement assistance, lost luggage assistance, concierge services, and any other service that is furnished in connection with planned travel. Travel assistance services are not insurance and are not related to insurance.

(11) "Travel insurance" means insurance coverage for personal risks incident to planned travel, including:

- (A) interruption or cancellation of a trip or event;
- (B) loss of baggage or personal effects;
- (C) damages to accommodations or rental vehicles;
- (D) sickness, accident, disability, or death occurring during travel;
- (E) emergency evacuation;
- (F) repatriation of remains; or
- (G) any other contractual obligations to indemnify or

pay a specified amount to the traveler on determinable contingencies related to travel as approved by the commissioner. Travel insurance does not include a major medical plan that provides comprehensive medical protection for a traveler on a trip of longer than six months, such as an individual working or residing overseas as an expatriate, or any other insurance product that must be sold by an agent with a specific agent's license.

(12) "Travel protection plan" means a plan that provides one or more of the following:

- (A) travel insurance;
- (B) travel assistance services; and
- (C) cancellation fee waivers.

Added by Acts 2019, 86th Leg., R.S., Ch. 1000 (H.B. 2587), Sec. 1, eff. September 1, 2019.

Sec. 3504.0002. APPLICABILITY. (a) This chapter applies to a travel insurance policy or certificate that:

(1) provides coverage to a resident of this state or is sold, solicited, negotiated, or offered in this state; and

(2) is delivered or issued for delivery in this state.

(b) This chapter does not apply to a cancellation fee waiver or travel assistance service except as expressly provided in this chapter.

Added by Acts 2019, 86th Leg., R.S., Ch. 1000 (H.B. 2587), Sec. 1, eff. September 1, 2019.

Sec. 3504.0003. LINE OF INSURANCE. (a) Except as provided by Subsection (b) and notwithstanding any other provision of this code, travel insurance is classified and filed for purposes of rates and forms under an inland marine line of insurance.

(b) Travel insurance that provides coverage for sickness, accident, disability, or death occurring during travel, exclusively or in conjunction with related coverage for emergency evacuation, repatriation of remains, or incidental limited property and casualty benefits, including baggage or trip cancellation, may be filed by an authorized insurer under an accident and health line of insurance or an inland marine line of insurance.

(c) Eligibility and underwriting standards for travel insurance may be developed and provided based on travel protection plans designed for individual or identified marketing or distribution channels if the standards meet underwriting standards for an inland marine line of insurance.

Added by Acts 2019, 86th Leg., R.S., Ch. 1000 (H.B. 2587), Sec. 1, eff. September 1, 2019.

Sec. 3504.0004. PREMIUM TAX. (a) A travel insurer shall pay premium tax, as provided by Section 221.002, on travel insurance premiums paid by any of the following:

(1) an individual primary policyholder who is a resident of this state;

(2) a primary certificate holder who is a resident of this state and elects and purchases coverage under a group travel insurance policy; or

(3) a blanket travel insurance policyholder who buys a blanket travel insurance policy for members of an eligible group if:

(A) the policyholder is a resident of this state; or

(B) the policyholder's principal place of business is located in this state.

(b) A travel insurer shall:

(1) document the state of residence or principal place of business of the policyholder or certificate holder described by Subsection (a); and

(2) report as premium:

(A) only the amount allocable to travel insurance and not amounts received for travel assistance services or cancellation fee waivers; and

(B) only the amount allocable to residents of this state.

(c) Amounts received for travel assistance services and cancellation fee waivers, whether the travel assistance services and cancellation waivers are offered separately or for a combined price authorized by Section 3504.0005, are not subject to taxation under Section 221.002(b).

Added by Acts 2019, 86th Leg., R.S., Ch. 1000 (H.B. [2587](#)), Sec. 1, eff. September 1, 2019.

Sec. 3504.0005. TRAVEL PROTECTION PLANS. A travel protection plan composed of multiple features may be offered for a combined price if:

(1) at the time or before the consumer buys the travel protection plan it is clearly disclosed to the consumer that the plan includes travel insurance, travel assistance services, and cancellation fee waivers, as applicable, and provides information and an opportunity for the consumer to obtain additional information regarding the features and the pricing of each feature; and

(2) the fulfillment materials:

(A) describe the travel insurance, travel assistance services, and cancellation fee waivers in the travel protection plan; and

(B) include the travel insurance disclosures and the contact information for persons providing travel assistance services and cancellation fee waivers, as applicable.

Added by Acts 2019, 86th Leg., R.S., Ch. 1000 (H.B. 2587), Sec. 1, eff. September 1, 2019.

Sec. 3504.0006. SALES PRACTICES; PROHIBITED PRACTICES. (a) Offering or selling a travel insurance policy that could never result in payment of a claim for an insured under the policy is an unfair trade practice under Subtitle C, Title 5.

(b) All documents provided to a consumer before the purchase of travel insurance, including sales materials, advertising materials, and marketing materials, must be consistent with the travel insurance policy, including forms, endorsements, policies, rate filings, and certificates of insurance.

(c) Before the consumer buys travel insurance and subsequently in the fulfillment materials, the consumer must be provided information about any preexisting condition exclusion that is included in the travel insurance policy or certificate. The consumer must have the opportunity to learn more about the exclusion.

(d) The fulfillment materials and the information described in Section 4055.154(a) must be provided to a policyholder or certificate holder as soon as practicable after the purchase of a travel protection plan. Unless the policyholder or certificate holder has started a covered trip or filed a claim under the travel insurance coverage, the policyholder or certificate holder may cancel a policy or certificate for a full refund of the travel protection plan price. The policyholder or certificate holder must exercise the right to cancel a travel protection plan before:

(1) the 15th day after the date of delivery of the travel protection plan's fulfillment materials by United States mail or a later date specified by the plan; or

(2) the 10th day after the date of delivery of the travel protection plan's fulfillment materials by means other than United States mail or a later date specified by the plan.

(e) For the purposes of this section, delivery means handing fulfillment materials to the policyholder or certificate holder or sending fulfillment materials by United States mail or electronic means to the policyholder or certificate holder.

(f) The company shall disclose in the policy documentation and fulfillment materials if the travel insurance is primary or secondary to other applicable coverage.

(g) If travel insurance is marketed directly to a consumer through an insurer's Internet website or by others through an aggregator site, it is not an unfair trade practice or other violation of law if:

(1) an accurate summary or short description of coverage is provided on the Internet website; and

(2) the consumer has access to the full provisions of the policy through electronic means.

(h) A person offering, soliciting, or negotiating travel insurance or travel protection plans on an individual or group basis may not do so by using a negative option or opt out that requires a consumer to take an affirmative action to deselect coverage, such as unchecking a box on an electronic form, when the consumer purchases a trip.

(i) It is an unfair trade practice to market blanket travel insurance coverage as free.

(j) If a consumer's destination jurisdiction requires insurance coverage, it is not an unfair trade practice to require that a consumer choose between the following options as a condition of purchasing a trip or travel package:

(1) purchasing the coverage required by the destination jurisdiction through the travel retailer or supervising entity supplying the trip or travel package; or

(2) agreeing to obtain and provide proof of coverage that meets the destination jurisdiction's requirements before departure.

Added by Acts 2019, 86th Leg., R.S., Ch. 1000 (H.B. [2587](#)), Sec. 1, eff. September 1, 2019.

Sec. 3504.0007. RULEMAKING. (a) The commissioner may adopt rules necessary to implement this chapter. Section 2001.0045, Government Code, does not apply to rules adopted under this section.

(b) The comptroller, in consultation with the commissioner, may adopt rules to implement this chapter.

Added by Acts 2019, 86th Leg., R.S., Ch. 1000 (H.B. 2587), Sec. 1, eff. September 1, 2019.

TITLE 13. REGULATION OF PROFESSIONALS
SUBTITLE A. GENERAL PROVISIONS
CHAPTER 4001. AGENT LICENSING IN GENERAL
SUBCHAPTER A. GENERAL PROVISIONS

Sec. 4001.001. PURPOSE. It is the intent of the legislature to:

- (1) simplify and reform the regulation of agents and other persons regulated under this title in this state by consolidating the kinds of licenses issued to those persons under this title; and
- (2) promote uniformity in the licensing, examination, continuing education, and disciplinary requirements for those persons in this state and with other states.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4001.002. APPLICABILITY. (a) Except as otherwise provided by this code, this title applies to each person licensed under:

- (1) Subchapter H, Chapter 885;
- (2) Subchapter F, Chapter 911;
- (3) Section 912.251;
- (4) Subchapter E, Chapter 981;
- (5) Subchapter D, Chapter 1152;
- (6) Subchapter C or D of this chapter;
- (7) Subtitle B, C, or D of this title; or
- (8) Subsection (c), Article 5.13-1.

(a-1) Except as otherwise provided by this code, this title applies to each individual who holds a specialty certification under Subchapter H, Chapter 4054.

(b) This title does not apply to:

- (1) a resident of this state who arbitrates in the adjustment of losses between an insurer and an insured, a marine adjuster who adjusts particular or general average losses of vessels

or cargoes if the adjuster paid an occupation tax of \$200 for the year in which the adjustment is made, or a practicing attorney at law in this state, acting in the regular transaction of the person's business as an attorney at law, who is not a local agent and is not acting as an adjuster for an insurer;

(2) an attorney in fact or the traveling salaried representative of a reciprocal or interinsurance exchange admitted to engage in the business of insurance in this state as to business transacted through the attorney in fact or salaried representative;

(3) the attorney in fact for a Lloyd's plan;

(4) the group motor vehicle insurance business or the group motor vehicle department of a company engaged in that business; or

(5) a salaried employee who is not involved in soliciting or negotiating insurance in the office of an agent and who devotes the employee's full time to clerical and administrative services, including the incidental taking of information from customers and receipt of premiums in the office of an agent, if:

(A) the employee does not receive any commissions; and

(B) the employee's compensation is not varied by the volume of premiums taken and received.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2J.001, eff. April 1, 2009.

Acts 2009, 81st Leg., R.S., Ch. 1338 (S.B. 79), Sec. 2, eff. September 1, 2009.

Acts 2019, 86th Leg., R.S., Ch. 643 (S.B. 1623), Sec. 16, eff. September 1, 2019.

Acts 2021, 87th Leg., R.S., Ch. 355 (H.B. 4030), Sec. 7, eff. September 1, 2021.

Sec. 4001.003. DEFINITIONS. Unless the context clearly indicates otherwise, in this title:

(1) "Agent" means a person who is an authorized agent of an insurer or health maintenance organization and any other person who performs the acts of an agent, whether through an oral, written, electronic, or other form of communication, by soliciting, negotiating, procuring, or collecting a premium on an insurance or

annuity contract, or who represents or purports to represent a health maintenance organization, including a health maintenance organization offering only a single health care service plan, in soliciting, negotiating, procuring, or effectuating membership in the health maintenance organization. The term does not include:

(A) a regular salaried officer or employee of an insurer, health maintenance organization, or agent who:

(i) devotes substantially all of the officer's or employee's time to activities other than the solicitation of applications for insurance, annuity contracts, or memberships;

(ii) does not receive a commission or other compensation directly dependent on the business obtained; and

(iii) does not solicit or accept from the public applications for insurance, annuity contracts, or memberships;

(B) an employer or an employer's officer or employee or a trustee of an employee benefit plan, to the extent that the employer, officer, employee, or trustee is engaged in the administration or operation of an employee benefits program involving the use of insurance or annuities issued by an insurer or memberships issued by a health maintenance organization, if the employer, officer, employee, or trustee is not directly or indirectly compensated by the insurer or health maintenance organization issuing the insurance or annuity contracts or memberships;

(C) except as otherwise provided by this code, a depository institution, or an officer or employee of a depository institution, to the extent that the depository institution or officer or employee collects and remits premiums or charges by charging those premiums or charges against accounts of depositors on the orders of those depositors; or

(D) a person or the employee of a person who has contracted to provide administrative, management, or health care services to a health maintenance organization and who is compensated for those services by the payment of an amount computed as a percentage of the revenues, net income, or profit of the health maintenance organization, if that method of compensation is the sole basis for subjecting that person or the employee of the person to this title.

(2) "Control" means the power to direct or cause the direction of the management and policies of a license holder, whether directly or indirectly. For the purposes of this title, a person is

considered to control:

(A) a corporate license holder if the person, individually or acting with others, directly or indirectly, holds with the power to vote, owns, or controls, or holds proxies representing, at least 10 percent of the voting stock or voting rights of the corporate license holder; or

(B) a partnership if the person through a right to vote or through any other right or power exercises rights in the management, direction, or conduct of the business of the partnership.

(3) "Corporation" means a legal entity that is organized under the business corporation laws or limited liability company laws of this state or another state and that has as one of its purposes the authority to act as an agent.

(4) "Depository institution" means:

(A) a bank or savings association as defined by 12 U.S.C. Section 1813, as amended;

(B) a foreign bank that maintains a branch, agency, or commercial lending company in the United States;

(C) a federal or state credit union as defined by 12 U.S.C. Section 1752, as amended;

(D) a bank branch; or

(E) a bank subsidiary, as defined by state or federal law.

(5) "Individual" means a natural person. The term includes a resident or a nonresident of this state.

(6) "Insurer" means an insurance company or insurance carrier regulated by the department. The term includes:

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

(B) a mutual life, health, or accident insurance company;

(C) a stock fire or casualty insurance company;

(D) a mutual fire or casualty insurance company;

(E) a Mexican casualty insurance company;

(F) a Lloyd's plan;

(G) a reciprocal or interinsurance exchange;

(H) a fraternal benefit society;

(I) a stipulated premium company;

(J) a nonprofit or for-profit legal services corporation;

- (K) a statewide mutual assessment company;
- (L) a local mutual aid association;
- (M) a local mutual burial association;
- (N) an association exempt under Section 887.102;
- (O) a nonprofit hospital, medical, or dental service corporation, including a company subject to Chapter 842;
- (P) a health maintenance organization;
- (Q) a county mutual insurance company; and
- (R) a farm mutual insurance company.

(7) "Partnership" means an association of two or more persons organized under the partnership laws or limited liability partnership laws of this state or another state. The term includes a general partnership, limited partnership, limited liability partnership, and limited liability limited partnership.

(8) "Person" means an individual, partnership, corporation, or depository institution.

(9) Repealed by Acts 2021, 87th Leg., R.S., Ch. 355 (H.B. 4030), Sec. 22(1), eff. September 1, 2021.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.
Amended by:

Acts 2021, 87th Leg., R.S., Ch. 355 (H.B. 4030), Sec. 8, eff. September 1, 2021.

Acts 2021, 87th Leg., R.S., Ch. 355 (H.B. 4030), Sec. 22(1), eff. September 1, 2021.

Sec. 4001.004. LIMITED LIABILITY COMPANIES. The licensing and regulation of a limited liability company are subject to each provision of this title that applies to a corporation licensed under this title.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4001.005. RULES. The commissioner may adopt rules necessary to implement this title and to meet the minimum requirements of federal law, including regulations.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4001.006. FEES. (a) The department shall collect from each agent of an insurer writing insurance in this state under this code:

- (1) a nonrefundable license application fee; and
- (2) a nonrefundable appointment fee for each appointment of the agent by an insurer.

(b) The department shall deposit the fees described by Subsection (a), together with other license application fees, examination fees, and license renewal application fees, to the credit of the Texas Department of Insurance operating account.

(c) The department shall set the fees in amounts reasonable and necessary to implement this title and may use any portion of those fees to enforce this title.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1172 (S.B. 876), Sec. 1, eff. September 1, 2015.

Sec. 4001.007. INVESTIGATION OF ALLEGED VIOLATIONS. (a) The department may:

- (1) employ persons as the department considers necessary to investigate and make reports regarding alleged violations of this code and misconduct on the part of agents; and

- (2) pay the salaries and expenses of those persons and office employees and other expenses necessary to enforce this title from the fees described by Section 4001.006.

(b) A person employed by the department under this section may:

- (1) administer the oath to, and examine under oath, any person considered necessary in gathering information and evidence; and

- (2) have that information and evidence reduced to writing if considered necessary.

(c) All expenses related to the activities described by Subsection (b) shall be paid from the fees described by Section 4001.006.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4001.008. COMMISSIONER AGENT FOR SERVICE OF PROCESS. In the manner provided by Subchapter C, Chapter 804, the commissioner is a corporation's or partnership's agent for service of process in a legal proceeding against the corporation or partnership if:

(1) the corporation or partnership is licensed to engage in business in this state and does not appoint or maintain an agent for service in this state;

(2) an agent for service cannot be found with reasonable diligence; or

(3) the license of the corporation or partnership is revoked.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

SUBCHAPTER B. ACTS CONSTITUTING ACTING AS AGENT; CONSEQUENCES OF AGENT'S ACTIONS

Sec. 4001.051. ACTS CONSTITUTING ACTING AS AGENT. (a) This section applies regardless of whether an insurer is incorporated under the laws of this state or another state or a foreign government.

(b) Regardless of whether the act is done at the request of or by the employment of an insurer, broker, or other person, a person is the agent of the insurer for which the act is done or risk is taken for purposes of the liabilities, duties, requirements, and penalties provided by this title or Chapter 21 if the person:

(1) solicits insurance on behalf of the insurer;

(2) receives or transmits other than on the person's own behalf an application for insurance or an insurance policy to or from the insurer;

(3) advertises or otherwise gives notice that the person will receive or transmit an application for insurance or an insurance policy;

(4) receives or transmits an insurance policy of the insurer;

(5) examines or inspects a risk;

(6) receives, collects, or transmits an insurance premium;

(7) makes or forwards a diagram of a building;

(8) takes any other action in the making or consummation of an insurance contract for or with the insurer other than on the

person's own behalf; or

(9) examines into, adjusts, or aids in adjusting a loss for or on behalf of the insurer.

(c) This section does not authorize an agent to orally, in writing, or otherwise alter or waive a term or condition of an insurance policy or an application for an insurance policy.

(d) The referral by an unlicensed person of a customer or potential customer to an agent is not an act of an agent under this section unless the unlicensed person discusses specific insurance policy terms or conditions with the customer or potential customer.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.
Amended by:

Acts 2021, 87th Leg., R.S., Ch. 355 (H.B. 4030), Sec. 9, eff. September 1, 2021.

Sec. 4001.052. SOLICITOR OF APPLICATION FOR INSURANCE CONSIDERED AGENT OF INSURER. (a) A person who solicits an application for life, accident, or health insurance or property or casualty insurance is considered the agent of the insurer issuing a policy on the application and not the agent of the insured in any controversy between the insurer and the insured, the insured's beneficiary, or the insured's dependents.

(b) The agent may not alter or waive a term or condition of the application or policy.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4001.053. PERSONAL LIABILITY FOR ACTING AS AGENT. A person who takes an action listed in Section 4001.051 for or on behalf of an insurer before the insurer complies with the requirements of the laws of this state is personally liable to the holder of any insurance policy with respect to which the action was taken for any loss covered by the insurance policy.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4001.054. LIABILITY OF AGENT AND INSURER FOR TAXES. (a)

If a person takes an action in this state listed in Section 4001.051 for or on behalf of an insurer, the insurer is considered to be engaged in the business of insurance in this state and is subject to the same state, county, and municipal taxes as an insurer that has been legally qualified and admitted to engage in the business of insurance in this state.

(b) Taxes shall be assessed against and collected from an insurer under this section in the same manner as taxes are assessed against and collected from insurers that are legally qualified and admitted to engage in the business of insurance in this state.

(c) A person who takes an action by means of which an insurer is considered to be engaged in the business of insurance in this state under this section is personally liable for any taxes assessed against the insurer under this section.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

SUBCHAPTER C. LICENSE REQUIREMENTS

Sec. 4001.101. LICENSE OR CERTIFICATE OF AUTHORITY REQUIRED; DESIGNATED PRODUCT CERTIFICATE. (a) Unless the person holds a license or certificate of authority issued by the department and, if required by rules adopted under Chapter 4008, a certificate to sell a designated product or product line, a person may not:

(1) solicit or receive an application for insurance in this state; or

(2) aid in the transaction of the business of an insurer.

(b) A person may not act as an agent of a health maintenance organization or other type of insurer authorized to engage in business in this state unless the person holds:

(1) a license issued by the department as provided by this title; and

(2) if required by rules adopted under Chapter 4008, a certificate to sell a designated product or product line.

(c) An insurer described by Subsection (b) may not appoint a person to act as its agent unless the person holds:

(1) a license under this title; and

(2) if required by rules adopted under Chapter 4008, a certificate to sell a designated product or product line.

(d) This subchapter does not permit an employee or agent of a

corporation or partnership to perform an act of an agent under this title without obtaining:

- (1) a license; and
- (2) if required by rules adopted under Chapter 4008, a certificate to sell a designated product or product line.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.
Amended by:

Acts 2009, 81st Leg., R.S., Ch. 451 (H.B. 2456), Sec. 1, eff. June 19, 2009.

Sec. 4001.102. LICENSE APPLICATION. (a) To become an agent for an insurer or health maintenance organization, a person must submit to the department a completed license application in the form required by the department.

(b) The commissioner by rule shall prescribe the requirements for a properly completed application.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4001.103. FAILURE TO PROVIDE COMPLETE SET OF FINGERPRINTS: GROUND FOR DENIAL OF APPLICATION. (a) In this section, "authorization" means any authorization issued by the department to engage in an activity regulated under this title, including a license or permit.

(b) The department may deny an application for an authorization if the applicant fails to provide a complete set of fingerprints on request by the department.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4001.104. ISSUANCE OF LICENSE: INTENT TO ACTIVELY ENGAGE IN BUSINESS OF INSURANCE FOR GENERAL PUBLIC. (a) The department may not issue a license as an agent to write any line of insurance unless the department determines that:

- (1) the applicant is or intends to be actively engaged in the soliciting or writing of insurance for the general public and is to be actively engaged in the business of insurance; and

(2) the application is not made to evade the laws against rebating and discrimination, either for the applicant or for another person.

(b) This subchapter does not prohibit an applicant from insuring property that the applicant owns or in which the applicant has an interest. It is the intent of this subchapter to prohibit coercion of insurance and to preserve to each individual the right to choose that individual's own agent or insurer and to prohibit the licensing of an applicant to engage in the business of insurance principally to handle business that the applicant controls only through ownership, mortgage, sale, family relationship, or employment. An applicant for an original license must have a bona fide intention to engage in business in which, in any calendar year, at least 25 percent of the total volume of premiums is derived from persons other than the applicant and from property other than that on which the applicant controls the placing of insurance through ownership, mortgage, sale, family relationship, or employment.

(c) The department may not deny a license application solely on the ground that the applicant will act only part-time as an agent.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4001.105. ISSUANCE OF LICENSE TO INDIVIDUAL. The department shall issue a license to an individual to engage in business as an agent if the department determines that the individual:

- (1) is at least 18 years of age;
- (2) has passed the licensing examination required under this code within the past 12 months;
- (3) has not committed an act for which a license may be denied under Subchapter C, Chapter 4005; and
- (4) has submitted the application, appropriate fees, and any other information required by the department.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4001.106. ISSUANCE OF LICENSE TO CORPORATION OR PARTNERSHIP. (a) In this section, "customer" means a person or firm to which a corporation or partnership sells or attempts to sell an

insurance policy or from which a corporation or partnership accepts an application for insurance.

(b) The department shall issue a license to a corporation or partnership if the department determines that:

(1) the corporation or partnership is:

(A) organized under the laws of this state or another state; and

(B) authorized by its articles of incorporation or its partnership agreement to act as an agent;

(2) at least one officer of the corporation or one active partner of the partnership and all other persons performing any acts of an agent on behalf of the corporation or partnership in this state are individually licensed by the department separately from the corporation or partnership;

(3) the corporation or partnership will have the ability to pay any amount up to \$25,000 that it might become legally obligated to pay under a claim made against it by a customer and caused by a negligent act, error, or omission of the corporation or partnership or a person for whose acts the corporation or partnership is legally liable in the conduct of its business under this code;

(4) if engaged in the business of insurance, the corporation or partnership intends to be actively engaged in that business as required under Section 4001.104(a);

(5) the corporation or partnership has submitted the application, appropriate fees, and any other information required by the department; and

(6) an officer, director, member, manager, partner, or other person who has the right or ability to control the corporation or partnership has not:

(A) had a license suspended or revoked or been the subject of any other disciplinary action by a financial or insurance regulator of this state, another state, or the United States; or

(B) committed an act for which a license may be denied under Subchapter C, Chapter 4005.

(c) A corporation or partnership shall maintain the ability to pay a claim described by Subsection (b)(3) by obtaining:

(1) an errors and omissions policy insuring the corporation or partnership against errors and omissions in at least the amount of \$250,000, with a deductible of not more than 10 percent of the full amount of the policy, issued by:

(A) an insurer authorized to engage in the business of insurance in this state; or

(B) if a policy cannot be obtained from an insurer authorized to engage in the business of insurance in this state, a surplus lines insurer under Chapter 981; or

(2) a bond in the principal amount of \$25,000 that is:

(A) executed by the corporation or partnership as principal and a surety company authorized to engage in business in this state as surety;

(B) payable to the department for the use and benefit of customers of the corporation or partnership; and

(C) conditioned that the corporation or partnership shall pay any final judgment recovered against it by a customer.

(d) A binding commitment to issue a policy or bond described by Subsection (c) is sufficient in connection with an application for a license.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.
Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 162 (H.B. 2503), Sec. 1, eff. September 1, 2011.

Acts 2021, 87th Leg., R.S., Ch. 355 (H.B. 4030), Sec. 10, eff. September 1, 2021.

Sec. 4001.107. ISSUANCE OF LICENSE TO DEPOSITORY INSTITUTION. The department shall issue a license to a depository institution in the manner provided by this subchapter for the licensing of a corporation.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4001.108. ISSUANCE OF LICENSE TO ENTITY CHARTERED BY FEDERAL FARM CREDIT ADMINISTRATION. The department may license an entity chartered by the federal Farm Credit Administration under the farm credit system established under 12 U.S.C. Section 2001 et seq., as amended, to solicit insurance in this state as provided by 12 U.S.C. Section 2218, as amended. The department shall issue the license in the manner provided by this subchapter for the licensing of a corporation.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

SUBCHAPTER D. TEMPORARY LICENSE

Sec. 4001.151. AUTHORITY TO ISSUE TEMPORARY LICENSE. The department may issue a temporary agent's license to an applicant for a license under Section 4001.102 who is being considered for appointment as an agent by another agent, an insurer, or a health maintenance organization.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4001.152. EXAMINATION NOT REQUIRED. An applicant is not required to pass a written examination to obtain a temporary license.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4001.153. APPLICATION FOR AND ISSUANCE OF TEMPORARY LICENSE. (a) Except as provided by Subsection (b), the department shall issue a temporary license immediately on receipt of a properly completed application executed by the applicant in the form required by Section 4001.102 and accompanied by:

(1) the nonrefundable filing fee set by the department; and
(2) a certificate signed by an officer or properly authorized representative of an agent, insurer, or health maintenance organization stating that:

(A) the applicant is being considered for appointment by the agent, insurer, or health maintenance organization as its full-time agent;

(B) the agent, insurer, or health maintenance organization desires that the applicant be issued a temporary license; and

(C) the applicant will complete training as prescribed by Section 4001.160 under the agent's, insurer's, or health maintenance organization's supervision.

(b) The department may deny a license application under this subchapter if the department determines that any of the grounds exist for license denial or disciplinary action under Section 4005.101, Insurance Code, or Chapter 53, Occupations Code.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.
Amended by:

Acts 2021, 87th Leg., R.S., Ch. 347 (H.B. 2819), Sec. 1, eff. September 1, 2021.

Acts 2021, 87th Leg., R.S., Ch. 355 (H.B. 4030), Sec. 11, eff. September 1, 2021.

Sec. 4001.154. AUTHORITY TO ACT AS AGENT PENDING RECEIPT OF TEMPORARY LICENSE. If a temporary license is not received from the department before the eighth day after the date the application, nonrefundable fee, and certificate are delivered or mailed to the department and the appropriate agent, insurer, or health maintenance organization has not been notified that the application is denied, the agent, insurer, or health maintenance organization may assume that the temporary license will be issued and the applicant may proceed to act as an agent.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4001.155. TERM OF TEMPORARY LICENSE. A temporary license is valid for 180 days after the date of issuance.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.
Amended by:

Acts 2021, 87th Leg., R.S., Ch. 347 (H.B. 2819), Sec. 2, eff. September 1, 2021.

Acts 2021, 87th Leg., R.S., Ch. 355 (H.B. 4030), Sec. 12, eff. September 1, 2021.

Sec. 4001.156. RESTRICTION ON ISSUANCE OR RENEWAL OF TEMPORARY LICENSE. (a) Repealed by Acts 2021, 87th Leg., R.S., Ch. 347 (H.B. 2819), Sec. 3, and Ch. 355 (H.B. 4030), Sec. 22(3), eff. September 1, 2021.

(b) A temporary license may not be issued to a person who does not intend to apply for a license to sell insurance or memberships to the general public.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Amended by:

Acts 2021, 87th Leg., R.S., Ch. 347 (H.B. 2819), Sec. 3, eff. September 1, 2021.

Acts 2021, 87th Leg., R.S., Ch. 355 (H.B. 4030), Sec. 22(3), eff. September 1, 2021.

Sec. 4001.157. OBTAINING CERTAIN COMMISSIONS PROHIBITED. (a) A temporary license holder may not obtain a commission on a sale made to a person who has a family, employment, or business relationship with the temporary license holder.

(b) An agent, insurer, or health maintenance organization may not knowingly pay, directly or indirectly, to a temporary license holder, and a temporary license holder may not receive or accept, a commission on the sale of a contract of insurance or membership covering:

- (1) the temporary license holder;
- (2) a person related to the temporary license holder by consanguinity or affinity;
- (3) a person who is or has been during the past six months the temporary license holder's employer, either as an individual or as a member of a partnership, association, firm, or corporation; or
- (4) a person who is or has been during the past six months an employee of the temporary license holder.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4001.158. REPLACEMENT OF EXISTING LIFE INSURANCE OR ANNUITY CONTRACT PROHIBITED. (a) A temporary license holder who is acting under the authority of that license may not:

(1) engage in an insurance solicitation, sale, or other agency transaction that the license holder knows or should know will result or is intended to result in:

(A) the purchase of a new life insurance or annuity contract; and

(B) any of the following actions with regard to an existing individual life insurance or annuity contract as a result of that purchase:

- (i) termination of the contract by lapse,

forfeiture, surrender, or other means;

(ii) conversion of the contract to reduced paid-up insurance, continuation of the contract as extended term insurance, or reduction in value of the contract by the use of nonforfeiture benefits or other policy values;

(iii) amendment of the contract to reduce:

(a) benefits; or

(b) the term for which coverage would otherwise remain in force or for which benefits would be paid;

(iv) reissuance of the contract with a reduction in cash value; or

(v) pledge of the contract as collateral or subjection of the contract to borrowing, whether in a single loan or under a schedule of borrowing, for amounts that in the aggregate exceed 25 percent of the loan value prescribed by the contract; or

(2) directly or indirectly receive a commission or other compensation that results or may result from a solicitation, sale, or other agency transaction described by Subdivision (1).

(b) A person who holds a permanent license may not circumvent or attempt to circumvent the intent of this section by acting for or with a person holding a temporary license.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4001.159. SUSPENSION OR REVOCATION OF TEMPORARY APPOINTMENT POWERS OF AGENT, INSURER, OR HEALTH MAINTENANCE ORGANIZATION. (a) The department may suspend or revoke the temporary appointment powers of an agent, insurer, or health maintenance organization if, after notice and opportunity for hearing, the department determines that the agent, insurer, or health maintenance organization has abused the temporary appointment powers.

(b) In determining whether abuse has occurred, the department may consider:

(1) the number of temporary appointments made;

(2) the percentage of appointees taking the examination required for licensing as an agent, as provided by Section 4001.161; and

(3) the number of appointees who pass the examination.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4001.160. TRAINING OF APPLICANT FOR TEMPORARY LICENSE.

(a) An agent, insurer, or health maintenance organization that is considering appointment of a temporary license applicant as its agent shall provide at least 40 hours of training to the applicant not later than the 30th day after the date the application, nonrefundable fee, and certificate are delivered or mailed to the department.

(b) At least 10 hours of the training must be taught in a classroom setting, including:

(1) an accredited college, university, junior college, or community college;

(2) a business school; or

(3) a private institute or classes sponsored by the agent, insurer, or health maintenance organization and specifically established for that purpose.

(c) The training program must be designed to provide an applicant with basic knowledge of:

(1) the broad principles of insurance, including the licensing and regulatory laws of this state;

(2) the broad principles of health maintenance organizations, including membership requirements and related licensing and regulatory laws of this state; and

(3) the ethical obligations and duties of an agent.

(d) If the department determines under Section 4001.159 that an abuse of temporary appointment powers has occurred, the department may require the affected agent, insurer, or health maintenance organization to:

(1) file with the department a description of the agent's, insurer's, or health maintenance organization's training program; and

(2) obtain the approval of the department before continuing to use the training program.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 134 (H.B. 1197), Sec. 1, eff. May 26, 2017.

Sec. 4001.161. DUTY TO ENSURE THAT APPLICANTS TAKE LICENSING EXAMINATION. An agent, insurer, or health maintenance organization shall ensure that, during any two consecutive calendar quarters, at least 70 percent of the agent's, insurer's, or health maintenance organization's applicants for temporary licenses take the required licensing examination. At least 50 percent of the applicants taking the examination must pass the examination during that period.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4001.162. RESTRICTION ON APPOINTMENT OF TEMPORARY LICENSE HOLDERS. (a) Except as provided by Subsection (b), an agent, insurer, or health maintenance organization may not appoint more than 500 temporary license holders during a calendar year.

(b) The commissioner shall adopt reasonable rules setting standards for an agent, insurer, or health maintenance organization to appoint more than 500 temporary license holders during a calendar year. The standards must include consideration of the ability of an agent, insurer, or health maintenance organization to monitor appointed temporary agents.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 201 (H.B. 1201), Sec. 1, eff. May 27, 2005.

Acts 2015, 84th Leg., R.S., Ch. 1172 (S.B. 876), Sec. 2, eff. September 1, 2015.

SUBCHAPTER E. APPOINTMENT OF AGENT

Sec. 4001.201. APPOINTMENT REQUIRED. A person who obtains a license under this title may not engage in business as an agent unless the person has been appointed to act as an agent by an insurer designated by the provisions of this code and authorized to engage in business in this state.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4001.202. APPOINTMENT BY MULTIPLE INSURERS. (a) Except

as specifically prohibited by this code, an agent may represent and act as an agent for more than one insurer.

(b) Not later than the 30th day after the effective date of the appointment, the agent and the insurer involved shall notify the department, on a form prescribed by the department, of any additional appointment authorizing the agent to act as agent for one or more additional insurers. The notice must be accompanied by a nonrefundable fee in an amount set by the department for each additional appointment for which the insurer applies.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4001.203. TERM OF APPOINTMENT. (a) An appointment authorizing an agent to act for an insurer continues in effect without the necessity of renewal until the appointment is terminated or withdrawn by the insurer or the agent.

(b) A renewal license issued to an agent authorizes the agent to represent and act for each insurer for which the agent holds an appointment until the appointment is terminated or withdrawn, and the agent is considered to be the agent of each appointing insurer for the purposes of this code.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4001.204. AUTHORITY TO ACT AS AGENT BEFORE NOTICE OF APPOINTMENT. An agent appointed under this subchapter may act on behalf of the appointing insurer before the department receives the notice filed under Section 4001.202(b).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4001.206. TERMINATION OF APPOINTMENT OF AGENT FOR CAUSE; LIABILITY. (a) On termination of the appointment of an agent for cause, the insurer or agent shall immediately file with the department a statement of the facts relating to the termination of the appointment and the date and cause of the termination. On receipt of the statement, the department shall record the termination of the appointment of that agent to represent the insurer in this

state.

(b) A document, record, statement, or other information required to be made or disclosed to the department under this section is a privileged and confidential communication and is not admissible in evidence in a court action or proceeding except under a subpoena issued by a court of record.

(c) A person, including an insurer or an employee or agent of an insurer, who provides without malice information required to be disclosed under this section is not liable for providing the information.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

SUBCHAPTER F. REGULATION OF AGENTS

Sec. 4001.251. INCORPORATION OF SOLE PROPRIETORSHIP. An individual engaged in business as a sole proprietorship under a license issued under this title may incorporate. The corporation does not have greater license authority than that granted to the license holder in the holder's individual capacity.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4001.252. NOTIFICATION TO DEPARTMENT OF CERTAIN INFORMATION. (a) An individual licensed as an agent shall notify the department on a monthly basis of:

- (1) a change of the license holder's mailing address;
- (2) a felony conviction of the license holder; or
- (3) an administrative action taken against the license holder by a financial or insurance regulator of this state, another state, or the United States.

(b) A corporation or partnership licensed as an agent under this title shall file under oath, on a form developed by the department, biographical information for:

- (1) each executive officer, director, or unlicensed partner who administers the entity's operations in this state;
- (2) each shareholder who is in control of the corporation or partner who has the right or ability to control the partnership; and
- (3) if the corporation or partnership is owned, in whole or

in part, by another entity, each individual who is in control of the parent entity.

(c) A corporation or partnership shall notify the department not later than the 30th day after the date of:

(1) a felony conviction of a licensed agent of the entity or an individual associated with the entity who is required to file biographical information with the department;

(2) an event for which notification would be required under Section 81.003; or

(3) the addition or removal of an officer, director, partner, member, or manager.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4001.253. RESTRICTION ON ACQUISITION OF OWNERSHIP INTEREST IN ENTITY LICENSED AS AGENT. (a) A person may not acquire in any manner an ownership interest in an entity licensed as an agent under this title if the person is, or after the acquisition would be, directly or indirectly in control of the license holder, or otherwise acquire control of or exercise any control over the license holder, unless the person has filed with the department under oath:

(1) a biographical form for each person by whom or on whose behalf the acquisition of control is to be effected;

(2) a statement certifying that no person who is acquiring an ownership interest in or control of the license holder has been the subject of a disciplinary action taken by a financial or insurance regulator of this state, another state, or the United States;

(3) a statement certifying that, immediately on the change of control, the license holder will be able to satisfy the requirements for the issuance of the license to solicit each line of insurance for which it is licensed; and

(4) any additional information that the commissioner by rule may prescribe as necessary or appropriate to the protection of the insurance consumers of this state or as in the public interest.

(b) The department may require a partnership, syndicate, or other group that is required to file a statement under Subsection (a) to provide the information under that subsection for each partner of the partnership, each member of the syndicate or group, and each

person who controls the partner or member. If the partner, member, or person is a corporation or the person required to file the statement under Subsection (a) is a corporation, the department may require that the information required under that subsection be provided regarding:

- (1) the corporation;
- (2) each individual who is an executive officer or director of the corporation; and
- (3) each person who is directly or indirectly the beneficial owner of more than 10 percent of the outstanding voting securities of the corporation.

(c) The department may disapprove an acquisition of control if, after notice and opportunity for hearing, the commissioner determines that:

- (1) immediately on the change of control the license holder would not be able to satisfy the requirements for the issuance of the license to solicit each line of insurance for which it is presently licensed;
- (2) the competence, trustworthiness, experience, and integrity of the persons who would control the operation of the license holder are such that it would not be in the interest of the insurance consumers of this state to permit the acquisition of control; or
- (3) the acquisition of control would violate this code or another law of this state, another state, or the United States.

(d) Notwithstanding Subsection (c), a change in control is considered approved if the department has not proposed to deny the requested change before the 61st day after the date the department receives all information required by this section.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4001.254. MAINTENANCE OF QUALIFICATIONS. The department shall, in the manner provided by Subchapter C, Chapter 4005, revoke, suspend, or refuse to renew the license of a license holder who does not maintain the qualifications necessary to obtain the license.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4001.255. MAINTENANCE OF RECORDS. An agent shall maintain all insurance records, including all records relating to customer complaints, separate from the records of any other business in which the agent may be engaged.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

SUBCHAPTER G. OTHER PERSONS WHO MAY SHARE IN PROFITS OF AGENCY

Sec. 4001.301. PROFITS AFTER DEATH OF AGENT WHO IS MEMBER OF AGENCY PARTNERSHIP. On the death of an agent who is a member of an agency partnership, the surviving spouse and children, if any, of the deceased partner, or a trust for the surviving spouse and children, may share in the profits of the agency partnership during the lifetime of the surviving spouse or children, as the case may be, as provided by:

- (1) a written partnership agreement; or
- (2) in the absence of a written agreement, an agreement by the surviving partner or partners and the surviving spouse, the trustee, and the legal representative of the surviving children.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4001.302. PROFITS AFTER DEATH OF AGENT WHO IS SOLE PROPRIETOR. (a) On the death of an agent who is a sole proprietor, unless otherwise provided by the probated will of the deceased agent, the surviving spouse and children, if any, of the deceased agent, or a trust for the surviving spouse or children, may share in the profits of the agency business of the deceased agent during the lifetime of the surviving spouse and children if the agency business is continued by an agent.

(b) The surviving spouse and children or trust is not required to qualify as an agent to share in the profits of the agency but may not perform an act of an agent in connection with the agency business without first being licensed as an agent.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4001.303. PROFITS AFTER DEATH OF SHAREHOLDER OF CORPORATE

AGENCY. (a) On the death of a shareholder of a corporate licensed agency, the surviving spouse and children, if any, of the deceased shareholder, or a trust for the surviving spouse and children, may share in the profits of the corporate agency during the lifetime of the surviving spouse or children as provided by a contract entered into by each shareholder and the corporation.

(b) The surviving spouse and children or trust is not required to qualify as an agent to share in the profits of the corporation but may not perform an act of an agent on behalf of the corporation without qualifying as an agent.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4001.304. TRANSFER OF INTEREST IN AGENCY BY AGENT WHO IS SOLE PROPRIETOR. (a) An agent who is a sole proprietor may transfer an interest in the agency to the agent's children, or a trust for the agent's children, and may operate that interest for their use and benefit. The children may share in the profits of the agency during their lifetime.

(b) The children are not required to qualify as agents to share in the profits of the agency but may not perform an act of an agent in connection with the agency business without first being licensed as agents.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4001.305. TRANSFER OF INTEREST IN AGENCY BY SHAREHOLDER OF CORPORATE AGENCY. (a) A shareholder of a corporate licensed agency may, if provided by a contract entered into by each shareholder and the corporation, transfer an interest in the agency to the shareholder's children or a trust for the shareholder's children. The children or trust may share in the profits of the agency to the extent of that interest during the children's lifetime.

(b) The children or trust is not required to qualify as an agent to share in the profits of the corporation but may not perform an act of an agent on behalf of the corporation without qualifying as an agent.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

SUBCHAPTER H. PROVISIONAL PERMIT

Sec. 4001.351. APPLICABILITY. This subchapter applies only to an applicant for a license as an agent under:

- (1) Subchapters B and E, Chapter 4051; and
- (2) Subchapters B, D, E, and G, Chapter 4054.

Added by Acts 2015, 84th Leg., R.S., Ch. 404 (H.B. 2145), Sec. 1, eff. September 1, 2015.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 128 (H.B. 1073), Sec. 1, eff. September 1, 2017.

Sec. 4001.352. AUTHORITY TO ISSUE PROVISIONAL PERMIT. (a) The department may, in conjunction with a license application under Section 4001.102, issue a provisional permit to an applicant who is being considered for appointment as an agent by another agent, an insurer, or a health maintenance organization.

(b) The department may suspend the issuance of a provisional permit under this subchapter if:

(1) the department's processing time for license applications has not exceeded 21 days in any month in the preceding 90 days before the suspension; and

(2) the department provides notice both on its Internet website and to applicants for provisional licenses that the provisional license applications are temporarily suspended because sufficient processing time for permanent licenses is available to allow for those licenses to be processed in not more than 21 days for a completed application.

Added by Acts 2015, 84th Leg., R.S., Ch. 404 (H.B. 2145), Sec. 1, eff. September 1, 2015.

Amended by:

Acts 2021, 87th Leg., R.S., Ch. 355 (H.B. 4030), Sec. 13, eff. September 1, 2021.

Sec. 4001.353. APPLICATION FOR AND ISSUANCE OF PROVISIONAL PERMIT. (a) The department may issue a provisional permit under

this subchapter on receipt of:

- (1) a written application for a provisional permit;
 - (2) a properly completed license application, nonrefundable fee, and each other item required for a license under this chapter and Subchapter B or E, Chapter 4051, or Subchapter B, D, E, or G, Chapter 4054, as applicable;
 - (3) the nonrefundable fee in an amount authorized by Subsection (c); and
 - (4) a certificate signed by the appointing agent, insurer, or health maintenance organization stating that:
 - (A) the applicant completed the training, if any, and passed the examination required for the issuance of the license for which the application is submitted;
 - (B) the appointing agent, insurer, or health maintenance organization completed a background check on the applicant that shows that the applicant has not been convicted of:
 - (i) a felony; or
 - (ii) an act that requires the applicant to receive written consent under 18 U.S.C. Section 1033 to engage in the business of insurance;
 - (C) the applicant has not responded affirmatively to any question on the license application that indicates the applicant has a criminal conviction or has been involved in an administrative action that may disqualify the applicant from receiving a license; and
 - (D) the appointing agent, insurer, or health maintenance organization will supervise the work of the applicant.
- (b) An applicant is not qualified to receive a provisional permit if the applicant has not taken and passed the examination required for the issuance of the permanent license for which the applicant applied under Section 4001.102.
- (c) The nonrefundable fee described by Subsection (a) shall be set by the department in an amount that:
- (1) is reasonable and necessary to implement this subchapter; and
 - (2) may not exceed the amount of the fee required for an application for a permanent license.

Added by Acts 2015, 84th Leg., R.S., Ch. 404 (H.B. [2145](#)), Sec. 1, eff. September 1, 2015.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 128 (H.B. 1073), Sec. 2, eff. September 1, 2017.

Sec. 4001.354. AUTHORITY TO ACT AS AGENT UNDER PROVISIONAL PERMIT. (a) An applicant may proceed to act as an agent if:

(1) a provisional permit is not received from the department before the eighth day after the date the application, nonrefundable fee, and other items required under Section 4001.353(a) are delivered or mailed to the department; and

(2) the applicant or appointing agent, insurer, or health maintenance organization has not been notified that the application for the permit is incomplete or is or may be denied.

(b) An applicant may act as an agent only for the appointing agent, insurer, or health maintenance organization except that an appointing insurer may include appointments for one or more affiliated insurers that are part of the same insurance holding company group.

Added by Acts 2015, 84th Leg., R.S., Ch. 404 (H.B. 2145), Sec. 1, eff. September 1, 2015.

Sec. 4001.355. TERM OF PROVISIONAL PERMIT. (a) Except as provided by Subsection (b), a provisional permit expires on the earlier of:

(1) the 90th day after the date the permit is issued; or

(2) the date a license is issued or the license application is denied.

(b) If the license, or a notice that the license is denied, is not received from the department on or before the 90th day after the date the application, nonrefundable fee, and other items required under Section 4001.353(a) are delivered or mailed to the department, the authority of the applicant to act as an agent under this subchapter automatically extends until the earlier of the date the license is issued or the license application is denied or the 90th day after the expiration of the 90-day period under Subsection (a).

Added by Acts 2015, 84th Leg., R.S., Ch. 404 (H.B. 2145), Sec. 1, eff. September 1, 2015.

Sec. 4001.356. NOTIFICATION REGARDING LICENSE. (a) The department may notify the applicant or appointing agent, insurer, or health maintenance organization that the license application is incomplete or is or may be denied at any time before the issuance or denial of a license.

(b) An applicant who receives a notice under Subsection (a) shall immediately cease acting as an agent under this subchapter. An appointing agent, insurer, or health maintenance organization that receives notice under Subsection (a) shall immediately notify the applicant of the notice.

(c) An applicant acting as an agent under this subchapter before receiving a notice under Subsection (a), if applicable, is not engaged in the unauthorized business of insurance and any transaction entered into by the applicant before receiving the notice, if applicable, is presumed lawful.

(d) A notification under this section applies only to a provisional permit, and the department shall continue to process an application for a license unless the license has been denied.

Added by Acts 2015, 84th Leg., R.S., Ch. 404 (H.B. [2145](#)), Sec. 1, eff. September 1, 2015.

Sec. 4001.357. DENIAL OR REVOCATION OF LICENSE. If the applicant's license application is denied or the applicant's license is revoked, an applicant is subject to Section 4005.105 with respect to an application for a provisional permit under this subchapter.

Added by Acts 2015, 84th Leg., R.S., Ch. 404 (H.B. [2145](#)), Sec. 1, eff. September 1, 2015.

Sec. 4001.358. COMPLIANCE WITH OTHER LAW. (a) A provisional permit holder who is acting under the authority of that permit is subject to all provisions of this code regulating the solicitation and sale of insurance that relate to the type of permanent license for which the provisional permit holder applied.

(b) A provisional permit holder that applied for a life and annuity license must comply with Chapter 1114 with respect to the

replacement of life insurance policies and annuities.

(c) A person who holds a permanent license may not circumvent or attempt to circumvent the intent of this section by acting for or with a provisional permit holder.

Added by Acts 2015, 84th Leg., R.S., Ch. 404 (H.B. 2145), Sec. 1, eff. September 1, 2015.

Sec. 4001.359. SUPERVISORY RESPONSIBILITY. An appointing agent, insurer, or health maintenance organization that allows a permit holder to act as an agent under a provisional permit has supervisory responsibility over the permit holder.

Added by Acts 2015, 84th Leg., R.S., Ch. 404 (H.B. 2145), Sec. 1, eff. September 1, 2015.

CHAPTER 4002. EXAMINATION OF LICENSE APPLICANTS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 4002.001. EXAMINATION REQUIRED. (a) Except as otherwise provided by this code, an applicant for a license to act as an agent in this state must:

(1) take a personal written examination prescribed by the commissioner; and

(2) pass the examination to the satisfaction of the department.

(b) The examination must determine the applicant's competence with respect to:

(1) the type of insurance contracts for which the applicant seeks a license;

(2) the laws of this state regulating the business of insurance; and

(3) the ethical obligations and duties of an agent.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4002.002. EXAMINATION FOR LIMITED LICENSE. (a) The commissioner shall prescribe a limited written examination for an applicant for a limited agent's license under Chapter 4051 or 4054.

(b) The examination must determine the applicant's competence and understanding of:

- (1) the basic principles of insurance contracts;
- (2) the basic laws of this state regulating the business of insurance; and
- (3) the ethical obligations and duties of an agent.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4002.003. EXEMPTIONS FROM EXAMINATION REQUIREMENT. (a) The department may not require a person to take an examination under this chapter if the person is:

- (1) an applicant for the renewal of an unexpired license issued by the department;
- (2) an applicant whose license issued by the department expired less than one year before the date of the application, if the previous license was not denied, revoked, or suspended by the commissioner;
- (3) a partnership, corporation, or depository institution;
- (4) an applicant for a life, accident, and health license who is designated as a chartered life underwriter (CLU);
- (5) an applicant for a property and casualty license who is designated as a chartered property casualty underwriter (CPCU);
- (6) an applicant for a specialty license issued under Chapter 4055;
- (7) a nonresident individual who is exempt from the examination requirement under Chapter 4056; or
- (8) an applicant for a general life, accident, and health license or a life agent license who was authorized to solicit or procure insurance on behalf of a fraternal benefit society on September 1, 1999, if the applicant:
 - (A) solicited or procured insurance on behalf of the fraternal benefit society for at least 24 months preceding September 1, 1999; and
 - (B) does not, on or after September 1, 1999, solicit or procure:
 - (i) insurance for any other insurer or a different fraternal benefit society;
 - (ii) an insurance contract from anyone other than a

person who is eligible for membership in the fraternal benefit society; or

(iii) an interest-sensitive life insurance contract that exceeds \$35,000 of coverage on an individual life, unless the applicant is designated as a "Fraternal Insurance Counselor" at the time the contract is solicited or procured.

(b) A license to which the exemption authorized by Subsection (a)(9) applies must be held by the applicant in an individual capacity and is not transferable.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 548 (S.B. 1263), Sec. 2.19, eff. September 1, 2007.

Acts 2021, 87th Leg., R.S., Ch. 355 (H.B. 4030), Sec. 14, eff. September 1, 2021.

Sec. 4002.005. EXAMINATION FEE. (a) The department shall charge each applicant an examination fee in an amount determined by the department as necessary to administer the examination.

(b) The examination fee must accompany each application to take the examination.

(c) An applicant may receive a refund of the examination fee only if:

- (1) the applicant fails to take the examination because of an emergency;
- (2) the applicant notifies the department of the emergency at least 24 hours before the time of the examination; and
- (3) the department agrees to refund the fee.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4002.006. BILINGUAL EXAMINATION. An examination administered under this chapter shall be offered in English and Spanish.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4002.007. EXAMINATION RESULTS. (a) The department shall notify each examinee of the results of a licensing examination administered under this code not later than the 30th day after the date the examination is administered. If an examination is graded or reviewed by a testing service, the department shall notify each examinee of the results of the examination not later than the 14th day after the date the department receives the results from the testing service.

(b) The department may require a testing service to notify examinees of the results of an examination.

(c) If the notice of the results of an examination graded or reviewed by a testing service will be delayed for longer than 90 days after the examination date, the department shall notify the examinee of the reason for the delay before the 90th day.

(d) If requested in writing by a person who fails a licensing examination administered under this code, the department shall provide to the person an analysis of the person's performance on the examination.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4002.008. STANDARDS FOR EXAMINATION PASS RATES; ANNUAL REPORT. (a) This section applies only to insurance agent license examinations for limited and single lines licenses, including agent licenses issued under:

- (1) Subchapters C and I, Chapter 4051; and
- (2) Subchapters C and G, Chapter 4054.

(b) The commissioner or, at the commissioner's discretion, a vendor under contract with the department, shall review a license examination subject to this section if, during any 12-month period beginning on September 1 of a year, that examination exhibits an overall pass rate of less than 70 percent for first-time examinees.

(c) The department shall collect demographic information, including, race, gender, and national origin, from an individual taking a license examination subject to this section.

(d) The department shall compile an annual report based on the review required under Subsection (b). The report must indicate whether there was any disparity in the pass rate based on demographic information.

(e) The commissioner by rule may establish procedures as necessary to:

(1) collect demographic information necessary to implement this section; and

(2) ensure that a review required under Subsection (b) is conducted and the resulting report is prepared.

(f) The commissioner shall deliver the report prepared under Subsection (d) to the governor, the lieutenant governor, and the speaker of the house of representatives not later than December 1 of each year.

Added by Acts 2009, 81st Leg., R.S., Ch. 398 (H.B. 1757), Sec. 1, eff. June 19, 2009.

SUBCHAPTER B. ADMINISTRATION OF EXAMINATION BY TESTING SERVICE

Sec. 4002.051. ADMINISTRATION BY TESTING SERVICE AUTHORIZED.

The commissioner may accept an examination administered by a testing service to satisfy the examination requirements of a person seeking a license as an agent, counselor, or adjuster under this code.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4002.052. AGREEMENT WITH TESTING SERVICE. (a) The commissioner may negotiate an agreement with a testing service to perform examination services, including:

(1) developing an examination;

(2) scheduling an examination;

(3) arranging the site for an examination; and

(4) administering, grading, reporting, and analyzing an examination.

(b) The commissioner may require a testing service to:

(1) correspond directly with applicants with regard to the administration of examinations;

(2) collect fees for administering examinations directly from applicants; and

(3) provide for the administration of examinations in specific locations and at specified frequencies.

(c) The commissioner shall retain the authority to establish the scope and type of each examination.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4002.053. HEARING REQUIRED BEFORE AGREEMENT. Before the department may negotiate and enter into an agreement with a testing service:

(1) a hearing must be held in accordance with Chapter 2001, Government Code; and

(2) the commissioner must adopt any rules or standards that the commissioner considers appropriate to implement the authority granted by this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

SUBCHAPTER C. DUTIES OF DEPARTMENT

Sec. 4002.101. ADMINISTRATION BY DEPARTMENT. In the absence of an agreement with a testing service, the department shall administer any required examination in accordance with this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4002.102. RULES. (a) The commissioner may adopt rules relating to:

(1) the scope, type, and conduct of an examination;

(2) the time and location in this state at which an examination is conducted; or

(3) the designation of textbooks, manuals, and other materials to be studied by an applicant for an examination.

(b) The textbooks, manuals, or other materials designated by the commissioner under Subsection (a)(3) may consist of:

(1) material available to an applicant by purchase from the publisher; or

(2) material prepared at the direction of the commissioner and distributed to an applicant on request and on payment of the reasonable cost of the material.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4002.103. CONTENT OF EXAMINATION QUESTIONS. All examination questions must be prepared from the contents of the textbooks, manuals, and other materials designated or prepared by the commissioner under Section 4002.102.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

CHAPTER 4003. LICENSE EXPIRATION AND RENEWAL

Sec. 4003.001. LICENSE EXPIRATION. (a) Unless a staggered renewal system is adopted under Section 4003.002, each license issued or renewed by the department under Chapter 981 or Subtitle A, B, or C and not suspended or revoked by the commissioner expires on:

- (1) the second anniversary of the date the license is issued to or renewed by a person that is not an individual; or
- (2) except as provided in Subsection (c):
 - (A) for a license issued or renewed in an even-numbered year, the individual license holder's birthday each even-numbered year; or
 - (B) for a license issued or renewed in an odd-numbered year, the individual license holder's birthday each odd-numbered year.

(b) The commissioner by rule may change the two-year expiration period if the commissioner determines that the change is necessary to promote uniformity of license periods of this state with those of other states.

(c) If a person holds more than one license, all licenses issued to the person expire on the earliest expiration date of the licenses held. Thereafter, all licenses expire in accordance with Subsection (a).

(d) Notwithstanding Section 4003.002(b), the commissioner may not prorate the initial application fee for a license based on the expiration period of the license under Subsection (c).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.
Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1172 (S.B. 876), Sec. 3, eff. September 1, 2015.

Sec. 4003.002. STAGGERED RENEWAL SYSTEM. (a) The commissioner

by rule may adopt a system under which licenses expire on various dates during a licensing period.

(b) For the licensing period in which the license expiration is changed, license fees shall be prorated so that each license holder pays only that portion of the license fee allocable to the period during which the license is valid. On renewal of the license on the new expiration date, the total renewal fee is payable.

(c) The commissioner shall adopt a system under which a person who holds more than one license may renew all the licenses held in a single process.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4003.003. NOTICE OF LICENSE EXPIRATION. Not later than the 30th day before the date a person's license expires, the department shall send written notice of the impending license expiration to the person at the person's last known mailing address according to the department's records.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4003.004. PROCEDURE FOR RENEWAL OF LICENSE. (a) A person may renew an unexpired license by:

- (1) filing a properly completed renewal application with the department in the form prescribed by the department; and
- (2) paying to the department the required renewal fee in an amount set by the department.

(b) A person may not renew a license that has been suspended or revoked.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4003.005. RENEWAL FEE NONREFUNDABLE. A renewal fee paid under this chapter is nonrefundable.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4003.006. CONTINUATION OF ORIGINAL LICENSE. The original license of a person who has applied for license renewal in compliance with Section 4003.004 remains in effect from the date the renewal application is filed until the date:

- (1) the department issues the renewal license;
- (2) the license is not renewed under Section 4004.055; or
- (3) the commissioner issues an order revoking the license.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.
Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1172 (S.B. 876), Sec. 4, eff. September 1, 2015.

Sec. 4003.007. RENEWAL OF EXPIRED LICENSE. (a) A person whose license has been expired for 90 days or less may renew the license by:

- (1) filing a renewal application with the department in the form prescribed by the department; and
- (2) paying to the department:
 - (A) the required renewal fee; and
 - (B) an additional fee equal to one-half of the required renewal fee.

(b) A person whose license has been expired for more than 90 days but less than one year may not renew the license. The person may obtain a new license without taking the applicable examination by:

- (1) filing a new application with the department; and
- (2) paying to the department:
 - (A) the license fee; and
 - (B) an additional fee equal to one-half of the license fee.

(c) A person whose license has been expired for one year or more may not renew the license. The person may obtain a new license by:

- (1) submitting to reexamination, if examination is required for original issuance of the license; and
- (2) complying with the other requirements and procedures for obtaining an original license.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4003.008. RENEWAL OF EXPIRED LICENSE BY OUT-OF-STATE AGENT. (a) The department may renew without reexamination an expired license of a person who was licensed in this state, moved to another state, and is currently licensed and has been in continual practice in the other state preceding the date of the application.

(b) The person must pay to the department a fee equal to the license application fee.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.
Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1172 (S.B. 876), Sec. 5, eff. September 1, 2015.

Sec. 4003.009. INTERSTATE MOVE BY AGENT. (a) Not later than the 30th day after moving from one state to another state, an agent licensed in this state shall file with the department:

(1) the agent's new address; and

(2) proof of authorization to engage in the business of insurance in the new state of residence.

(b) The department may not charge a fee or require a license application under this section.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4003.010. CHAPTER NOT APPLICABLE TO THIRD-PARTY ADMINISTRATORS. This chapter does not apply to a certificate of authority issued under Chapter 4151.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

CHAPTER 4004. CONTINUING EDUCATION

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 4004.001. DEPARTMENT JURISDICTION EXCLUSIVE. The department has exclusive jurisdiction of all matters relating to the continuing education of agents licensed under this code.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

SUBCHAPTER B. AGENT CONTINUING EDUCATION REQUIREMENTS

Sec. 4004.051. GENERAL REQUIREMENTS. (a) Except as provided by Section 4004.052 or other law, each individual who holds a license issued by the department shall complete, as a condition of licensure, continuing education as provided by this chapter.

(b) All required continuing education hours must be completed before the expiration date of the individual's license.

(c) At least 50 percent of all required continuing education hours must be completed in a classroom setting or a classroom equivalent setting approved by the department.

(d) The department may accept continuing education hours completed in other professions or in association with professional designations in an insurance-related field.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1172 (S.B. 876), Sec. 6, eff. September 1, 2015.

Sec. 4004.052. EXTENSIONS AND EXEMPTIONS. (a) On the timely written request of an agent, the department may extend the time for the agent to comply with the continuing education requirements of this chapter or may exempt the agent from some or all of the requirements for a licensing period if the department determines that the agent is unable to comply with the requirements because of illness, medical disability, or another extenuating circumstance beyond the control of the agent. The commissioner by rule shall prescribe the criteria for an exemption or extension under this subsection.

(b) An individual who has continuously held for at least 20 years an agent license issued under this code is exempt from the continuing education requirements of this chapter.

(c) The commissioner by rule may provide for other reasonable exemptions from the continuing education requirements of this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4004.053. REQUIREMENTS BASED ON TYPE OF LICENSE HELD. (a) An individual who holds a general life, accident, and health license, a life agent license, an adjuster license, a managing general agent license, a general property and casualty license, or a personal lines property and casualty license must complete 24 hours of continuing education during the license period. If the individual holds more than one license for which continuing education is otherwise required, the individual is not required to complete more than 24 continuing education hours for all licenses during the license period. An individual who is required under rules adopted under Chapter 4008 to hold a certificate to sell a designated product or product line may use continuing education programs administered under Section 4004.151 to satisfy the continuing education requirements under this subsection.

(b) An individual who holds a limited life, accident, and health license or a limited property and casualty license must complete five hours of continuing education annually.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 548 (S.B. 1263), Sec. 2.20, eff. September 1, 2007.

Acts 2009, 81st Leg., R.S., Ch. 451 (H.B. 2456), Sec. 2, eff. June 19, 2009.

Acts 2015, 84th Leg., R.S., Ch. 1172 (S.B. 876), Sec. 7, eff. September 1, 2015.

Acts 2021, 87th Leg., R.S., Ch. 355 (H.B. 4030), Sec. 15, eff. September 1, 2021.

Sec. 4004.0535. CONTINUING EDUCATION CREDIT FOR PARTICIPATION IN CERTAIN ASSOCIATIONS. (a) The commissioner by rule may authorize the department to grant not more than four hours of continuing education credit to an agent who is an active member of a state or national insurance association.

(b) The commissioner by rule shall:

(1) specify the types of associations that constitute state or national insurance associations; and

(2) establish reasonable requirements for active participation in such an association.

(c) An agent may not use continuing education credit granted under this section to satisfy:

(1) continuing education hours required to be completed in a classroom setting or classroom equivalent under Section 4004.051; or

(2) the ethics requirement adopted under Section 4004.054.

(d) An agent who seeks continuing education credit under this section shall provide to the department in the manner prescribed by the commissioner a sworn affirmation that the agent is an active member of a state or national insurance association described by Subsection (a) and, for the number of continuing education hours claimed, has:

(1) reviewed educational materials provided by that association; or

(2) attended educational presentations sponsored by that association.

Added by Acts 2005, 79th Leg., Ch. 691 (S.B. 265), Sec. 1, eff. September 1, 2005.

Sec. 4004.054. ETHICS REQUIREMENT. Each individual who holds a license issued by the department shall complete three hours of continuing education in ethics during each license renewal period.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.
Amended by:

Acts 2021, 87th Leg., R.S., Ch. 355 (H.B. 4030), Sec. 16, eff. September 1, 2021.

Sec. 4004.055. CONSEQUENCES OF FAILURE TO COMPLETE CONTINUING EDUCATION REQUIREMENT. (a) The department may not renew a license issued under this title if the license holder fails to:

(1) complete an applicable continuing education requirement not later than the 90th day after the last day of the licensing period; or

(2) pay an applicable fine related to the failure to timely complete continuing education.

(b) The department may not issue a new license under this title to an individual who was previously licensed under this title if the individual fails to:

- (1) provide evidence of completion of an applicable continuing education requirement for the expired, nonrenewed, canceled, or revoked license; or
- (2) pay an applicable fine related to the failure to timely complete continuing education.

(c) Completion of continuing education after expiration of a license is not a defense in a disciplinary action under Section 4005.101, Section 4005.109, or another provision of this code against an individual who failed to complete continuing education as required by this chapter.

Added by Acts 2015, 84th Leg., R.S., Ch. 1172 (S.B. 876), Sec. 8, eff. September 1, 2015.

SUBCHAPTER C. CONTINUING EDUCATION PROGRAMS

Sec. 4004.101. PROGRAM CERTIFICATION. (a) The department shall certify continuing education programs for agents and adjusters. The certification criteria must be designed to ensure that continuing education programs enhance the knowledge, understanding, and professional competence of the license holder.

(b) Only a program that satisfies the criteria established by rule by the commissioner may receive certification.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.
Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1172 (S.B. 876), Sec. 9, eff. September 1, 2015.

Sec. 4004.102. CERTIFICATION FEE. (a) A nonrefundable certification fee, in an amount set by the commissioner as necessary to administer this chapter, must accompany each application for certification of a continuing education program.

(b) The commissioner by rule shall establish the certification fee based on a graduated scale according to the number of hours required to complete the program.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4004.103. PROVIDER REGISTRATION; OTHER REQUIREMENTS. (a) Each continuing education program provider shall register with the department as a course provider.

(b) The department shall assess a registration fee for each application for registration as a course provider, set by the commissioner in an amount necessary for the proper administration of this chapter.

(c) The commissioner may adopt rules establishing other requirements for continuing education program providers.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4004.104. INDEPENDENT CONTRACTORS. (a) The department may enter into agreements with independent contractors under which the independent contractor certifies and registers continuing education programs and providers.

(b) The department may require the independent contractors to correspond directly with providers with regard to the administration of continuing education programs. The contractors may collect fees from the providers for administration of the courses.

(c) Notwithstanding Subsections (a) and (b), the department retains the authority to establish the scope and type of continuing education requirements for each type of license.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4004.105. ADJUSTER CONTINUING EDUCATION PROGRAM CONTENTS. A continuing education program for adjusters licensed under Chapter 4101 must include education relating to:

- (1) Chapter 541;
- (2) Chapter 547;
- (3) Subchapter A, Chapter 542;
- (4) Subchapter E, Chapter 17, Business & Commerce Code; and
- (5) any other similar laws specified by the department.

Added by Acts 2015, 84th Leg., R.S., Ch. 1172 (S.B. 876), Sec. 10,

eff. September 1, 2015.

**SUBCHAPTER D. AGENT EDUCATION PROGRAMS
FOR COMPLEX PRODUCTS**

Sec. 4004.151. AGENT EDUCATION PROGRAMS. The department shall administer continuing education and precertification training programs required by rules adopted under Chapter 4008.

Added by Acts 2009, 81st Leg., R.S., Ch. 451 (H.B. 2456), Sec. 3, eff. June 19, 2009.

Sec. 4004.152. PROGRAM ADMINISTRATION. (a) The department shall administer a program described by Section 4004.151 in a manner consistent with the administration of continuing education programs under Subchapter C.

(b) The department may enter into agreements with independent contractors for programs described by Section 4004.151 in the manner prescribed by Section 4004.104 for continuing education programs.

Added by Acts 2009, 81st Leg., R.S., Ch. 451 (H.B. 2456), Sec. 3, eff. June 19, 2009.

**SUBCHAPTER E. CONTINUING EDUCATION REQUIREMENTS FOR SALE OF
ANNUITIES**

Sec. 4004.201. DEFINITION. In this subchapter, "annuity" has the meaning assigned by Section 1115.002.

Added by Acts 2009, 81st Leg., R.S., Ch. 362 (H.B. 1294), Sec. 1.002, eff. September 1, 2009.

Sec. 4004.202. REQUIRED CONTINUING EDUCATION REGARDING ANNUITIES. (a) This section applies to a resident agent who:

(1) sells, solicits, or negotiates a contract for an annuity in this state; or

(2) represents or purports to represent an insurer in relation to such an annuity.

(b) Each agent described by Subsection (a) must complete eight

hours of continuing education that specifically relates to annuities during the agent's two-year licensing period.

(c) The continuing education required under this section may be used to satisfy the continuing education requirements under Subchapter B.

Added by Acts 2009, 81st Leg., R.S., Ch. 362 (H.B. 1294), Sec. 1.002, eff. September 1, 2009.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 998 (H.B. 2154), Sec. 1, eff. September 1, 2011.

Sec. 4004.203. PROGRAM CERTIFICATION REQUIREMENTS. (a) The commissioner by rule shall adopt criteria for continuing education programs used to satisfy the requirements of Section 4004.202. Those criteria must include:

- (1) topics related specifically to annuities;
- (2) state laws and rules related to annuities, including requirements adopted under Chapter 1115;
- (3) prohibited sales practices regarding annuities;
- (4) recognition of indicators that a prospective insured may lack the short-term memory or judgment to knowingly purchase an annuity; and
- (5) fraudulent and unfair trade practices regarding the sale of annuities.

(b) Subject matter determined by the commissioner to be primarily intended to promote the sale or marketing of annuities does not qualify as continuing education for purposes of this subchapter.

(c) Subchapter C applies to continuing education programs described by Subsection (a) and training under Section 1115.056. Any training program disapproved under Subsection (b) shall be presumed invalid for certification under Subchapter C unless the program is approved in writing by the commissioner.

Added by Acts 2009, 81st Leg., R.S., Ch. 362 (H.B. 1294), Sec. 1.002, eff. September 1, 2009.

**SUBCHAPTER F. ADDITIONAL CONTINUING EDUCATION REQUIREMENTS
FOR SALE OF MEDICARE-RELATED PRODUCTS**

Sec. 4004.251. DEFINITIONS. In this subchapter:

(1) "Medicare advantage plan" means a health benefit plan operated under the Medicare program as a managed care plan, special needs plan, or private fee-for-service plan.

(2) "Medicare program" means the federal health insurance program that is operated under the Health Insurance for the Aged Act (42 U.S.C. Section 1395 et seq.).

(3) "Medicare-related product" means a Medicare advantage plan, a Medicare prescription drug plan, or another health plan operated under the Medicare program, such as a Medicare cost plan or a Medicare demonstration plan. The term does not include a Medicare supplement benefit plan regulated under Chapter 1652.

Redesignated from Insurance Code, Subchapter D, Chapter 4004 by Acts 2011, 82nd Leg., R.S., Ch. 91 (S.B. 1303), Sec. 27.001(41), eff. September 1, 2011.

Sec. 4004.252. AGENT EDUCATION REQUIREMENTS. (a) Unless an agent has completed eight hours of professional training related to a Medicare-related product, an agent may not:

(1) sell, solicit, negotiate, or receive an application or contract for the Medicare-related product in this state; or

(2) represent an insurer in relation to the Medicare-related product in this state.

(b) The training required under Subsection (a) may be used to satisfy the continuing education requirements established under Subchapter B.

Redesignated from Insurance Code, Subchapter D, Chapter 4004 by Acts 2011, 82nd Leg., R.S., Ch. 91 (S.B. 1303), Sec. 27.001(41), eff. September 1, 2011.

Sec. 4004.253. REQUIRED CONTINUING EDUCATION REGARDING MEDICARE PRODUCTS. (a) This section applies to an agent who:

(1) solicits, negotiates, procures, or collects a premium on a Medicare-related product; or

(2) represents or purports to represent an insurer, a health maintenance organization, or a preferred provider organization in relation to such a Medicare-related product.

(b) Each agent described by Subsection (a) must complete four hours of continuing education that specifically relates to Medicare-related products during the agent's two-year licensing period.

(c) Only training in a program that has been certified by the department may be used to satisfy the requirements of Subsection (b).

(d) The continuing education required under Subsection (b) may be used to satisfy the continuing education requirements established under Subchapter B.

Redesignated from Insurance Code, Subchapter D, Chapter 4004 by Acts 2011, 82nd Leg., R.S., Ch. 91 (S.B. 1303), Sec. 27.001(41), eff. September 1, 2011.

Sec. 4004.254. PROGRAM CERTIFICATION REQUIREMENTS. (a) Subchapter C, including the authorization to contract with an independent contractor under Section 4004.104, applies to programs used to satisfy the requirements of Sections 4004.252 and 4004.253. For the purpose of administering this subchapter, professional training courses shall be considered to be continuing education courses under Subchapter C.

(b) The commissioner by rule shall adopt criteria for the programs used to satisfy the requirements of Sections 4004.252 and 4004.253 that are designed to ensure that an agent has knowledge, understanding, and professional competence concerning a Medicare-related product. The rules adopted under this subsection may incorporate by reference any requirements established by the Centers for Medicare and Medicaid Services or any other appropriate federal agency.

Redesignated from Insurance Code, Subchapter D, Chapter 4004 by Acts 2011, 82nd Leg., R.S., Ch. 91 (S.B. 1303), Sec. 27.001(41), eff. September 1, 2011.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 91 (S.B. 1303), Sec. 27.002(13), eff. September 1, 2011.

Sec. 4004.255. NONAPPLICATION OF CERTAIN EXEMPTIONS. The continuing education exemptions for certain agents established under Section 4004.052(b) and Section 9.02(e), Chapter 703 (S.B. 414), Acts

of the 77th Legislature, Regular Session, 2001, do not apply to requirements under this subchapter.

Redesignated from Insurance Code, Subchapter D, Chapter 4004 by Acts 2011, 82nd Leg., R.S., Ch. 91 (S.B. 1303), Sec. 27.001(41), eff. September 1, 2011.

CHAPTER 4005. CONDUCT, DISCIPLINARY ACTIONS, AND SANCTIONS
SUBCHAPTER A. AUTHORIZED CONDUCT

Sec. 4005.001. DEFINITION. In this subchapter, "client" means:
(1) an applicant for insurance coverage; or
(2) an insured.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4005.002. AUTHORIZATION TO OBTAIN CERTAIN RECORDS OR PHOTOGRAPHS. (a) In connection with a client's application for insurance coverage or with the issuance of an insurance policy to a client, or on a client's request, a general property and casualty agent or personal lines property and casualty agent may obtain:

(1) the motor vehicle record of a person insured under or to be insured under an insurance policy; or
(2) a photograph of property insured under or to be insured under an insurance policy.

(b) The agent must provide a copy of the motor vehicle record to the client.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 548 (S.B. 1263), Sec. 2.21, eff. September 1, 2007.

Sec. 4005.003. FEES. (a) A general property and casualty agent or personal lines property and casualty agent may charge a client a fee to reimburse the agent for costs the agent incurred in obtaining a motor vehicle record or photograph of property described under Section 4005.002. The fee may not exceed the actual costs to the agent.

(b) For services provided to a client, a property and casualty agent described by Subsection (a) may charge a reasonable fee, including a fee for:

- (1) special delivery or postal charges;
- (2) printing or reproduction costs;
- (3) electronic mail costs;
- (4) telephone transmission costs; and
- (5) similar costs that the agent incurs on behalf of the

client.

(c) A property and casualty agent described by Subsection (a) may charge a client a fee under this section only if, before the agent incurs an expense for the client, the agent:

- (1) notifies the client of the agent's fee; and
- (2) obtains the client's written consent for each fee to be

charged.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 548 (S.B. [1263](#)), Sec. 2.22, eff. September 1, 2007.

Sec. 4005.004. DISCLOSURE OF COMPENSATION. (a) In this section:

(1) "Affiliate" has the meaning described by Section 823.003(a).

(2) "Agent" means a person licensed under Chapter 4051, 4053, 4054, or 4056.

(3) "Compensation from an insurer or other third party" includes payments, commissions, fees, awards, overrides, bonuses, contingent commissions, loans, stock options, gifts, prizes, or any other form of valuable consideration, whether or not payable under a written contract or agreement.

(4) "Compensation from a customer" does not include a fee described by Section 4005.003, an application fee, or an inspection fee.

(5) "Customer" means the person signing the application for insurance or the authorized representative of the insured actually negotiating the placement of an insurance product with the agent. A person is not to be considered a "customer" of an agent for purposes

of this section solely because the person is a participant or beneficiary:

(A) of an employee benefit plan; or

(B) of, or otherwise covered by, a group or blanket insurance policy or group annuity contract sold, solicited, or negotiated by an agent or the agent's affiliate.

(6) "Documented acknowledgment" means a customer's dated acknowledgment, obtained before the customer's purchase of an insurance product, as demonstrated by the customer's written or electronic signature or recorded voice, or by other additional methods that the commissioner may authorize by rule.

(b) If an agent, or any affiliate of an agent, receives compensation from a customer for the placement or renewal of an insurance product, other than a service fee described under Section 4005.003, an application fee, or an inspection fee, the agent or the affiliate may not accept or receive any compensation from an insurer or other third party for that placement or renewal unless the agent has, before the customer's purchase of insurance:

(1) obtained the customer's documented acknowledgment that the compensation will be received by the agent or affiliate; and

(2) provided a description of the method and factors used to compute the compensation to be received from the insurer or other third party for that placement.

(c) This section does not apply to:

(1) a licensed agent who acts only as an intermediary between an insurer and the customer's agent, including a managing general agent;

(2) a reinsurance intermediary or surplus lines agent placing reinsurance or surplus lines insurance; or

(3) an agent whose sole compensation for the placement or servicing of an insurance product is derived from commissions, salaries, and other remuneration paid by the insurer.

(d) An agent may satisfy any requirements imposed by this section through an affiliate.

(e) The commissioner may adopt rules as necessary to implement the disclosure and acknowledgment of disclosure requirements under this section.

Added by Acts 2005, 79th Leg., Ch. 755 (H.B. [2941](#)), Sec. 1, eff. September 1, 2005.

SUBCHAPTER B. PROHIBITED CONDUCT

Sec. 4005.051. APPLICABILITY OF SUBCHAPTER. This subchapter does not apply to a person who holds a license or certificate of authority issued under Title 11.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4005.052. CERTAIN CONDUCT PROHIBITED AFTER REVOCATION OF LICENSE. A person whose insurance license has been revoked in this state or any other state may not:

(1) solicit or otherwise engage in business under Chapter 885 unless the department determines it to be in the public interest, for good cause shown, to permit the person to act in that capacity; or

(2) act as an officer, director, member, manager, or partner, or as a shareholder with a controlling interest, of an entity holding a license issued under this title unless the department determines it to be in the public interest, for good cause shown, to permit the person to act in that capacity.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4005.053. CERTAIN PAYMENTS PROHIBITED TO OR FROM PERSON NOT HOLDING LICENSE. (a) An insurer or agent engaged in the business of insurance in this state may not pay to any person, directly or indirectly, and may not accept from any person a commission or other valuable consideration for a service performed by that person as an agent in this state unless the person holds a license to act as an agent in this state.

(b) Subsection (a) does not prevent the payment of a renewal or other deferred commission to a person or the acceptance of a renewal or other deferred compensation by a person solely because the person no longer holds a license to act as an agent.

(c) An agent may not pay, permit, or give or offer to pay, permit, or give, directly or indirectly, to any person who does not hold a license as an agent:

(1) a rebate of premiums payable, a commission, employment,

a contract for service, or any other valuable consideration or inducement that is not specified in the insurance policy or contract for or on account of the solicitation or negotiation of an insurance contract; or

(2) a fee or other valuable consideration for referring a customer who seeks to purchase an insurance product or seeks an opinion on or advice regarding an insurance product, based on that customer's purchase of insurance.

(d) Subsection (c) does not prohibit an agent from, in connection with an offer or sale of an insurance policy or contract, giving, providing, or allowing or offering to give, provide, or allow an item that is a promotional advertising item, educational item, or traditional courtesy commonly extended to consumers and that is valued at \$25 or less.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.
Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 28 (S.B. 840), Sec. 6, eff. September 1, 2013.

Sec. 4005.054. RECEIVING ADDITIONAL FEE PROHIBITED. A person who holds a license under this code and receives a commission or other consideration for services as an agent may not receive an additional fee for those services provided to the same client except for a fee:

- (1) described by Section 550.001 or 4005.003; and
- (2) for which disclosure is made as required under Section 4005.003 or Section 4005.004.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.
Amended by:

Acts 2005, 79th Leg., Ch. 755 (H.B. 2941), Sec. 2, eff. September 1, 2005.

Sec. 4005.055. CERTAIN COVERAGE FOR LOSS BY FIRE PROHIBITED. A property and casualty agent may not knowingly grant, write, or permit a greater amount of insurance against loss by fire than the reasonable value of the insured subject.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

SUBCHAPTER C. DISCIPLINARY ACTIONS AND PROCEDURES; ENFORCEMENT

Sec. 4005.101. GROUND FOR LICENSE DENIAL OR DISCIPLINARY ACTION. (a) This section does not apply to a person who holds a license or certificate of authority issued under Title 11.

(b) The department may deny a license application or discipline a license holder under this subchapter if the department determines that the applicant or license holder, individually or through an officer, director, or shareholder:

- (1) has wilfully violated an insurance law of this state;
- (2) has intentionally made a material misstatement in the license application;
- (3) has obtained or attempted to obtain a license by fraud or misrepresentation;
- (4) has misappropriated, converted to the applicant's or license holder's own use, or illegally withheld money belonging to:
 - (A) an insurer;
 - (B) a health maintenance organization; or
 - (C) an insured, enrollee, or beneficiary;
- (5) has engaged in fraudulent or dishonest acts or practices;
- (6) has materially misrepresented the terms and conditions of an insurance policy or contract, including a contract relating to membership in a health maintenance organization;
- (7) has made or issued, or caused to be made or issued, a statement misrepresenting or making incomplete comparisons regarding the terms or conditions of an insurance or annuity contract legally issued by an insurer or a membership issued by a health maintenance organization to induce the owner of the contract or membership to forfeit or surrender the contract or membership or allow it to lapse for the purpose of replacing the contract or membership with another;
- (8) has been convicted of a felony;
- (9) has offered or given a rebate of an insurance premium or commission to an insured or enrollee;
- (10) is not actively engaged in soliciting or writing insurance for the public generally as required by Section 4001.104(a); or
- (11) has obtained or attempted to obtain a license, not for

the purpose of holding the applicant or license holder out to the general public as an agent, but primarily for the purpose of soliciting, negotiating, or procuring an insurance or annuity contract or membership covering:

- (A) the applicant or license holder;
- (B) a member of the applicant's or license holder's family; or
- (C) a business associate of the applicant or license holder.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4005.102. REMEDIES FOR VIOLATION OF INSURANCE LAWS OR COMMISSIONER RULES. In addition to any other remedy available under Chapter 82, for a violation of this code, another insurance law of this state, or a rule of the commissioner, the department may:

- (1) deny an application for:
 - (A) an original license; or
 - (B) a certificate issued under Chapter 4008;
- (2) suspend, revoke, or deny renewal of:
 - (A) a license; or
 - (B) a certificate issued under Chapter 4008;
- (3) place on probation a person whose license has been suspended;
- (4) assess an administrative penalty;
- (5) reprimand a license holder; or
- (6) require a license holder to qualify, or re-qualify if the agent has already qualified, for a certificate to sell a product or product line designated by rule under Chapter 4008.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 451 (H.B. [2456](#)), Sec. 4, eff. June 19, 2009.

Sec. 4005.103. PROBATED LICENSE SUSPENSION. If a license suspension is probated, the commissioner may require the license holder to:

- (1) report regularly to the department on any matter that

is the basis of the probation;

(2) limit the license holder's practice to the areas prescribed by the department; or

(3) continue or review professional education until the license holder attains a degree of skill satisfactory to the commissioner in each area that is the basis of the probation.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4005.104. HEARING. (a) If the department proposes to deny an application for an original license or to suspend, revoke, or deny renewal of a license, the applicant or license holder is entitled to a hearing conducted by the State Office of Administrative Hearings as provided by Chapter 40.

(b) Notice of the hearing shall be provided to:

(1) the applicant or license holder; and

(2) any insurer indicated on the application as desiring that the license be issued.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4005.105. APPLICATION FOR LICENSE AFTER DENIAL OF APPLICATION OR REVOCATION OF LICENSE. (a) This section does not apply to a person who holds a license or certificate of authority issued under Title 11.

(b) An individual whose license application has been denied or whose license has been revoked under this subchapter may not apply for an agent license before the fifth anniversary of:

(1) the effective date of the denial or revocation; or

(2) the date of a final court order affirming the denial or revocation if judicial review was sought.

(c) A license application filed after the time required by Subsection (b) may be denied by the commissioner if the applicant fails to show good cause why the denial or revocation should not be a bar to the issuance of a new license.

(d) Subsections (b) and (c) do not apply to an applicant whose license application was denied or revoked for failure by the applicant to:

(1) pass a required written examination;

- (2) complete continuing education or pay an applicable fine under Section 4004.055(a); or
- (3) submit a properly completed license application.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.
Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1172 (S.B. 876), Sec. 11, eff. September 1, 2015.

Sec. 4005.106. APPLICATION FOR LICENSE AFTER CERTAIN DETERMINATIONS. (a) In addition to any other penalty imposed under this code, a person who the department determines has engaged in conduct described by this section may not obtain a license as an agent before the fifth anniversary of the date of the determination.

(b) This section applies to a person who:

- (1) acts as an agent without holding a license under this code;
- (2) solicits an insurance contract or acts as an agent without having been appointed or designated by an authorized insurer, association, or organization to do so as provided by this code;
- (3) solicits an insurance contract or acts as an agent for a person, including an insurer, association, or organization, who is not authorized to engage in the business of insurance in this state without holding a surplus lines agent license issued under Chapter 981; or
- (4) as an officer or representative of an insurer, knowingly contracts with or appoints as an agent a person who does not hold a valid license.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4005.107. DISCIPLINARY PROCEEDING FOR CONDUCT COMMITTED BEFORE SURRENDER OR FORFEITURE OF LICENSE. (a) The department may institute a disciplinary proceeding against a former license holder for conduct committed before the effective date of a voluntary surrender or automatic forfeiture of the license.

(b) In a proceeding under this section, the fact that the license holder has surrendered or forfeited the license does not affect the former license holder's culpability for the conduct that

is the subject of the proceeding.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4005.108. DISABILITY PROBATION. (a) This section does not apply to a person who holds a license or certificate of authority issued under Title 11.

(b) Instead of or in addition to taking disciplinary action under Section 4005.102, 4005.103, 4005.105(c), or 4005.107, the department may order that a license holder who is disabled be placed on disability probation under the terms specified under Chapter 4006 and department rules.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4005.109. FINES. (a) To expedite the department's processing of certain violations of this code, the commissioner by rule may establish fines for certain violations.

(b) A violation for which a fine may be assessed under this section includes a failure to:

(1) obtain the total number of continuing education hours before the expiration date of a license;

(2) timely report a change of address to the department; or

(3) notify the department of an administrative action against the agent by a financial or insurance regulator of another state or of the federal government.

(c) This section does not limit the department's authority to take any other disciplinary action against a license holder as otherwise provided by this code.

(d) The dispute of an assessment of a fine under this section is a contested case subject to Chapter 2001, Government Code.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1172 (S.B. 876), Sec. 12, eff. September 1, 2015.

Sec. 4005.110. ENFORCEMENT OF TITLE. The attorney general, a

district or county attorney, or the department acting through the commissioner may bring a proceeding for an injunction or bring any other proceeding to enforce this title and to enjoin any person, firm, corporation, or depository institution from engaging in or attempting to engage in the business of insurance in violation of this code or any other insurance law of this state.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

SUBCHAPTER D. CRIMINAL PENALTIES

Sec. 4005.151. ACTING AS AGENT AFTER LICENSE SUSPENSION OR REVOCATION; CRIMINAL PENALTY. (a) A person commits an offense if the person acts as an agent after the person's agent license has been suspended or revoked.

(b) An offense under this section is a felony of the third degree.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 58 (H.B. [1305](#)), Sec. 1, eff. September 1, 2013.

Sec. 4005.152. AGENT ASSISTING OR CONSPIRING WITH PERSON WHOSE LICENSE HAS BEEN SUSPENDED OR REVOKED; CRIMINAL PENALTY. (a) A person commits an offense if the person is an agent who holds a license under this code and the person assists or conspires with a person whose license as an agent has been suspended or revoked to act as an agent.

(b) An offense under this section is a misdemeanor punishable by:

- (1) a fine not to exceed \$1,000;
- (2) confinement in jail for a term of not more than six months; or
- (3) both fine and confinement in jail under this subsection.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4005.153. EMBEZZLEMENT OR CONVERSION BY AGENT; CRIMINAL PENALTY. (a) A person commits an offense if the person, as an agent for an insurer lawfully engaged in the business of insurance in this state, collects premiums or otherwise receives money or a substitute for money, and the person:

(1) embezzles, fraudulently converts, or appropriates to the person's own use the money or substitute for money; or

(2) with intent to embezzle and contrary to the instructions of or without the consent of the insurer, takes, secretes, or otherwise disposes of or fraudulently withholds, appropriates, lends, invests, or otherwise uses or applies, any money or substitute for money received by the person in the person's capacity as agent or broker.

(b) A person who commits an offense under this section shall be punished as if the person had stolen the money or substitute for money.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

CHAPTER 4006. DISABILITY PROBATION OF AGENTS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 4006.001. DEFINITION. In this chapter, "disability" means any physical, mental, or emotional condition that results in an agent's inability to carry out the agent's professional responsibilities to insureds, the profession, or the public.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4006.002. RULES. The commissioner may adopt rules as necessary to implement this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

SUBCHAPTER B. POWERS AND DUTIES OF DEPARTMENT

Sec. 4006.051. DISABILITY PROBATION ORDER. (a) The department may order that an agent be placed on disability probation if, after notice and an opportunity for a hearing, the department determines that the agent is suffering from a disability.

(b) The department may order disability probation for an agent only if the agent demonstrates that:

(1) the disability can be successfully arrested and treated while the agent is engaged in the agent's professional business;

(2) the disability is unlikely to cause harm to the public during the period of rehabilitation;

(3) adequate supervision of any necessary conditions of the probation will occur; and

(4) the agent is capable of competently performing the agent's professional duties.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4006.052. RESTITUTION. (a) The department may order disability probation for an agent only if the agent makes full restitution during the probation period to all insureds and other persons harmed by the agent's:

(1) violation of this code or other laws regulating the business of insurance in this state; or

(2) failure to comply with other professional responsibilities.

(b) The department shall require the restitution described by Subsection (a) as a condition of the probation.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4006.053. DURATION OF PROBATION. (a) If the department orders disability probation, the department shall set the probation for a specified period or until further order of the department.

(b) The department may order a probation period that exceeds the one-year maximum suspension authorized under Section 82.052(1).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4006.054. PROBATION CONDITIONS. (a) An order placing an agent on disability probation must state the probation conditions.

(b) In establishing the probation conditions, the department shall consider:

- (1) the nature and circumstances of the agent's conduct;
- (2) the agent's history, character, and condition; and
- (3) the nature of the agent's disability.

(c) The department may impose on the agent any of the following probation conditions:

- (1) periodic reports to the department;
- (2) satisfactory completion of a course of study required by the department;
- (3) payment of costs, including reasonable attorney's fees and other expenses, related to the proceedings before the department;
- (4) psychological evaluation, counseling, and treatment;
- (5) drug and alcohol abuse evaluation, counseling, and treatment;
- (6) abstinence from alcohol or drugs;
- (7) mandatory attendance at meetings of Alcoholics Anonymous, Narcotics Anonymous, or similar support groups;
- (8) periodic random urine testing to screen for drug and alcohol abuse; and
- (9) any other probation condition that the department considers appropriate.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4006.055. SUPERVISION DURING PROBATION. The department shall supervise an agent placed on disability probation.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4006.056. EFFECT OF NONCOMPLIANCE. On a showing of an agent's failure to comply with the disability probation conditions, the department may:

- (1) revoke the probation; or
- (2) impose other conditions that the department considers necessary for the public's protection and the agent's rehabilitation.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

**CHAPTER 4007. NOTICE TO DEPARTMENT BY CERTAIN PROPERTY AND CASUALTY
INSURANCE COMPANIES REGARDING AGENTS**

Sec. 4007.001. APPLICABILITY OF CHAPTER. This chapter applies only to an insurance company authorized to engage in the business of insurance in this state under:

- (1) a provision of:
 - (A) Chapter 5, 1805, or 2171; or
 - (B) Subtitle B, C, D, E, F, H, or I, Title 10; or
- (2) Chapter 861, 862, 883, 911, 912, 941, 942, 984, or

3503.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1I.001, eff. April 1, 2009.

Sec. 4007.002. NOTICE TO DEPARTMENT REQUIRED. (a) On forms prescribed by the commissioner, an insurance company shall notify the department not later than the 30th day after the date on which:

(1) balances due from an insurance agent for more than 90 days exceed \$1 million or 10 percent of the company's policyholder surplus computed on December 31 of the preceding year or the most recent quarter if a report is specifically required by the department;

(2) an agent's authority to settle claims for the company is withdrawn; or

(3) the contract with an agent is canceled or terminated.

(b) An insurance company may comply with the notification requirement of Subsection (a)(1) by submitting a single annual report if:

(1) the company routinely operates above the limit established by Subsection (a)(1); and

(2) the commissioner verifies that fact under a procedure adopted by the commissioner.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1I.001, eff. April 1, 2009.

CHAPTER 4008. AGENT CERTIFICATION AND EDUCATION PROGRAMS FOR COMPLEX INSURANCE PRODUCTS

Sec. 4008.001. PURPOSE. Certain insurance products are so complex that the general agent licensing and continuing education requirements are insufficient to ensure the level of agent expertise

necessary to safeguard consumer interests. Agents should be equipped with the necessary skills and knowledge to assist insureds appropriately in their purchases. Requiring agent training or demonstration of knowledge before an agent may sell particularly complex products mitigates the negative impact caused by agents selling complex products without the training and knowledge necessary to sell those products in a manner that is fair and beneficial to insureds.

Added by Acts 2009, 81st Leg., R.S., Ch. 451 (H.B. 2456), Sec. 5, eff. June 19, 2009.

Sec. 4008.002. TRAINING AND EXAMINATION REQUIREMENTS AUTHORIZED. (a) The commissioner may adopt rules requiring an agent who holds a license issued under this code to be certified, through specific education, training, examination, and experience requirements as provided by this chapter, before an agent may sell a product or product line designated by the commissioner.

(b) Education, training, examination, and experience requirements established by rule under this chapter may be used to satisfy any other agent education, training, examination, and experience requirements otherwise established under this code.

Added by Acts 2009, 81st Leg., R.S., Ch. 451 (H.B. 2456), Sec. 5, eff. June 19, 2009.

Sec. 4008.003. RULES. (a) In adopting rules under this chapter, the commissioner shall:

(1) designate the products or product lines that may not be sold without certification under this chapter; and

(2) specify the reasons why it is necessary that the sale of a designated product or product line requires education, experience, or examination.

(b) By rule, the commissioner may specify:

(1) any precertification education or experience that must be completed before a designated product or product line may be sold by an agent;

(2) whether an agent must complete a precertification examination concerning the designated product or product line the

agent intends to sell;

(3) whether an agent certified under this chapter must complete specific continuing education to maintain the certificate; and

(4) whether, and if so, how frequently, an agent certified under this chapter must periodically retake the examination to maintain the certificate.

Added by Acts 2009, 81st Leg., R.S., Ch. 451 (H.B. 2456), Sec. 5, eff. June 19, 2009.

Sec. 4008.004. APPLICATION OF CERTIFICATION REQUIREMENTS TO CERTAIN AGENTS. (a) The commissioner by rule shall establish whether the certification requirements established under this chapter for sale by an agent of a designated product or product line apply:

(1) only to an agent who, as of the effective date of the certification requirement, does not hold the underlying agent license required to sell that product or product line; or

(2) to each licensed agent who engages in the sale of that product or product line.

(b) If the commissioner adopts rules requiring each agent described by Subsection (a)(2) to be certified under this chapter, the rules must specify the date by which the agent must comply with the certification requirements.

Added by Acts 2009, 81st Leg., R.S., Ch. 451 (H.B. 2456), Sec. 5, eff. June 19, 2009.

Sec. 4008.005. ISSUANCE OF CERTIFICATE. The department shall issue a certificate under this chapter to an agent if the department determines that the agent:

(1) has submitted a properly completed certification application to the department in a form acceptable to the department;

(2) has completed, within the 12-month period preceding the date of the certification application, all requirements for the certification required by rules adopted under this chapter; and

(3) has not committed an act for which a license or certification may be denied under Subchapter C, Chapter 4005.

Added by Acts 2009, 81st Leg., R.S., Ch. 451 (H.B. 2456), Sec. 5, eff. June 19, 2009.

Sec. 4008.006. CERTIFICATE EXPIRATION. Unless the commissioner by rule specifies a different period, each certificate issued under this chapter expires on the expiration date of the agent's appropriate underlying license.

Added by Acts 2009, 81st Leg., R.S., Ch. 451 (H.B. 2456), Sec. 5, eff. June 19, 2009.

Sec. 4008.007. CERTIFICATE RENEWAL. (a) An agent may renew an unexpired certificate before the expiration of the certificate by:

(1) completing all renewal requirements established by rule under this chapter; and

(2) filing a properly completed renewal application with the department in a form acceptable to the department.

(b) A person may not renew a certificate that has been suspended or revoked.

Added by Acts 2009, 81st Leg., R.S., Ch. 451 (H.B. 2456), Sec. 5, eff. June 19, 2009.

Sec. 4008.008. ADMINISTRATION BY TESTING SERVICE AUTHORIZED. The commissioner may accept an examination administered by a testing service, as provided under Subchapter B, Chapter 4002, to satisfy an examination requirement required by rule under this chapter.

Added by Acts 2009, 81st Leg., R.S., Ch. 451 (H.B. 2456), Sec. 5, eff. June 19, 2009.

SUBTITLE B. AGENTS

CHAPTER 4051. PROPERTY AND CASUALTY AGENTS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 4051.001. APPLICABILITY OF CHAPTER. (a) This subchapter and Subchapters B-E, G, and I apply to each agent of an insurer authorized to engage in the business of property and casualty

insurance in this state.

(b) This subchapter and Subchapters B-E, G, and I apply to each person who performs the acts of an agent, as described by Section 4001.051, whether through an oral, written, electronic, or other form of communication, by soliciting, negotiating, procuring, or collecting a premium on an insurance contract offered by any kind of insurer authorized to engage in the business of property and casualty insurance in this state, including:

- (1) a fidelity or surety company;
- (2) a mutual insurance company, including a farm mutual or a county mutual;
- (3) a reciprocal or interinsurance exchange; and
- (4) a Lloyd's plan.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 548 (S.B. 1263), Sec. 2.23, eff. September 1, 2007.

Sec. 4051.002. REQUIREMENTS APPLICABLE TO CERTAIN AGENT CONTRACTS. An agent's contract entered into on or after August 27, 1973, by an insurer engaged in the business of property and casualty insurance in this state is subject to Chapter 444.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2J.003, eff. April 1, 2009.

SUBCHAPTER B. GENERAL PROPERTY AND CASUALTY LICENSE

Sec. 4051.051. LICENSE REQUIRED. (a) A person is required to hold a general property and casualty license if the person acts as:

- (1) an agent who writes property and casualty insurance for an insurer authorized to engage in the business of property and casualty insurance in this state; or
- (2) an agent who writes any other kind of insurance as required by the commissioner for the protection of the insurance consumers of this state.

(b) Notwithstanding Subsection (a), a person is not required to

hold a general property and casualty license to engage in an activity described by Subsection (a) if the person:

(1) holds a license under this chapter as a personal lines property and casualty agent; and

(2) limits activities described by Subsection (a) to those activities authorized under the scope of the person's license.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 548 (S.B. 1263), Sec. 2.24, eff. September 1, 2007.

Acts 2021, 87th Leg., R.S., Ch. 355 (H.B. 4030), Sec. 17, eff. September 1, 2021.

Sec. 4051.052. AUTHORITY TO WRITE ADDITIONAL LINES. A person who holds a general property and casualty license may, in addition, write the kinds of insurance contracts described by:

(1) Section 4051.101 and Subchapter E; or

(2) Chapter 4055.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4051.053. AUTHORITY TO WRITE CERTAIN ACCIDENT AND HEALTH INSURANCE. A person who holds a general property and casualty license may, without holding a license under Chapter 4054, write health and accident insurance for a property and casualty insurer authorized to sell those insurance products in this state.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4051.054. DECEASED, DISABLED, OR INSOLVENT AGENTS; EMERGENCY LICENSE. (a) If a property and casualty agent dies, becomes disabled, or is found to be insolvent and unable to pay for premiums as they become due to an insurer, the department may issue, without examination, to an applicant for a property and casualty agent license an emergency license on receipt of proof satisfactory to the department that the emergency license is necessary to preserve the agency assets of the deceased, disabled, or insolvent agent.

(b) An emergency license is valid for 90 days in any 12 consecutive months and may be renewed by the department for an additional 90 days during the 12-month period if the other requirements of Subtitle A are satisfied.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

SUBCHAPTER C. LIMITED PROPERTY AND CASUALTY LICENSE

Sec. 4051.101. LICENSE REQUIRED. (a) Except as provided by Section 4051.052, a person is required to hold a limited property and casualty license if the person acts as an agent who writes:

- (1) job protection insurance as defined by Section 962.002;
- (2) exclusively, insurance on growing crops under Subchapter F;
- (3) any form of insurance authorized under Chapter 911 for a farm mutual insurance company;
- (4) exclusively, any form of insurance authorized to be solicited and written in this state that relates to:
 - (A) the ownership, operation, maintenance, or use of a motor vehicle designed for use on the public highways, including a trailer or semitrailer, and the motor vehicle's accessories or equipment; or
 - (B) the ownership, occupancy, maintenance, or use of a manufactured home classified as personal property under Section 2.001, Property Code;
- (5) a prepaid legal services contract under Article 5.13-1 or Chapter 961;
- (6) exclusively, an industrial fire insurance policy:
 - (A) covering dwellings, household goods, and wearing apparel;
 - (B) written on a weekly, monthly, or quarterly basis on a continuous premium payment plan; and
 - (C) written for an insurer exclusively engaged in the business as described by Section 912.310;
- (7) credit insurance, except as otherwise provided by Chapter 4055; or
- (8) any other kind of insurance, if holding a limited property and casualty license to write that kind of insurance is determined necessary by the commissioner for the protection of the

insurance consumers of this state.

(b) Subsection (a)(2) applies to an entity chartered by the federal Farm Credit Administration, as provided by the farm credit system under 12 U.S.C. Section 2001 et seq., as amended.

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

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

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

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

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2J.004, eff. April 1, 2009.

Acts 2011, 82nd Leg., R.S., Ch. 1147 (H.B. 1951), Sec. 11.001, eff. September 1, 2011.

Sec. 4051.102. DESIGNATION OF KINDS OF INSURANCE. A person who holds a limited property and casualty license may write only the kind of insurance designated on the license.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

SUBCHAPTER E. COUNTY MUTUAL AGENT LICENSE

Sec. 4051.201. LICENSE ISSUANCE. The department shall issue a license to an individual applicant to act as an agent for a county mutual insurance company under Chapter 912 on receipt of certification from the company that the applicant has:

(1) completed a course of study and instruction in compliance with this subchapter; and

(2) passed without aid a written examination administered by the company.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4051.202. COURSE. (a) To be eligible to receive a license under this subchapter, an applicant must complete a course of study and instruction offered by the applicable company on motor vehicle insurance and insurance covering dwellings.

(b) The course of study and instruction must:

(1) be at least five hours in duration; and

(2) include instruction on:

(A) the policies to be sold; and

(B) the laws relating to the regulation of insurance in this state.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4051.203. EXAMINATION. (a) The commissioner shall prescribe a uniform examination for applicants that fairly tests knowledge of the information contained in the course provided under Section 4051.202.

(b) The department shall authorize a county mutual insurance company to administer the examination after approval by the department of a complete outline and explanation of the course and the manner of conducting the examination.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4051.204. INVESTIGATION BY DEPARTMENT. The department may investigate as necessary the manner of instruction and the examination administered by a company under this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4051.205. WITHDRAWAL OF COMPANY'S AUTHORITY. The department may withdraw from a county mutual insurance company the authority under this subchapter to offer instruction and administer an examination.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4051.206. APPLICABILITY OF LIMITED LICENSE LAWS. Except as specifically provided by this subchapter, the provisions of this title that apply to the holder of a limited license apply to the holder of a license issued under this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

SUBCHAPTER F. AGRICULTURAL INSURANCE AGENT

Sec. 4051.251. APPOINTMENT OF AGENT. (a) An insurer that holds a valid certificate of authority to engage in the business of insurance in this state and whose authority in this state and each other jurisdiction in which the insurer is authorized to engage in the business of insurance is limited to the business of insuring risks on growing crops may, subject to this subchapter, appoint and act through an agent licensed under Subchapter B, C, or E.

(b) An agent appointed under Subsection (a) may act as an agent for more than one insurer but may act as an agent under this subchapter only with respect to the business of insuring risks on growing crops.

(c) This title applies to the licensing and regulation of an agent appointed under this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4051.252. REQUIREMENTS FOR APPOINTMENT; PROCEDURE. (a) To appoint an agent under this subchapter, an insurer must submit a completed appointment form to the department and pay a nonrefundable fee in an amount set by the department.

(b) The appointment form must be signed by a representative of the insurer.

(c) The department shall approve an appointment unless the department determines that the applicant does not meet the requirements of this title.

(d) The department may waive any examination requirement imposed by this title for a license applicant seeking an appointment under this subchapter who has passed an examination as required by Federal Crop Insurance Corporation guidelines for administering the federal crop insurance program.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4051.253. ACCEPTANCE OF CERTAIN CONTINUING EDUCATION. The department may accept continuing education hours completed under the guidelines of the Federal Crop Insurance Corporation as satisfying the continuing education requirements imposed under this title.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4051.254. RULES. The commissioner may adopt rules necessary to implement this subchapter and to meet the minimum requirements of federal law, including regulations.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

**SUBCHAPTER H. TERMINATION OR SUSPENSION OF AGENT CONTRACTS BY
PROPERTY AND CASUALTY INSURERS**

Sec. 4051.351. APPLICABILITY OF SUBCHAPTER. (a) Except as provided by Subsection (b), this subchapter applies to each contract between an agent and an insurer engaged in the business of property and casualty insurance in this state.

(b) This subchapter does not apply to:

(1) the termination or suspension by an insurer of an agent's contract because of:

(A) insolvency;

(B) abandonment;

(C) gross and wilful misconduct;

(D) failure to pay the insurer money due to the insurer after receipt of a written demand; or

(E) revocation of the agent's license by the department; or

(2) the termination or suspension by an insurer of an agent's contract if the insurance policies and insurance business are owned by the insurer rather than the agent.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4051.352. SUSPENSION OF AGENT'S CONTRACT; OTHER DEFINITIONS. (a) For purposes of this subchapter, "suspension," with regard to an agent's contract, means the temporary cessation of business relations between an insurer and an agent and refusal by the insurer to accept insurance contracts submitted by the agent. The term does not include a situation in which business is suspended immediately after a natural disaster.

(b) The commissioner shall adopt reasonable rules to provide definitions necessary to accomplish the purposes of this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4051.353. NOTICE REQUIRED BEFORE TERMINATION OR SUSPENSION OF CONTRACT. (a) An insurer may not terminate or suspend a contract with an appointed agent that has been in effect for at least two years unless the insurer provides written notice of the termination or suspension to the agent at least six months before the date the termination or suspension takes effect.

(b) A contract that replaces or revises a contract that has been in effect for at least two years is subject to this subchapter if there has not been a material change in the ownership of the agency.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4051.354. AUTOMATIC TERMINATION OF CONTRACT ON WITHDRAWAL FROM STATE OR REDUCTION OF BUSINESS. (a) An insurer that withdraws from this state or reduces the insurer's total annual premium volume by at least 75 percent in any year is considered to have terminated the contracts of the insurer's agents. Except as provided by Subsection (b), the insurer shall comply with the requirements of this subchapter.

(b) An insurer described by Subsection (a) shall renew each contract for property and casualty insurance for the affected agent for 24 months from the date of the notice of termination or suspension of the contract.

(c) This section does not apply to the transfer of business from an insurer to another insurer with which the agent has a contract and that:

- (1) is under common ownership; and
- (2) is admitted to engage in the business of insurance in this state.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4051.355. RENEWAL OF INSURANCE CONTRACTS AFTER NOTICE OF TERMINATION OR SUSPENSION. (a) Except as provided by Subsection (b), an insurer that terminates or suspends an agent's contract with an appointed agent shall renew all contracts for property and casualty insurance for the agent during the six months after the effective date of the termination or suspension of the contract.

(b) The insurer may decline to renew an insurance contract if any risk does not meet the insurer's current underwriting standards. The insurer must provide at least 60 days' notice to the agent of the insurer's intent not to renew the contract.

(c) An insurer that renews an insurance contract under this section shall pay to the agent commissions for the renewal according to the commission schedule that was in effect for the agent before the insurer's decision to terminate or suspend the agent's contract.

(d) An insurer that renews an insurance contract under this section may not require the agent to convert from agency billing to company billing during the termination period unless the agent agrees in writing to the conversion.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4051.356. INSURER REFUSAL TO RENEW AGENT'S BUSINESS PROHIBITED. During the term of the agent's contract, the insurer may not refuse to renew business from the agent that complies with the underwriting standards in effect for agents of the insurer whose contracts have not been terminated or suspended.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4051.357. INSURER APPROVAL FOR NEW BUSINESS OR INCREASE IN LIABILITY. An agent who receives notice of termination or suspension of the agent's contract from an insurer may not write, without the

written approval of the insurer:

- (1) any new business; or
- (2) any increase in liability on a renewal policy or an existing policy.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4051.358. PROVISION OF UNDERWRITING STANDARDS TO AGENT WHOSE CONTRACT IS TERMINATED OR SUSPENDED. (a) On providing notice to an agent of termination or suspension of the agent's contract under this subchapter, the insurer shall provide to the agent the insurer's written underwriting standards. The standards must conform to the underwriting standards that were in effect for that agent before the insurer's decision to terminate or suspend the agent's contract.

(b) An insurer may provide different underwriting standards to different agents of the insurer if the standards are not used in a way that prevents or discourages the renewal of the insurance policies of an agent whose contract is terminated or suspended.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4051.359. PAYMENT OF MONEY DUE INSURER. An insurer shall allow an agent whose contract has been terminated or suspended under this subchapter to pay to the insurer all money due under the same accounts current payment terms in effect for agents of the insurer whose contracts have not been terminated or suspended.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4051.360. REVISION OF TERMINATION PROVISIONS OF AGENT'S CONTRACT. (a) This subchapter does not prohibit an amendment of or addendum to an agent's contract providing that the contract may be terminated before the time required by this subchapter if the agent agrees in writing to the earlier termination.

(b) An insurer that proposes to revise the termination provisions of an agent's contract must first present the agent with a separate written impact statement that summarizes any effect that the

proposed amendment or addendum would have on the agent's rights under this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4051.361. ADMINISTRATIVE PENALTY. If the department determines that an insurer has violated this subchapter, the insurer is subject to an administrative penalty as provided by Chapter 84 of not less than \$1,000 or more than \$10,000.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4051.362. ACTION FOR DAMAGES. An agent who has sustained actual damages as a result of an insurer's violation of this subchapter may bring an action against the insurer regardless of whether the department has determined that there has been a violation of this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

SUBCHAPTER I. PERSONAL LINES PROPERTY AND CASUALTY AGENT

Sec. 4051.401. PERSONAL LINES PROPERTY AND CASUALTY LICENSE; LICENSE REQUIRED. A person is required to hold a personal lines property and casualty license if the person acts as an agent who writes property and casualty insurance sold to individuals and families primarily for personal or household use for an insurer authorized to engage in the business of property and casualty insurance in this state.

Added by Acts 2007, 80th Leg., R.S., Ch. 548 (S.B. [1263](#)), Sec. 1.01, eff. September 1, 2007.

Amended by:

Acts 2021, 87th Leg., R.S., Ch. 355 (H.B. [4030](#)), Sec. 18, eff. September 1, 2021.

Sec. 4051.402. AUTHORITY TO WRITE ADDITIONAL LINES. (a) A person who holds a personal lines property and casualty license may

write the kind of insurance contracts described by:

- (1) this subchapter;
- (2) Subchapters C and E; and
- (3) Chapter 4055.

(b) In addition to any of the insurance contracts described by Subsection (a), a person who holds a personal lines property and casualty license may write accident and health insurance contracts for individuals and families for personal, family, or household purposes for a property and casualty insurer authorized to sell those insurance products in this state.

Added by Acts 2007, 80th Leg., R.S., Ch. 548 (S.B. 1263), Sec. 1.01, eff. September 1, 2007.

Sec. 4051.403. PERSONAL LINES INCLUDED IN GENERAL PROPERTY AND CASUALTY LICENSE. Notwithstanding Section 4051.401, a person who holds a general property and casualty license under Subchapter B may write the kinds of insurance described by this subchapter.

Added by Acts 2007, 80th Leg., R.S., Ch. 548 (S.B. 1263), Sec. 1.01, eff. September 1, 2007.

Sec. 4051.404. FEES. Section 4001.006 applies to all fees collected under this subchapter.

Added by Acts 2007, 80th Leg., R.S., Ch. 548 (S.B. 1263), Sec. 1.01, eff. September 1, 2007.

CHAPTER 4053. MANAGING GENERAL AGENTS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 4053.001. DEFINITIONS. In this chapter:

- (1) "Affiliate" means a person who is classified as an affiliate under Section 823.003(a).
- (2) "Insurer" means an insurance company, carrier, corporation, reciprocal or interinsurance exchange, mutual, association, county mutual insurance company, Lloyd's plan, or other insurance carrier authorized to engage in the business of insurance in this state.

(3) "Managing general agent" means a person, firm, or corporation that has supervisory responsibility for the local agency and field operations of an insurer in this state or that is authorized by an insurer to accept or process on the insurer's behalf insurance policies produced and sold by other agents.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4053.002. EXCEPTION. An agent licensed under Subchapter E, Chapter 981, Subchapters B-E or I, Chapter 4051, or Chapter 4056 is not a managing general agent unless the agent accepts 50 percent or more of the agent's total annual business or does \$500,000 or more of total annual business as measured by premium volume, whichever amount is less, from insurance policies produced and sold by other agents.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 548 (S.B. [1263](#)), Sec. 2.25, eff. September 1, 2007.

Sec. 4053.003. INAPPLICABILITY OF CHAPTER. This chapter does not apply to:

(1) the transaction of the business of life, health, and accident insurance, including variable life insurance and variable annuity contracts;

(2) a full-time salaried employee of an insurer acting for and in connection with the insurance business of the insurer; or

(3) an adjuster or inspector of risks for an insurer.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4053.004. REGULATION OF MANAGING GENERAL AGENTS. This title applies to the licensing and regulation of a person acting as a managing general agent.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4053.005. RULES. The commissioner may adopt reasonable rules for the administration of this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

SUBCHAPTER B. LICENSE REQUIREMENTS

Sec. 4053.051. LICENSE REQUIRED; EXEMPTIONS. (a) Except as provided by Subsection (b), a person, firm, or corporation may not act as a managing general agent unless the person, firm, or corporation holds a license issued under this chapter.

(b) A business corporation is not required to hold a license issued under this chapter to act as a managing general agent if:

(1) the corporation is authorized to engage in business in this state;

(2) all of the corporation's outstanding stock is solely owned by an insurer authorized to engage in business in this state and the corporation's business affairs are completely controlled by that insurer;

(3) the principal purpose for which the corporation exists is to facilitate the accumulation of commissions from the insurer and its subsidiaries and affiliates for the account of and payment to an agent who could otherwise lawfully receive the commissions directly from the insurer and its subsidiaries and affiliates; and

(4) the corporation does not engage in any other act of a managing general agent as provided by this chapter.

(c) Notwithstanding Subsection (b), the managing general agent shall execute on the insurer's behalf a contract entered into with an agent.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4053.053. SINGLE LICENSE REQUIRED. A license issued under this chapter entitles the license holder to represent or act for one or more insurers as a managing general agent. The license holder is not required to hold a separate license for each insurer the license holder represents.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4053.054. NOTICE AND APPROVAL OF APPOINTMENT. (a) Each appointment to act as a managing general agent shall be reported to the commissioner on a form prescribed by the commissioner.

(b) The form must include:

- (1) the details required by rules adopted under this chapter;
- (2) the insurer's name and identifying number;
- (3) the managing general agent's name and address;
- (4) a statement by an officer of the insurer that the officer or the officer's agent has personal knowledge that the managing general agent has had experience or instruction that qualifies the agent to act as a managing general agent;
- (5) a statement of whether the managing general agent may exercise claim settlement authority for the insurer and, if so:
 - (A) whether that authority exceeds \$25,000 on any one claim; and
 - (B) whether that authority includes third-party liability other than property damage; and
- (6) a statement of whether funds exceeding \$100,000 are customarily held by the managing general agent to pay losses and loss adjustment expenses for the insurer.

(c) For each additional appointment for which a managing general agent applies, the agent shall pay a nonrefundable fee in an amount not to exceed \$16 as determined by the department.

(d) If approval of an additional appointment is not received from the commissioner before the eighth day after the date the commissioner receives the completed application and fee, the managing general agent and insurer may assume, in the absence of notice of disapproval from the commissioner, that the commissioner approves the application and the managing general agent may act for the insurer.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4053.055. LAPSE OF LICENSE. If a license holder is not appointed or under appointment to represent an insurer at the time the license is subject to renewal, the license lapses and the commissioner shall deny the renewal application.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

SUBCHAPTER C. POWERS AND DUTIES OF MANAGING GENERAL AGENTS

Sec. 4053.101. GENERAL POWERS AND DUTIES. A managing general agent acting for an insurer may:

- (1) receive and pass on daily reports and monthly accounts;
- (2) receive and be responsible for agency balances;
- (3) handle the adjustment of losses; or
- (4) appoint or direct general property and casualty agents and personal lines property and casualty agents in this state.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 548 (S.B. 1263), Sec. 2.26, eff. September 1, 2007.

Sec. 4053.102. CONTRACTS. (a) An insurer may not accept business from a managing general agent and the agent may not place business with the insurer without a written contract that addresses:

- (1) the responsibilities of each party;
- (2) cancellation or termination;
- (3) reports, records, and auditing; and
- (4) if applicable:
 - (A) premium volume limits;
 - (B) appointment or cancellation of agents;
 - (C) claims settlement;
 - (D) underwriting; and
 - (E) reinsurance.

(b) The commissioner may adopt rules establishing requirements for a contract with a managing general agent.

(c) A contract with a managing general agent and a report or record submitted under that contract are subject to review by the department under Section 38.001.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4053.103. ACCOUNT REPORT. (a) At least once each calendar quarter, a managing general agent shall submit an account report to each insurer with whom the agent has a contract.

(b) The account report must include, as applicable, a statement of:

- (1) written, earned, and unearned premiums;
- (2) losses and loss expenses paid and outstanding;
- (3) losses incurred but not reported; and
- (4) management fees.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4053.104. SEPARATE RECORDS. (a) For each insurer with which a managing general agent has a contract, the agent shall maintain separate records of the business handled by the agent for the insurer.

(b) The managing general agent shall make a record required under Subsection (a) available for inspection by:

- (1) each insurer; and
- (2) the department's examiners.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4053.105. ESCROW ACCOUNT. (a) A managing general agent shall maintain an escrow account in a bank that:

- (1) is a member of the Federal Reserve System; and
- (2) has its accounts insured by the Federal Deposit

Insurance Corporation.

(b) On receipt, the managing general agent shall deposit in the escrow account all money collected for each insurer with which the agent has a contract.

(c) Except as provided by the contract required by Section 4053.102, a managing general agent may not use, take as an offset, or convert money that is or should have been deposited in the escrow account.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4053.106. FIDUCIARY CAPACITY. A managing general agent holds money on behalf of an insured or insurer in a fiduciary capacity and shall properly account for that money as required by law, department rules, and a contract with an insurer. The department's examiners may audit money held in a fiduciary capacity.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4053.107. FINANCIAL EXAMINATION. (a) As the commissioner considers necessary, a managing general agent shall submit to an examination of the agent's financial condition and the agent's compliance with the laws of this state affecting the conduct of the agent's business.

(b) The examination may be conducted by:

- (1) the commissioner;
- (2) one or more commissioned examiners; or
- (3) a certified public accountant or other person or firm qualified to perform those examinations.

(c) The managing general agent shall pay the examination expenses in an amount the commissioner certifies as just and reasonable.

(d) A person with whom another state contracts to perform any examination initiated by the other state of a managing general agent licensed under this chapter shall register with and provide the following information to the department's chief examiner:

- (1) the person's name;
- (2) if the person is not an individual, the identity of each examiner or other person who will perform any part of the examination;
- (3) the name of the state that contracted with the person;
- (4) the identity of the managing general agent to be examined;
- (5) a description of each issue that the person has been contracted to examine;
- (6) an estimate of the examination costs to be charged to the managing general agent to be examined;
- (7) a copy of any contract between the person and the state regulatory body that initiated the examination and the letter authorizing the examination; and
- (8) a list of the previous examinations conducted on the same managing general agent on behalf of any state within the last three years.

(d-1) On accepting a person's registration under Subsection (d), the department shall send written confirmation of the acceptance to:

- (1) the person;
- (2) the managing general agent to be examined; and
- (3) the state regulatory body that initiated the examination.

(e) It is a violation of this code for a person to accept compensation from multiple states for the same examination, if doing so results in duplicative costs to the managing general agent being examined. It is not a violation of this code for:

- (1) an examiner to conduct an examination of a managing general agent for the benefit of multiple states in a coordinated examination; and

- (2) the examiner to accept compensation from the states participating in the coordinated examination to reduce the examination costs to the managing general agent being examined.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.
Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1030 (H.B. [4359](#)), Sec. 3, eff. June 19, 2009.

Acts 2011, 82nd Leg., R.S., Ch. 185 (S.B. [1229](#)), Sec. 3, eff. May 28, 2011.

Sec. 4053.108. REQUIRED NOTICES TO DEPARTMENT. (a) On forms prescribed by the department, a managing general agent shall notify the department not later than the 30th day after the date any of the following occurs:

- (1) balances due to an insurer for more than 90 days exceed:

- (A) \$1 million; or

- (B) 10 percent of the insurer's policyholder surplus, as reported in the annual statement filed with the department;

- (2) balances due for more than 60 days from a property and casualty agent or managing general agent appointed by or reporting to the managing general agent exceed \$500,000;

- (3) authority to settle claims for an insurer is withdrawn;

- (4) money held for an insurer for losses is greater than an amount that is \$100,000 more than the amount necessary to pay the losses and loss adjustment expenses expected to be paid on the insurer's behalf within the next 60-day period; or

(5) the contract required under Section 4053.102 is canceled or terminated.

(b) Notwithstanding the time limitation imposed by Subsection (a), the requirement to file under Subsections (a)(1), (2), and (4) may be met with a single annual report if:

(1) the managing general agent routinely operates above the limits established by those subsections; and

(2) the department verifies that fact in accordance with rules adopted by the commissioner.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4053.109. REINSURANCE. (a) A managing general agent may not knowingly cede, arrange, facilitate, or bind an insurer to reinsurance.

(b) Notwithstanding Subsection (a), a managing general agent may bind a facultative reinsurance contract in accordance with an obligatory facultative agreement if the contract with the insurer contains reinsurance underwriting guidelines including, for both assumed and ceded reinsurance:

(1) a list of reinsurers with whom the automatic agreements are in effect;

(2) the coverages and amounts or percentages that may be reinsured; and

(3) commission schedules.

(c) A managing general agent may not commit an insurer to participate in insurance or reinsurance syndicates.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4053.110. REDEMPTION OF CORPORATE SHARES. A corporation acting as a managing general agent may redeem the shares of a shareholder or a deceased shareholder:

(1) on terms agreed on by the board of directors and the shareholder or the shareholder's personal representative; or

(2) at a price and on terms provided in the articles of incorporation, the bylaws, or an existing contract entered into between the shareholders.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

SUBCHAPTER D. ENFORCEMENT

Sec. 4053.151. DISCIPLINARY ACTION. A person, firm, or corporation that violates this chapter or a rule or order adopted under this title, including this chapter, is subject to:

- (1) Subchapters B and C, Chapter 4005; and
- (2) Chapter 82.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4053.152. GUARANTY FUND REIMBURSEMENT. (a) If a court finds by a final nonappealable judgment that a violation of this chapter by a managing general agent contributes materially to the insolvency of an insurer under which the agent held an appointment, the agent shall reimburse the appropriate guaranty fund for money paid to cover losses of the insolvent insurer in an amount equal to all payments made from that guaranty fund in excess of:

- (1) gross earned premiums and investment income earned on those premiums; and
- (2) loss reserves for that business.

(b) The reimbursement made under this section shall be used for losses, loss adjustments, and administrative expenses on business placed by the managing general agent.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

CHAPTER 4054. LIFE, ACCIDENT, AND HEALTH AGENTS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 4054.001. APPLICABILITY OF CHAPTER. (a) This chapter applies to each agent of an insurer authorized to provide life, accident, and health insurance coverage in this state.

(b) This chapter applies to each person who:

- (1) performs the acts of an agent, as described by Section 4001.051, whether through an oral, written, electronic, or other form of communication by soliciting, negotiating, procuring, or collecting a premium on an insurance or annuity contract offered by any type of insurer authorized to engage in the business of life, accident, and

health insurance in this state; or

(2) represents or purports to represent a health maintenance organization in soliciting, negotiating, procuring, or effecting membership in the health maintenance organization.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

SUBCHAPTER B. GENERAL LIFE, ACCIDENT, AND HEALTH LICENSE

Sec. 4054.051. LICENSE REQUIRED. Except as provided by Subchapter G, a person is required to hold a general life, accident, and health license if the person acts as:

(1) an agent who represents a health maintenance organization;

(2) an industrial life insurance agent for an insurer that writes only weekly premium life insurance on a debit basis under Chapter 1151;

(3) an agent who writes life, accident, and health insurance for a life insurance company;

(4) an agent who writes only accident and health insurance;

(5) an agent who writes fixed or variable annuity contracts or variable life contracts;

(6) an agent who writes for a stipulated premium company:

(A) only life insurance in excess of \$25,000 on any one life;

(B) only accident and health insurance; or

(C) both kinds of insurance described by Paragraphs (A) and (B);

(7) an agent who writes life, accident, and health insurance for any type of authorized life insurance company that is domiciled in this state, including a legal reserve life insurance company, and who represents the company:

(A) in a foreign country or territory; and

(B) on a United States military installation or with United States military personnel;

(8) an agent who writes life, accident, and health insurance for a fraternal benefit society except as provided by Section 885.352; or

(9) an agent who writes any other kind of insurance as required by the commissioner for the protection of the insurance

consumers of this state.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 548 (S.B. 1263), Sec. 2.27, eff. September 1, 2007.

Acts 2009, 81st Leg., R.S., Ch. 1309 (H.B. 2570), Sec. 7, eff. September 1, 2009.

Sec. 4054.052. COMBINATION LIFE INSURANCE AGENT. (a) In this section, a "combination company" means an insurer that writes weekly premium life insurance or monthly ordinary life insurance on a debit basis.

(b) A person may not act as a combination life insurance agent for a combination company unless the person holds a general life, accident, and health license or a life agent license.

(c) A combination company and a combination life insurance agent may also write ordinary life insurance contracts.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 548 (S.B. 1263), Sec. 2.28, eff. September 1, 2007.

Sec. 4054.053. AUTHORITY TO WRITE ADDITIONAL LINES. A person who holds a general life, accident, and health license may, without obtaining an additional license, write the kinds of insurance contracts described by:

- (1) Subchapter C, D, or E; or
- (2) Chapter 4055.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

SUBCHAPTER C. LIMITED LIFE, ACCIDENT, AND HEALTH LICENSE

Sec. 4054.101. LICENSE REQUIRED. Except as provided by Section 4054.053, an agent is required to hold a limited life, accident, and health license if the agent writes:

- (1) a policy or rider to a policy that provides only:

(A) lump-sum cash benefits in the event of accidental death or dismemberment; or

(B) ambulance expense benefits in the event of accident or sickness;

(2) a prepaid legal services contract under Article 5.13-1 or Chapter 961;

(3) credit insurance, except as otherwise provided by Chapter 4055; or

(4) any other kind of insurance, if holding a limited life, accident, and health license to write that kind of insurance is determined necessary by the commissioner for the protection of the insurance consumers of this state.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4054.102. DESIGNATION OF KINDS OF INSURANCE. A person who holds a limited life, accident, and health license may write only the kind of insurance designated on the license.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4054.103. TEMPORARY LICENSE. An applicant for a limited life, accident, and health license is eligible for a temporary license under Subchapter D, Chapter 4001.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

SUBCHAPTER D. FUNERAL PREARRANGEMENT LIFE INSURANCE LICENSE

Sec. 4054.151. FUNERAL PREARRANGEMENT LIFE INSURANCE AGENT. A funeral prearrangement life insurance agent is a life insurance agent who, subject to the limitations of this subchapter, writes only life insurance policies and fixed annuity contracts to secure the delivery of funeral services and merchandise under prepaid funeral contracts regulated by the Texas Department of Banking under Chapter 154, Finance Code.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4054.152. LICENSE ISSUANCE. The department shall issue a license to an individual applicant to act as a funeral prearrangement life insurance agent on receipt of certification from an insurer authorized to write life insurance policies and fixed annuity contracts in this state that the applicant has:

- (1) completed a course of study and instruction in compliance with this subchapter; and
- (2) passed without aid a written examination administered by the insurer.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4054.153. COURSE. (a) To be eligible to receive a license under this subchapter, an applicant must complete a course of study and instruction offered by an insurer under this section on life insurance policies and fixed annuity contracts.

(b) The course of study and instruction must:

- (1) be at least five hours in duration; and
- (2) include instruction on:
 - (A) the life insurance policies and fixed annuity contracts to be sold; and
 - (B) the laws relating to funeral prearrangement.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4054.154. EXAMINATION. (a) The commissioner shall prescribe a uniform examination for applicants that fairly tests knowledge of the information contained in the course under Section 4054.153.

(b) The department shall authorize an insurer to administer the examination as provided by this section after approval by the department of a complete outline and explanation of the course and the manner of conducting the examination.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4054.155. INVESTIGATION BY DEPARTMENT. The department may investigate as necessary the manner of instruction and the

examination administered by an insurer under this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4054.156. WITHDRAWAL OF INSURER'S AUTHORITY. The department may withdraw from an insurer the authority under this subchapter to offer instruction and administer an examination.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4054.157. LIMIT ON AGENT'S AUTHORITY. Except as provided by Section 154.2021, Finance Code, a funeral prearrangement life insurance agent licensed under this subchapter may not write any coverage or combination of coverages with an initial guaranteed death benefit on any life that exceeds the total cost of the prepaid funeral benefits purchased under the prepaid funeral contract.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 615 (S.B. 579), Sec. 1, eff. September 1, 2011.

Sec. 4054.158. REVOCATION; NOTIFICATION. (a) A license issued under this subchapter to act as an agent for an insurer is revoked if the license holder ceases to act as an agent for the insurer.

(b) Not later than the 15th day after the date on which the license holder ceases to act as an agent for an insurer, the insurer or agent shall send written notification to the department.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4054.159. CONTINUING EDUCATION EXEMPTION. (a) Notwithstanding any other provision of this code, a funeral home employee or other person who holds a funeral prearrangement life insurance agent license and who writes only life insurance policies and fixed annuity contracts to secure the delivery of funeral

services and merchandise under prepaid funeral contracts regulated by the Texas Department of Banking under Chapter 154, Finance Code, is not required to comply with any continuing education requirements to maintain the license, except that the appointing insurer must educate its appointed agents about any new products sold by the agent to fund prepaid funeral contracts.

(b) A license holder to whom this section applies may be appointed by more than one insurer.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4054.160. APPLICABILITY OF LIMITED LICENSE LAWS. Except as specifically provided by this subchapter, the provisions of this title that apply to the holder of a limited license apply to the holder of a license issued under this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

**SUBCHAPTER E. LIFE INSURANCE NOT
EXCEEDING \$25,000**

Sec. 4054.201. LICENSE ISSUANCE; EXCEPTION. (a) The department shall issue a license to an individual applicant to act as an agent who writes only life insurance policies in an amount that does not exceed \$25,000 on any one life on receipt of certification from a stipulated premium company, a statewide mutual assessment company, a local mutual aid association, or a local mutual burial association, that the applicant has:

- (1) completed a course of study and instruction in compliance with this subchapter; and
- (2) passed without aid a written examination administered by the insurer.

(b) A license is not required under this subchapter for an agent who, in the preceding calendar year, wrote policies that generated, in the aggregate, less than \$20,000 in direct premium.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1309 (H.B. [2570](#)), Sec. 9, eff. September 1, 2009.

Sec. 4054.202. COURSE. (a) To be eligible to receive a license under this subchapter, an applicant must complete a course of study and instruction offered by an insurer under this section on life insurance and fixed annuities.

(b) The course of study and instruction must:

(1) be at least five hours in duration; and

(2) include instruction on:

(A) the policies to be sold; and

(B) the laws relating to the regulation of insurance in this state.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4054.203. EXAMINATION. (a) The commissioner shall prescribe a uniform examination for applicants that fairly tests knowledge of the information contained in the course provided under Section 4054.202.

(b) The department shall authorize an insurer described by Section 4054.201 to administer the examination as provided by this section after approval by the department of a complete outline and explanation of the course and the manner of conducting the examination.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4054.204. INVESTIGATION BY DEPARTMENT. The department may investigate as necessary the manner of instruction and the examination administered by an insurer under this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4054.205. WITHDRAWAL OF INSURER'S AUTHORITY. The department may withdraw from an insurer the authority under this subchapter to offer instruction and administer an examination.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4054.206. LIMIT ON AGENT'S AUTHORITY. An insurance agent licensed under this subchapter may not write any coverage or combination of coverages with an initial guaranteed death benefit that exceeds \$25,000 on any life.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.
Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1309 (H.B. 2570), Sec. 10, eff. September 1, 2009.

Sec. 4054.207. CONTINUING EDUCATION EXEMPTION. (a)
Notwithstanding any other provision of this code, a person who holds a license under this subchapter and who writes only life insurance policies and fixed annuity contracts to secure the delivery of funeral services and merchandise under prepaid funeral contracts regulated by the Texas Department of Banking under Chapter 154, Finance Code, is not required to comply with any continuing education requirements to maintain the license, except that the appointing insurer must educate its appointed agents about any new products sold by the agent to fund prepaid funeral contracts.

(b) A license holder to whom this section applies may be appointed by more than one insurer.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4054.208. APPLICABILITY OF LIMITED LICENSE LAWS. Except as specifically provided by this subchapter, the provisions of this title that apply to the holder of a limited license apply to the holder of a license issued under this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

**SUBCHAPTER F. RENEWAL OR SERVICE COMMISSIONS TO AGENTS OF LIFE
INSURANCE COMPANIES DISCONTINUING BUSINESS IN STATE**

Sec. 4054.251. INSURANCE COMPANY LIABILITY FOR PAYMENT OF COMMISSIONS. A life insurance company that discontinues the business

of issuing life insurance policies on the lives of residents of this state remains liable for the payment of renewal or service commissions on life insurance policies previously written by the company under the terms of the company's contracts previously made with agents residing in this state.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4054.252. MONTHLY AND QUARTERLY STATEMENTS. (a) A life insurance company shall provide to each agent who may be entitled to receive renewal or service commissions from the company under Section 4054.251:

(1) a monthly statement that shows the policies written by the agent for the company that terminated during the month for which the statement is made; and

(2) at least quarterly, a detailed statement of all policies written by the agent for the company on the lives of residents of this state that shows:

(A) the policies in force; and

(B) the policies that have terminated, with the reason for the termination.

(b) A life insurance company is not required to provide an agent with a statement under this section after the expiration of the period during which renewal or service commissions are payable as to all of the policies written by the agent for the company.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4054.253. PRESUMPTION IN LAWSUIT. In a suit against a life insurance company for the recovery of a renewal or service commission under this subchapter, a presumption exists that each policy written by the company on the life of a resident of this state by the agent bringing the suit continues in effect unless the defendant proves the contrary by competent evidence.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

SUBCHAPTER G. LIFE AGENT

Sec. 4054.301. LICENSE REQUIRED. (a) Except as provided by Subsection (b), a person is required to hold a life agent license if the person does not hold a general life, accident, and health license under Subchapter B and the person acts as:

(1) an agent who writes insurance coverage on human lives, including endowment benefits and annuities, benefits in the event of death or dismemberment by accident, and benefits for disability income;

(2) an industrial life insurance agent for an insurer that writes only weekly premium life insurance on a debit basis under Chapter 1151;

(3) an agent who writes fixed or variable annuity contracts or variable life contracts;

(4) an agent who writes for a stipulated premium company only life insurance in excess of \$25,000 on any one life; or

(5) an agent who writes any other kind of insurance as required by the commissioner for the protection of the insurance consumers of this state.

(b) A person who holds a limited license under Subchapter C and who engages in the business of insurance only within the scope of that license is not required to hold a life agent license. A person who holds a life agent license may write the insurance described by that subchapter.

(c) A person who holds a funeral prearrangement life insurance license under Subchapter D and who engages in the business of insurance only within the scope of that license is not required to hold a life agent license. A person who holds a life agent license may write the insurance described by that subchapter.

(d) A person who holds a license to write life insurance not exceeding \$25,000 under Subchapter E and who engages in the business of insurance only within the scope of that license is not required to hold a life agent license. A person who holds a life agent license may write the insurance described by that subchapter.

(e) This subchapter does not apply to a person who holds a specialty license under Chapter 4055 and who engages in the business of insurance only within the scope of the specialty license.

Added by Acts 2007, 80th Leg., R.S., Ch. 548 (S.B. [1263](#)), Sec. 1.02, eff. September 1, 2007.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1309 (H.B. 2570), Sec. 11, eff. September 1, 2009.

Sec. 4054.302. AUTHORITY TO WRITE SPECIFIED COVERAGES. A person who holds a license under this subchapter may write only insurance described by Sections 4054.301(a)-(d).

Added by Acts 2007, 80th Leg., R.S., Ch. 548 (S.B. 1263), Sec. 1.02, eff. September 1, 2007.

Sec. 4054.303. APPLICABILITY OF CERTAIN REQUIREMENTS. Except as otherwise provided by this code, the provisions of this title that apply to the holder of a general life, accident, and health license apply to the holder of a license issued under this subchapter.

Added by Acts 2007, 80th Leg., R.S., Ch. 548 (S.B. 1263), Sec. 1.02, eff. September 1, 2007.

Sec. 4054.304. FEES. Section 4001.006 applies to all fees collected under this subchapter.

Added by Acts 2007, 80th Leg., R.S., Ch. 548 (S.B. 1263), Sec. 1.02, eff. September 1, 2007.

SUBCHAPTER H. SPECIALTY CERTIFICATION FOR AGENTS SERVING CERTAIN EMPLOYER GROUPS

Sec. 4054.351. CERTIFICATION PROGRAM. The department shall establish a voluntary specialty certification program for individuals who market small employer health benefit plans in accordance with Chapter 1501.

Added by Acts 2009, 81st Leg., R.S., Ch. 1338 (S.B. 79), Sec. 1, eff. September 1, 2009.

Sec. 4054.352. QUALIFICATIONS. (a) To be eligible to receive a specialty certification under this subchapter, an individual must:

(1) hold a general life, accident, and health license under this chapter;

(2) satisfy the requirements of this subchapter; and

(3) submit evidence of completion of training to the department in the manner prescribed by the commissioner.

(b) To maintain a specialty certification under this subchapter, an individual must continue to hold a general life, accident, and health license under this chapter.

Added by Acts 2009, 81st Leg., R.S., Ch. 1338 (S.B. 79), Sec. 1, eff. September 1, 2009.

Sec. 4054.353. INITIAL TRAINING. (a) To be certified under this subchapter, an individual must first complete training in the law, including department rules, applicable to small employer health benefit plans offered under Chapter 1501.

(b) An individual seeking specialty certification under this subchapter must complete a course applicable to small employer health benefit plans under Chapter 1501, as prescribed and approved by the commissioner. Except as provided by Subsection (c), an individual is not eligible for the specialty certification unless, on completion of the course, it is certified to the commissioner as required by the department that the individual has:

(1) completed the course; and

(2) passed an examination testing the individual's knowledge and qualification.

(c) An individual seeking specialty certification under this subchapter is not required to complete the course and examination required by Subsection (b) if the individual demonstrates to the department, in the manner prescribed by the department, that the individual holds a designation as:

(1) a Registered Health Underwriter (RHU);

(2) a Certified Employee Benefit Specialist (CEBS); or

(3) a Registered Employee Benefits Consultant (REBC).

Added by Acts 2009, 81st Leg., R.S., Ch. 1338 (S.B. 79), Sec. 1, eff. September 1, 2009.

Sec. 4054.354. RENEWAL. To renew a specialty certification

under this subchapter, the individual must complete five hours of continuing education applicable to small employer health benefit plans during the two-year certification period.

Added by Acts 2009, 81st Leg., R.S., Ch. 1338 (S.B. 79), Sec. 1, eff. September 1, 2009.

Sec. 4054.355. SATISFACTION OF CONTINUING EDUCATION REQUIREMENTS. Each hour of education completed in accordance with this subchapter to obtain or renew a specialty license may be used to satisfy an hour of a continuing education requirement otherwise applicable to the agent under this title.

Added by Acts 2009, 81st Leg., R.S., Ch. 1338 (S.B. 79), Sec. 1, eff. September 1, 2009.

Sec. 4054.356. OFFER OF SERVICES TO ALL GROUP SIZES. To hold a specialty certification under this subchapter, an individual must agree to market small employer health benefit plans to small employers that satisfy the requirements of Chapter 1501 without regard to the number of employees to be covered under the plan.

Added by Acts 2009, 81st Leg., R.S., Ch. 1338 (S.B. 79), Sec. 1, eff. September 1, 2009.

Sec. 4054.357. ADVERTISING. An individual who holds a specialty certification may advertise, in the manner specified by department rule, that the individual is specially trained to serve small employers.

Added by Acts 2009, 81st Leg., R.S., Ch. 1338 (S.B. 79), Sec. 1, eff. September 1, 2009.

Sec. 4054.358. LIST MAINTAINED BY DEPARTMENT; WEBSITE. The department shall maintain a list of all individuals who hold a specialty certification under this subchapter, together with the business address and phone number of each individual and a general

description of the individual's service area. The department shall publish the list on the department website.

Added by Acts 2009, 81st Leg., R.S., Ch. 1338 (S.B. 79), Sec. 1, eff. September 1, 2009.

Sec. 4054.359. RULES. The commissioner, in accordance with Section 36.001, may adopt rules as necessary to administer this subchapter.

Added by Acts 2009, 81st Leg., R.S., Ch. 1338 (S.B. 79), Sec. 1, eff. September 1, 2009.

CHAPTER 4055. SPECIALTY AGENTS
SUBCHAPTER A. GENERAL PROVISIONS

Sec. 4055.001. DEFINITION. In this chapter, "specialty license holder" means a person who holds a license issued under this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4055.002. APPLICABILITY OF CHAPTER TO CERTAIN AGENTS. (a) A person who holds a general property and casualty license issued under Chapter 4051 or a general life, accident, and health license issued under Chapter 4054 or who holds a substantially equivalent license under this code, as determined by the commissioner, is not required to obtain a specialty license.

(b) A person described by Subsection (a) is subject to the other requirements of this chapter in the solicitation, sale, or delivery of an insurance product that is subject to this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4055.003. RULES. The commissioner may adopt rules necessary to implement this chapter and to meet the minimum requirements of federal law, including regulations.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4055.004. APPLICATION. To obtain a specialty license an applicant must:

(1) submit to the commissioner:

(A) a written application:

(i) signed by the applicant;

(ii) on a form and supplements to the form prescribed by the commissioner; and

(iii) containing the information prescribed by the commissioner;

(B) a certification by an insurer authorized to engage in business in this state:

(i) signed and sworn to by an officer of the insurer;

(ii) stating that the insurer is satisfied that the applicant is trustworthy and competent to act as the insurer's agent for a limited purpose authorized by this chapter; and

(iii) stating that if the specialty license applied for is issued by the department the insurer will appoint the applicant to act as an agent for a kind of insurance that is subject to this chapter; and

(C) a nonrefundable license fee set by the department in an amount necessary to administer this chapter; and

(2) comply with the other requirements of this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4055.005. LICENSE ISSUANCE. The commissioner may issue a specialty license to an applicant who complies with Section 4055.004 and the other requirements of this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4055.006. EXAMINATION AND CONTINUING EDUCATION NOT REQUIRED. (a) An examination is not required for issuance of a specialty license.

(b) A person is not required to comply with continuing education requirements to hold a specialty license.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4055.007. APPOINTMENT AS AGENT BY INSURER. An insurer that appoints an agent under this chapter shall:

- (1) submit a certification of the appointment signed by an officer of the insurer; and
- (2) affirm that the insurer is satisfied that the specialty license holder is trustworthy and competent to act as an agent on behalf of the insurer.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4055.008. GENERAL POWERS AND DUTIES. (a) A specialty license holder may act as an agent for the kinds of insurance that are subject to this chapter for any insurer authorized to engage in the business of those kinds of insurance in this state.

(b) Except as otherwise provided by this chapter, a specialty license holder acting under this chapter shall comply with this title.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4055.009. CERTAIN REPRESENTATIONS PROHIBITED. A specialty license holder may not advertise, represent, or otherwise hold out the license holder or an employee of the license holder as an agent licensed under another chapter unless the entity or individual holds the applicable license.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4055.010. TREATMENT OF CERTAIN PREMIUMS. Notwithstanding any other provision of this title or any rule adopted by the commissioner, a specialty license holder is not required to treat as money received in a fiduciary capacity premiums collected from a consumer who purchases insurance coverage when completing a consumer transaction associated with the coverage if:

- (1) the insurer represented by the license holder has

consented in writing, signed by an officer of the insurer, that premiums are not required to be segregated from money received by the license holder because of the consumer transaction associated with the insurance coverage; and

(2) the charges for insurance coverage are itemized but not billed to the consumer separately from the charges for the associated consumer transaction.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4055.011. AUTHORITY OF EMPLOYEE OF SPECIALTY LICENSE HOLDER. An employee of a specialty license holder may act as an agent with respect to the kinds of insurance the license holder is authorized to offer under this chapter only if the employee:

(1) is trained under Section 4055.012 to act individually on behalf of the license holder;

(2) acts on behalf of and under the supervision of the license holder; and

(3) is not compensated based primarily on the amount of insurance sold by the employee under this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4055.012. TRAINING REQUIRED TO ACT ON BEHALF OF SPECIALTY LICENSE HOLDER. (a) A specialty license holder may not allow an individual to act on the license holder's behalf with respect to a kind of insurance that the license holder is authorized to offer unless the individual has completed an approved training program.

(b) The materials for the training program must be provided to the specialty license holder by an insurer that writes the kind of insurance authorized under the specialty license.

(c) An insurer that provides training program materials under Subsection (b) must submit the training program to the commissioner for approval before the training program is used.

(d) The training program must meet the following minimum standards:

(1) each trainee must receive basic instruction about the kinds of insurance the specialty license holder is authorized to offer for purchase by prospective consumers;

(2) each trainee must be instructed to inform a prospective consumer that, except as may be specifically provided by another law of this state or the United States, the purchase of the kind of insurance offered is not required to complete the associated consumer transaction; and

(3) each trainee must be instructed with respect to the disclosures required to be made to consumers.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4055.013. ASSIGNMENT AND TRANSFER OF COMPENSATION BY CERTAIN AGENTS. A person who is licensed as a general life, accident, and health agent, life insurance agent, general property and casualty agent, or personal lines property and casualty agent or who holds a substantially equivalent license under this code, as determined by the commissioner, and who enters into a contract with an insurer to act as the insurer's agent in soliciting or writing policies or certificates of insurance that are subject to this chapter may assign and transfer to the agent's employer any commission, fee, or other compensation to be paid to the agent under the agent's contract with the insurer only if the sale of the insurance product occurs within the scope of the agent's employment.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 548 (S.B. 1263), Sec. 2.29, eff. September 1, 2007.

Sec. 4055.014. DISCLOSURES REQUIRED BEFORE ISSUANCE OF INSURANCE. Except as provided by Section 4055.105, insurance coverage may not be issued under this chapter unless:

(1) at each location at which sales of the coverage occur, brochures or other written materials are prominently displayed and readily available to a prospective consumer that:

(A) summarize, clearly and correctly, the material terms of the coverage offered to consumers, including the identity of the insurer;

(B) disclose that the coverage offered by the specialty license holder may duplicate coverage already provided by a

consumer's personal auto insurance policy, homeowner's insurance policy, personal liability insurance policy, or another source of coverage;

(C) state that, except as specifically provided by another law of this state or the United States, the purchase by the consumer of the kind of insurance offered is not required to complete the associated consumer transaction;

(D) describe the process for filing a claim for benefits; and

(E) contain any additional information required by the commissioner by rule regarding the price, benefits, exclusions, conditions, or other limitations of the coverage; and

(2) evidence of coverage is provided to each consumer who purchases the coverage.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4055.015. VIOLATION BY SPECIALTY LICENSE HOLDER; PENALTIES. If a specialty license holder violates this title, the commissioner may:

(1) impose any disciplinary action authorized by Subchapter C, Chapter 4005; or

(2) after notice and opportunity for hearing, impose other penalties, including suspending the transaction of insurance at specific locations where a violation of this title has occurred, as the commissioner considers necessary or appropriate to implement the purposes of this title.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

SUBCHAPTER B. RENTAL CAR COMPANY LICENSE

Sec. 4055.051. DEFINITIONS. In this subchapter:

(1) "Rental agreement" means a written agreement that states the terms and conditions governing the use of a vehicle or vehicle equipment provided by a rental car company.

(2) "Rental car company" means a person engaged in the business of providing leased or rented vehicles or vehicle equipment to the public.

(3) "Renter" means a person who obtains the use of a

vehicle or vehicle equipment from a rental car company under the terms of a rental agreement.

(4) "Vehicle" means:

(A) a private passenger motor vehicle, including passenger vans and minivans that are primarily intended for the transport of persons;

(B) a motor home;

(C) a motorcycle;

(D) a trailer with a gross vehicle weight rating of 10,000 pounds or less; or

(E) a truck with a gross vehicle weight rating of 26,000 pounds or less and the operation of which does not require a commercial driver's license.

(5) "Vehicle equipment" means a cartop carrier, tow bar, or tow dolly specifically designed for use with a vehicle.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4055.052. ISSUANCE OF LICENSE. Notwithstanding any other provision of this chapter or this code, the commissioner shall issue a specialty license to a rental car company, or to the franchisee of a rental car company, that complies with this subchapter. The specialty license may be issued only for the limited purposes specified by this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4055.053. AUTHORITY OF RENTAL CAR COMPANY OR FRANCHISEE.

(a) A rental car company or franchisee licensed under this chapter may act as an agent for an authorized insurer only:

(1) in connection with the rental of vehicles or vehicle equipment; and

(2) with respect to:

(A) excess liability insurance that provides coverage in excess of the standard liability limits provided by the rental car company in the rental agreement to the rental car company or franchisee and to renters and other authorized drivers of rental vehicles for liability arising from the negligent operation or use of the rental vehicle or vehicle equipment;

(B) accident and health insurance that provides coverage to renters and other rental vehicle occupants for accidental death or dismemberment and for medical expenses resulting from an accident involving the vehicle or vehicle equipment that occurs during the rental period;

(C) personal effects insurance that provides coverage to renters and other rental vehicle occupants for the loss of or damage to personal effects or household belongings that occurs during the rental period; or

(D) any other coverage the commissioner approves as meaningful and appropriate in connection with the rental of vehicles or vehicle equipment.

(b) A rental car company or franchisee licensed under this chapter may not issue insurance under this subchapter in connection with a rental agreement if the rental period under the agreement exceeds 30 consecutive days.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

SUBCHAPTER C. CREDIT INSURANCE LICENSE

Sec. 4055.101. GENERAL DEFINITIONS. In this subchapter:

(1) "Credit insurance" includes:

(A) credit life insurance;

(B) credit accident and health insurance;

(C) credit property insurance;

(D) credit involuntary unemployment insurance; and

(E) insurance that covers the difference between the actual cash value of a motor vehicle used as security for a loan or lease and the outstanding balance of that loan or lease if loss or damage renders the vehicle an actual or constructive total loss while the debt for which the vehicle serves as security exceeds the actual cash value of the vehicle.

(2) "Credit insurance agent" means a person licensed under this chapter to sell credit insurance as specifically provided by this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4055.102. DEFINITION OF CREDIT PROPERTY INSURANCE. (a)

In this subchapter, "credit property insurance" means insurance that covers personal property:

(1) used as security for a personal or consumer loan; or
 (2) under an installment sales agreement or through a consumer credit transaction that is purchased in connection with or in relation to the personal or consumer loan, installment sale, or consumer credit transaction.

(b) "Credit property insurance" does not include insurance that:

(1) provides theft, collision, liability, property damage, or comprehensive insurance coverage on an automobile, motorized aircraft, motorcycle, truck, truck-tractor, traction engine, or any other self-propelled vehicle or craft that is designed primarily for operation in the air, or on highways, roadways, waterways, or the sea, and the operating equipment of the self-propelled vehicle or craft; or

(2) is necessary because of liability imposed by law for damages arising out of the ownership, operation, maintenance, or use of a vehicle or craft described by Subdivision (1), other than single interest coverage on any vehicle or craft described by Subdivision (1) that insures the interest of the creditor in the same manner as security for a loan.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4055.103. ISSUANCE OF LICENSE. Notwithstanding any other provision of this chapter or this code, the commissioner may issue a specialty license to a retail distributor of goods, an automobile dealer, a bank, a state or federal savings and loan, a state or federal credit union, a finance company, a production credit association, a manufactured home retailer, or a mobile home retailer that complies with this subchapter. The specialty license may be issued only for the limited purposes specified by this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4055.104. AUTHORITY OF CREDIT INSURANCE AGENT. A credit insurance agent appointed by an insurer authorized to engage in the business of insurance under this code may act as the agent for the

insurer in the sale of any kind of credit insurance in the business of which the insurer is authorized to engage, including individual or group credit insurance.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4055.105. EXEMPTION FROM CERTAIN DISCLOSURE REQUIREMENTS. A specialty license holder and the license holder's representative are not required to make the disclosures required by Section 4055.014 as that section relates to the sale or delivery of a credit insurance product that is subject to this subchapter if the license holder or representative complies with all disclosure requirements prescribed by another provision of this code or another law of this state or the United States with regard to the sale or delivery of that product.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

SUBCHAPTER D. TRAVEL INSURANCE

Sec. 4055.151. DEFINITIONS. In this subchapter:

(1) "Offer and disseminate" means to:

(A) provide general information, including the price and a description of the coverage; and

(B) process the application and collect premiums.

(1-a) "Planned trip" means any journey or travel arranged through the services of a travel agency.

(1-b) "Supervising entity" means a travel insurance supervising entity designated by an insurer under Section 4055.1515.

(1-c) "Travel administrator" means a person who directly or indirectly underwrites, collects a charge, collateral, or premium from, or adjusts or settles a claim of, a resident of this state in connection with travel insurance. A person is not a travel administrator if the person's only actions that would otherwise cause the person to be considered a travel administrator include:

(A) the person working for a travel administrator to the extent the person's activities are subject to the supervision and control of the travel administrator;

(B) an insurance agent selling insurance or engaged in administrative and claims-related activities within the scope of the agent's license;

(C) a travel retailer, registered under the license of a supervising entity in accordance with this subchapter, offering and disseminating travel insurance;

(D) an individual adjusting or settling claims in the normal course of the individual's practice or employment as an attorney and who does not collect charges or premiums in connection with insurance coverage; or

(E) a business entity that is affiliated with a licensed insurer acting as a travel administrator for the direct and assumed insurance business of an affiliated insurer.

(2) "Travel agency" means an entity engaged in the business of selling or arranging transportation or accommodations for the public.

(2-b) "Travel retailer" means a business entity that makes, arranges, or offers travel services.

(3) "Traveler" means an individual who seeks the assistance of a travel agency in connection with the planning and purchase of a trip.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.
Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 805 (S.B. [1672](#)), Sec. 2, eff. September 1, 2013.

Acts 2019, 86th Leg., R.S., Ch. 1000 (H.B. [2587](#)), Sec. 2, eff. September 1, 2019.

Sec. 4055.1515. TRAVEL INSURANCE SUPERVISING ENTITY AND TRAVEL ADMINISTRATOR. (a) An insurer authorized to engage in the business of travel insurance in this state may designate a travel insurance supervising entity for purposes of this subchapter. The supervising entity must be:

- (1) a licensed managing general agent;
- (2) a licensed third-party administrator;
- (3) a licensed insurance agent, including a specialty license holder and a person described by Section 4055.002(a); or
- (4) a travel administrator.

(b) Notwithstanding any other provisions of this code, a person may not act or represent the person as a travel administrator for travel insurance unless the person is:

(1) a licensed property and casualty insurance agent;
(2) a licensed managing general agent; or
(3) a third-party administrator engaging in the business of insurance in this state under a certificate of authority.

(c) A travel administrator and a travel administrator's employees are exempt from the licensing requirements under Chapter 4101 with respect to travel insurance.

(d) An insurer is responsible for the acts of a travel administrator administering travel insurance underwritten by the insurer. The insurer must ensure that the travel administrator maintains all books and records relevant to the insurer and makes the books and records available to the department on request of the commissioner.

Added by Acts 2013, 83rd Leg., R.S., Ch. 805 (S.B. 1672), Sec. 3, eff. September 1, 2013.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 1000 (H.B. 2587), Sec. 3, eff. September 1, 2019.

Sec. 4055.152. SPECIALTY LICENSE; LICENSE NOT REQUIRED FOR TRAVEL RETAILER. (a) The commissioner may issue to an applicant under this chapter a specialty license that authorizes the license holder to sell, solicit, or negotiate travel insurance through a licensed insurer.

(b) Notwithstanding any other provision of this chapter or this code, a travel retailer that operates on behalf of and under the license and direction of a supervising entity does not require a license issued under this title, subject to Section 4055.153.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 805 (S.B. 1672), Sec. 4, eff. September 1, 2013.

Sec. 4055.153. AUTHORITY OF TRAVEL RETAILER. A travel retailer may offer and disseminate travel insurance as a service to the retailer's customers on behalf of and under the license and direction of a supervising entity only:

- (1) in connection with the sale or arrangement of transportation, accommodations, or events for travelers; and
- (2) with respect to travel insurance.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.
Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 805 (S.B. 1672), Sec. 4, eff. September 1, 2013.

Acts 2019, 86th Leg., R.S., Ch. 1000 (H.B. 2587), Sec. 3, eff. September 1, 2019.

Sec. 4055.154. TRAVEL INSURANCE GENERALLY. (a) A travel retailer, or the supervising entity, shall provide to a traveler seeking to purchase travel insurance:

- (1) a description of the material terms or the actual terms of the insurance coverage;
- (2) a description of the claims filing process;
- (3) a description of the review and cancellation process for the travel insurance policy; and
- (4) the name and contact information for the insurer and the supervising entity.

(b) Travel insurance coverage may be provided under an individual or group insurance policy or a blanket travel insurance policy, as defined by Section 3504.0001.

Added by Acts 2013, 83rd Leg., R.S., Ch. 805 (S.B. 1672), Sec. 5, eff. September 1, 2013.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 1000 (H.B. 2587), Sec. 3, eff. September 1, 2019.

Sec. 4055.155. DUTIES OF INSURERS AND SUPERVISING ENTITIES.

(a) An insurer must notify the department in the manner prescribed by the commissioner by rule of the designation of a supervising entity described by Subsection (b).

(b) A supervising entity designated by an insurer that provides travel insurance may authorize a travel retailer to offer and disseminate a travel insurance policy on behalf of the supervising entity by establishing a retailer registry.

(c) The registry established under Subsection (b) must be maintained and updated on an ongoing basis in a form prescribed by the commissioner by rule. The registry must include the name, address, and contact information, and federal employer identification number, if any, of each registered travel retailer and an individual contact person at the retailer.

(d) The registry must be submitted to the department on the request of the commissioner.

(e) The supervising entity must certify in a form prescribed by the commissioner by rule that each registered travel retailer is in compliance with 18 U.S.C. Section 1033. The grounds for suspension or revocation and the penalties that apply to a resident insurance agent apply to a supervising entity and travel retailer.

(f) The supervising entity shall designate an individual who is an officer of the entity and a licensed agent as the compliance officer responsible for compliance with insurance laws, rules, and regulations related to travel insurance.

(g) The compliance officer and the officers of the supervising entity that direct or control the travel insurance business of the supervising entity must submit fingerprints as required by the commissioner by rule.

(g-1) The supervising entity shall pay all applicable licensing fees required by state law with respect to travel insurance.

(h) The supervising entity shall provide travel insurance instruction and training to each employee of a registered travel retailer whose duties include offering and disseminating travel insurance. The instruction and training material are subject to review by the commissioner and must include instruction relating to the insurance offered, ethical sales practices, and required disclosures to travelers.

(i) The supervising entity is responsible for the acts of a travel retailer and shall use reasonable means to ensure each registered retailer's compliance with this subchapter.

(j) Any person licensed in a major line of authority, as determined by the commissioner, as an insurance agent may sell, solicit, and negotiate travel insurance. A property and casualty insurance agent is not required to be appointed by an insurer to sell, solicit, or negotiate travel insurance.

Added by Acts 2013, 83rd Leg., R.S., Ch. 805 (S.B. [1672](#)), Sec. 5, eff.

September 1, 2013.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 1000 (H.B. 2587), Sec. 4, eff. September 1, 2019.

Sec. 4055.156. DUTIES OF TRAVEL RETAILERS. (a) A travel retailer offering and disseminating travel insurance under this subchapter shall register with an insurer in a registry established under Section 4055.155.

(b) The travel retailer shall make available to travelers brochures or other written materials that:

(1) provide the name, address, and contact information of the authorized insurer and the supervising entity;

(2) explain that the purchase of travel insurance is not required for the purchase from the travel retailer of any other product or service; and

(3) disclose that the travel retailer is authorized to provide general information about travel insurance, including a description of coverage and the price for coverage, but is not qualified or authorized to provide answers to questions about specific policy terms or to evaluate the adequacy of the traveler's existing insurance coverage.

(c) A travel retailer may not:

(1) evaluate or interpret technical words or phrases used in a travel insurance policy or benefits under or terms of the policy;

(2) evaluate or provide advice related to a traveler's existing insurance coverage; or

(3) advertise or otherwise hold out the travel retailer as a license holder or an insurance expert.

(d) A travel retailer that complies with this subchapter may receive compensation for offering and disseminating travel insurance on behalf of a supervising entity on or after the date the retailer registers with the insurer under this subchapter.

Added by Acts 2013, 83rd Leg., R.S., Ch. 805 (S.B. 1672), Sec. 5, eff. September 1, 2013.

Sec. 4055.157. ENFORCEMENT. A supervising entity and a travel retailer registered with the supervising entity are subject to Chapters 82 and 83 and Subtitle C, Title 5.

Added by Acts 2013, 83rd Leg., R.S., Ch. 805 (S.B. 1672), Sec. 5, eff. September 1, 2013.

Sec. 4055.158. RULEMAKING. The commissioner shall adopt rules necessary to implement this subchapter. Section 2001.0045, Government Code, does not apply to rules adopted under this section.

Added by Acts 2019, 86th Leg., R.S., Ch. 1000 (H.B. 2587), Sec. 5, eff. September 1, 2019.

SUBCHAPTER E. SELF-SERVICE STORAGE FACILITY LICENSE

Sec. 4055.201. DEFINITIONS. In this subchapter:

(1) "Rental agreement" means a written agreement that states the terms governing the use of storage space provided by a self-service storage facility.

(2) "Renter" means a person who obtains the use of storage space from a self-service storage facility under a rental agreement.

(3) "Self-service storage facility" means a person engaged in the business of providing leased or rented storage space to the public.

(4) "Storage space" means a room, unit, locker, or open space offered for rental to the public for temporary storage of personal belongings or light commercial goods.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4055.202. ISSUANCE OF LICENSE. Notwithstanding any other provision of this chapter or this code, the commissioner may issue a specialty license to a self-service storage facility or to the franchisee of a self-service storage facility that complies with this subchapter. The specialty license may be issued only for the limited purposes specified by this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4055.203. AUTHORITY OF SELF-SERVICE STORAGE FACILITY OR FRANCHISEE. A self-service storage facility or franchisee licensed under this chapter may act as an agent for any authorized insurer only:

- (1) in connection with the rental of storage space; and
- (2) with respect to:

(A) hazard insurance coverage provided to a renter for loss of or damage to tangible personal property in storage or in transit during the rental period; or

(B) any other coverage the commissioner approves as meaningful and appropriate in connection with the rental of storage space.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

SUBCHAPTER F. PORTABLE ELECTRONIC VENDOR LICENSE

Sec. 4055.251. DEFINITIONS. In this subchapter:

(1) "Customer" means a person who purchases a portable electronic device or a related service.

(2) "Portable electronic devices" means personal, self-contained, easily carried by an individual, battery-operated electronic communication, viewing, listening, recording, gaming, computing or global positioning devices, including cell or satellite phones, pagers, personal global positioning satellite units, portable computers, portable audio listening, video viewing or recording devices, digital cameras, video camcorders, portable gaming systems, docking stations, automatic answering devices, and other similar devices and their accessories.

(3) "Vendor" means a person or entity engaged in the business of leasing, selling, or providing portable electronic devices or related services to customers.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 121 (H.B. [2569](#)), Sec. 1, eff. September 1, 2009.

Sec. 4055.252. ISSUANCE OF LICENSE; LICENSE FEE. (a)

Notwithstanding any other provision of this chapter or this code, the commissioner may issue a specialty license to a vendor who complies with this subchapter. The specialty license may be issued only for the limited purposes specified by this subchapter.

(b) A specialty license issued to a vendor under this subchapter authorizes the vendor and any employee or authorized representative of the vendor to offer the type of coverage specified in this subchapter at each location at which the vendor engages in business.

(c) The commissioner shall impose an annual license fee for a specialty license issued under this subchapter. The commissioner shall set the license fee in an amount reasonable and necessary to cover the costs of administering this subchapter, not to exceed \$5,000.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.
Amended by:

Acts 2009, 81st Leg., R.S., Ch. 121 (H.B. 2569), Sec. 1, eff. September 1, 2009.

Sec. 4055.253. AUTHORITY OF VENDOR OF PORTABLE ELECTRONIC

DEVICES. (a) A vendor licensed under this subchapter and the vendor's employee and authorized representative may act as an agent for an authorized insurer in connection with the sale and use of portable electronic devices and related services only with respect to:

(1) insurance coverage provided to customers that covers portable electronic devices against one or more of the following:

- (A) loss;
- (B) theft;
- (C) mechanical failure;
- (D) malfunction;
- (E) damage; or
- (F) other applicable perils; or

(2) the provision of any other coverage the commissioner approves as meaningful and appropriate in connection with the use of portable electronic devices or related services.

(b) A vendor licensed under this subchapter may bill a customer

for, and collect from a customer payment for, insurance coverage provided to the customer under this subchapter.

(c) An insurer issuing a policy to a licensed vendor is considered to have received a premium from a vendor's customer enrolled in coverage on the customer's payment of the premium to the vendor.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.
Amended by:

Acts 2009, 81st Leg., R.S., Ch. 121 (H.B. 2569), Sec. 1, eff. September 1, 2009.

Acts 2013, 83rd Leg., R.S., Ch. 1174 (S.B. 839), Sec. 2, eff. September 1, 2013.

Sec. 4055.254. INSURANCE POLICY; REQUIREMENTS. (a) Insurance provided under this subchapter may be issued to a licensed vendor under a master or group policy of personal or commercial inland marine insurance. A customer may be designated as an additional insured or certificate holder under the policy.

(b) A licensed vendor shall provide to each customer designated as an additional insured or certificate holder a coverage form, certificate, or other evidence of coverage in a brochure or separate document.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 121 (H.B. 2569), Sec. 1, eff. September 1, 2009.

Sec. 4055.255. REQUIRED TRAINING. (a) Notwithstanding Section 4055.012, an agent who holds a license issued under Chapter 4051 or a substantially equivalent license issued under this code and who is appointed by the insurer that insures a vendor may:

(1) provide the materials for the training program required under Section 4055.012; and

(2) conduct the applicable training.

(b) An agent described by Subsection (a) shall submit the training program materials for approval as required under Section 4055.012(c).

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 121 (H.B. 2569), Sec. 1, eff. September 1, 2009.

Sec. 4055.256. REQUIRED DISCLOSURES. (a) A licensed vendor must separately itemize on a customer's bill any charge to the customer for insurance coverage provided under this subchapter that is not included in the cost associated with the purchase or lease of the covered portable electronic device or related services.

(b) If insurance coverage provided under this subchapter is included in the cost associated with the purchase or lease of a covered portable electronic device or related services, a licensed vendor shall, at the time of the purchase or lease, clearly and conspicuously disclose the inclusion of that coverage to the customer.

Added by Acts 2013, 83rd Leg., R.S., Ch. 1174 (S.B. 839), Sec. 3, eff. September 1, 2013.

CHAPTER 4056. NONRESIDENT AGENTS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 4056.001. APPLICABILITY OF TITLE. This title applies to licensing of a nonresident agent under this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4056.002. RIGHTS OF LICENSE HOLDERS. Except as otherwise specifically provided by this code, an individual who is not a resident of this state and to whom a license is issued under this chapter has the same rights and privileges as a resident license holder.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4056.003. RECIPROCAL LICENSING AGREEMENTS. The commissioner may enter into an agreement with the appropriate official of another state as necessary to implement reciprocal

licensing of nonresident agents.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4056.005. RULES. The commissioner may adopt rules as necessary to implement this subchapter and Subchapter B and to meet the minimum requirements of federal law, including regulations.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

SUBCHAPTER B. NONRESIDENT AGENT LICENSE

Sec. 4056.051. APPLICATION FOR NONRESIDENT AGENT LICENSE; CRIMINAL HISTORY. (a) To apply for a license to act as a nonresident agent, a person who is not a resident of this state must submit to the department:

(1) an application on a form prescribed by the department;
and

(2) the nonrefundable license application fee.

(b) An applicant who does not hold an insurance agent's license in the applicant's state of residence must, through the law enforcement agency of the state of residence, submit to the department a copy of the applicant's criminal history records. The department shall use the criminal history records to determine the applicant's eligibility for issuance of a license in accordance with this title and other laws of this state.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4056.052. ISSUANCE OF LICENSE TO NONRESIDENT AGENT LICENSED IN OTHER STATE. (a) The department shall issue a license to an applicant under this chapter if:

(1) the applicant holds a license in good standing as an agent in the applicant's state of residence; and

(2) the applicant's state of residence will grant a nonresident agent license on a reciprocal basis to a resident agent of this state.

(b) The department may issue a reciprocal nonresident agent license to an applicant if the authority granted by the license

issued by the applicant's state of residence is generally comparable to the authority granted by a license issued by this state.

(c) A license issued under this section shall be automatically suspended, canceled, or revoked if the licensee's home state suspends, cancels, or revokes the licensee's corresponding resident license.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.
Amended by:

Acts 2021, 87th Leg., R.S., Ch. 355 (H.B. 4030), Sec. 19, eff. September 1, 2021.

Sec. 4056.053. ISSUANCE OF LICENSE TO NONRESIDENT AGENT NOT LICENSED IN OTHER STATE. The department shall issue a license to an applicant under this chapter if the applicant has:

(1) passed the examination for an agent's license required under this title;

(2) met the eligibility requirements for issuance of a license after an examination of the applicant's criminal history records under Section 4056.051(b); and

(3) satisfied the requirements for a license for an individual under this code, including Subchapter C, Chapter 4001.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4056.054. ISSUANCE OF LICENSE TO CORPORATION OR PARTNERSHIP. The department shall issue a license to an applicant under this chapter if the applicant has satisfied the requirements for a license for a corporation or partnership under Subchapter C, Chapter 4001.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4056.055. WAIVER OF REQUIREMENTS FOR NONRESIDENT AGENT LICENSED IN OTHER STATE OR JURISDICTION. The department may waive any license requirement for an applicant who holds a valid license from another state or jurisdiction if:

(1) that state or jurisdiction has license requirements

substantially equivalent to those of this state; or

(2) the waiver is necessary to promote reciprocal licensing of nonresident agents among a majority of the states.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4056.056. RESTRICTIONS ON LINE OF INSURANCE BUSINESS FOR RECIPROCAL NONRESIDENT AGENT LICENSE. A nonresident agent licensed under Section 4056.052 may not act as a nonresident agent for a line of insurance business in this state unless the agent is authorized in the agent's state of residence to act in that state as an agent for that line of insurance business.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4056.057. CONTINUING EDUCATION. (a) The continuing education requirements imposed under Chapter 4004 do not apply to a person who:

(1) holds a license issued under this chapter; and
(2) is in compliance with the continuing education requirements of the person's state of residence.

(b) A person who holds a license issued under this chapter and who does not hold an insurance agent's license in the person's state of residence shall comply with the continuing education requirements imposed under Chapter 4004.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4056.058. SERVICE OF PROCESS. The commissioner is the agent for service of process in the manner provided by Subchapter C, Chapter 804, in a legal proceeding against a nonresident agent who holds a license issued under this chapter if:

(1) the nonresident agent does not appoint or maintain an agent for service in this state;
(2) an agent for service is appointed but cannot with reasonable diligence be found; or
(3) the license of the nonresident agent is revoked.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4056.059. TRANSITION TO RESIDENT AGENT LICENSE. (a) This section applies only to an individual who is a nonresident agent licensed under Section 4056.052 and who has moved from the other state that licensed the individual to this state.

(b) A nonresident agent may apply to the department for a comparable license for residents of this state. An application must include:

(1) a notification of the agent's change of address and contact information; and

(2) fingerprint forms in the format prescribed by the department, which may be electronic.

(c) If a nonresident agent submits a satisfactory application in accordance with Subsection (b), the department shall issue a comparable resident agent license to the agent and cancel the agent's nonresident agent license.

Added by Acts 2015, 84th Leg., R.S., Ch. 1172 (S.B. 876), Sec. 13, eff. September 1, 2015.

Amended by:

Acts 2021, 87th Leg., R.S., Ch. 355 (H.B. 4030), Sec. 20, eff. September 1, 2021.

SUBTITLE C. ADJUSTERS

CHAPTER 4101. INSURANCE ADJUSTERS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 4101.001. DEFINITIONS. (a) In this chapter:

(1) "Adjuster" means a person who:

(A) investigates or adjusts losses on behalf of an insurer as an independent contractor or as an employee of:

(i) an adjustment bureau;

(ii) an association;

(iii) a general property and casualty agent or personal lines property and casualty agent;

(iv) an independent contractor;

(v) an insurer; or

(vi) a managing general agent;

(B) supervises the handling of claims; or

(C) investigates, adjusts, supervises the handling of, or settles workers' compensation claims, including claims arising from services provided through a certified workers' compensation health care network as authorized under Chapter 1305, on behalf of an administrator, as defined by Chapter 4151, or on behalf of an insurance carrier, as defined by Section 401.011, Labor Code.

(2) "Automated claims adjudication system" means a computer program designed for the collection, data entry, calculation, and final resolution of portable consumer electronic insurance claims that a licensed independent adjuster, a licensed agent, an officer of a business entity licensed under this chapter, or a supervised individual uses as described by this chapter.

(3) "Business entity" means a corporation, association, partnership, limited liability company, limited liability partnership, or other legal entity.

(4) "Home state," with respect to an adjuster, means:

(A) the state in which the adjuster maintains the adjuster's principal place of residence or business and is licensed to act as a resident adjuster; or

(B) if the state of the adjuster's principal place of residence or business does not license adjusters for the line of authority sought, a state in which the adjuster is licensed and in good standing and that is designated by the adjuster as the adjuster's home state.

(5) "Person" means an individual or business entity.

(b) For purposes of this chapter, "insurer" includes a self-insured.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 548 (S.B. 1263), Sec. 2.30, eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 1176 (H.B. 472), Sec. 2.04, eff. September 1, 2007.

Acts 2011, 82nd Leg., R.S., Ch. 544 (H.B. 2699), Sec. 1, eff. September 1, 2011.

Sec. 4101.002. GENERAL EXEMPTIONS. (a) This chapter does not

apply to:

- (1) an attorney who:
 - (A) adjusts insurance losses periodically and incidentally to the practice of law; and
 - (B) does not represent that the attorney is an adjuster;
- (2) a salaried employee of an insurer who is not regularly engaged in the adjustment, investigation, or supervision of insurance claims;
- (3) a person employed only to furnish technical assistance to a licensed adjuster, including:
 - (A) an attorney;
 - (B) an engineer;
 - (C) an estimator;
 - (D) a handwriting expert;
 - (E) a photographer; and
 - (F) a private detective;
- (4) an agent or general agent of an authorized insurer who processes an undisputed or uncontested loss for the insurer under a policy issued by the agent or general agent;
- (5) a person who performs clerical duties and does not negotiate with parties to disputed or contested claims;
- (6) a person who handles claims arising under life, accident, and health insurance policies;
- (7) a person:
 - (A) who is employed principally as:
 - (i) a right-of-way agent; or
 - (ii) a right-of-way and claims agent;
 - (B) whose primary responsibility is the acquisition of easements, leases, permits, or other real property rights; and
 - (C) who handles only claims arising out of operations under those easements, leases, permits, or other contracts or contractual obligations;
- (8) an individual who is employed to investigate suspected fraudulent insurance claims but who does not adjust losses or determine claims payments;
- (9) a public insurance adjuster licensed under Chapter 4102;
- (10) an individual who:
 - (A) collects claim information from, or furnishes claim

information to, an insured or claimant and enters data into an automated claims adjudication system; and

(B) is employed by a licensed independent adjuster or its affiliate under circumstances in which no more than 25 individuals performing duties described by Paragraph (A) are supervised by a single licensed independent adjuster or a single licensed agent; or

(11) an individual employed by an insurer or an affiliate of the insurer who adjusts a loss not to exceed \$500, or authorizes a payment on a claim for a loss for which there is a specified coverage limit of \$500 or less, arising from a first-party claim under a property and casualty insurance policy.

(b) A nonresident adjuster is not required to hold a license under this chapter to:

(1) adjust a single loss in this state;

(2) adjust losses arising out of a catastrophe common to all those losses; or

(3) act as a temporary substitute for a licensed adjuster.

(c) For purposes of Subsection (a)(6), claims arising under workers' compensation insurance policies, including claims relating to services provided through a certified workers' compensation health care network authorized under Chapter 1305, do not constitute claims arising under life, accident, or health insurance policies.

(d) A licensed agent acting as a supervisor under Subsection (a)(10) is not required to be licensed as an adjuster.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.
Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.081(a), eff. September 1, 2005.

Acts 2007, 80th Leg., R.S., Ch. 1176 (H.B. 472), Sec. 2.05, eff. September 1, 2007.

Acts 2011, 82nd Leg., R.S., Ch. 544 (H.B. 2699), Sec. 2, eff. September 1, 2011.

Acts 2017, 85th Leg., R.S., Ch. 198 (S.B. 718), Sec. 1, eff. September 1, 2017.

Sec. 4101.003. TEMPORARY EXEMPTION. An individual who is undergoing training as an adjuster under the supervision of a

licensed adjuster may act as an adjuster for a period not to exceed 12 months without having a license issued under this chapter if, at the beginning of the period, the individual has been registered with the commissioner as a trainee.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4101.004. RECIPROCITY. The department may waive any license requirement imposed under this chapter for an applicant who holds a valid license from another state if the state has license requirements substantially equivalent to the requirements for a license issued under this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4101.005. RULES. The commissioner may adopt rules necessary to implement this chapter and to meet the minimum requirements of federal law, including regulations.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

SUBCHAPTER B. LICENSE REQUIREMENTS

Sec. 4101.051. LICENSE REQUIRED. Except as otherwise provided by this chapter, a person may not act as or represent that the person is an adjuster in this state unless the person holds a license under this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4101.052. APPLICATION. (a) An applicant for a license under this chapter must submit to the department an application on a form prescribed and provided by the department, and include as part of or in connection with the application any information that the department reasonably requires, including information about the applicant's:

- (1) identity;
- (2) personal history;

- (3) experience; and
- (4) business record.

(b) The application must be accompanied by the fee required by Section 4101.057.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4101.053. QUALIFICATIONS; ISSUANCE. (a) To qualify for a license under this chapter, an individual must:

- (1) comply with this chapter;
- (2) present evidence satisfactory to the department that the applicant:
 - (A) is at least 18 years of age;
 - (B) resides in this state or a state or country that permits a resident of this state to act as an adjuster in that state or country;
 - (C) has complied with all federal laws relating to employment or the transaction of business in the United States, if the applicant does not reside in the United States;
 - (D) is trustworthy; and
 - (E) has had experience, special education, or training of sufficient duration and extent regarding the handling of loss claims under insurance contracts to make the applicant competent to fulfill the responsibilities of an adjuster; and

(3) pass an examination conducted under this subchapter or present evidence that the applicant has been exempted under Section 4101.056.

(b) The commissioner shall issue a license to an applicant who meets the qualifications prescribed by this section.

(c) To qualify for a license under this chapter, a business entity must:

- (1) comply with this chapter; and
- (2) present evidence satisfactory to the department that the applicant:
 - (A) is eligible to designate this state as its home state;
 - (B) is trustworthy;
 - (C) has designated a licensed adjuster responsible for the business entity's compliance with the insurance laws of this

state;

(D) has not committed an act that is a ground for probation, suspension, revocation, or refusal of an adjuster's license under Section 4101.201; and

(E) has paid the fees prescribed under Section 4101.057.

(d) An individual who is a resident of Canada may not be licensed under this chapter or designate this state as the individual's home state unless the individual has successfully passed the adjuster examination and complied with the other applicable portions of this section, except that the individual is not required to comply with Subsection (a)(2)(B) or (C).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.
Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 544 (H.B. 2699), Sec. 3, eff. September 1, 2011.

Sec. 4101.054. EXAMINATION REQUIRED. (a) To be eligible for a license under this chapter, an applicant must personally take and pass, to the satisfaction of the commissioner, a written examination of the applicant's qualifications and competency.

(b) The department may supplement a written examination under Subsection (a) with an oral examination.

(c) The commissioner shall prescribe each examination under this section. An examination must be of sufficient scope to reasonably test the applicant's knowledge relative to the kinds of insurance that may be dealt with under the license and of:

(1) the duties of a licensed adjuster; and

(2) the laws of this state that apply to a licensed adjuster.

(d) The commissioner may require a reasonable waiting period before an applicant who fails to pass an examination is eligible to be retested on a similar examination.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4101.055. EXAMINATION PROCEDURES. (a) The department shall prepare and make available to applicants instructions

specifying in general terms the subjects that may be covered in an examination required under Section 4101.054.

(b) An examination under this subchapter shall be given at times and locations in this state necessary to reasonably serve the convenience of the department and applicants.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4101.056. EXEMPTION FROM EXAMINATION REQUIREMENT. (a) An applicant for a license under this chapter is not required to pass an examination under Section 4101.054 to receive the license if the applicant:

- (1) had been principally engaged in the investigation, adjustment, or supervision of losses on August 27, 1973, and during the 90-day period preceding that date;
- (2) is applying for a renewal license under this chapter;
- (3) is licensed as an adjuster in another state with which a reciprocal agreement has been entered into by the commissioner; or
- (4) has completed a course in adjusting losses as prescribed and approved by the commissioner and it is certified, by a form signed by a person described by Subsection (b)(2), to the commissioner on completion of the course that the applicant has:
 - (A) completed the course; and
 - (B) passed an examination, in a manner described by Subsection (b)(2), testing the applicant's knowledge and qualification, as prescribed by the commissioner.

(b) An applicant wishing to claim an exemption under Subsection (a)(4) must:

- (1) schedule the required examination; and
- (2) take the required examination in a testing environment that is controlled, supervised, and proctored by a disinterested third party approved by the commissioner to administer the examination.

(c) In this section, "disinterested third party" means an individual who:

- (1) is not related to an applicant by consanguinity or affinity as a first cousin or within the third degree by consanguinity or affinity as described by Subchapter B, Chapter 573, Government Code; and

(2) is not an employee or a subordinate of the applicant.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 433 (S.B. 569), Sec. 1, eff. June 14, 2013.

Sec. 4101.057. FEES. (a) Before issuing or renewing a license under this chapter, the department shall set and collect a nonrefundable license application fee in an amount not to exceed \$50.

(b) An applicant for a renewal license must remit the fee required by Subsection (a) before the expiration of the license being renewed. If the applicant's license has been expired for not more than 90 days, an applicant for a renewal license must remit, in addition to the fee assessed under Subsection (a), a fee equal to one-half of the original application fee.

(c) Before administering an examination under this subchapter, the department shall set and collect a nonrefundable examination fee in an amount not to exceed \$50.

(d) Before issuing a duplicate license requested by an adjuster, the department shall set and collect a duplicate license application fee.

(e) The department shall deposit a fee collected under this chapter to the credit of the Texas Department of Insurance operating account.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1172 (S.B. 876), Sec. 14, eff. September 1, 2015.

Sec. 4101.058. LICENSE FORM. (a) The commissioner shall prescribe the form of a license issued under this chapter.

(b) A license must contain:

- (1) the adjuster's name;
- (2) the address of the adjuster's place of business;
- (3) the date of issuance and the date of expiration of the license; and
- (4) the name of the firm or insurer with whom the adjuster

is employed at the time the license is issued.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4101.059. CONTINUING EDUCATION: GENERAL REQUIREMENTS.

(a) To renew a license under this chapter, a licensed adjuster must participate in a continuing education program under Chapter 4004.

(b) The department may certify continuing education programs.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1172 (S.B. 876), Sec. 15, eff. September 1, 2015.

Sec. 4101.060. CONTINUING EDUCATION: EXEMPTIONS AND WAIVERS.

(a) On written request of a licensed adjuster and if the department determines that the adjuster is unable to comply with continuing education requirements under this subchapter because of illness, medical disability, or another extenuating circumstance beyond the control of the adjuster, the department may:

(1) extend the time for the adjuster to comply with the continuing education requirements; or

(2) exempt the adjuster from any of the requirements for a licensing period.

(b) The commissioner by rule shall establish the criteria for an extension or exemption under Subsection (a).

(c) The department may waive any continuing education requirement imposed under this chapter for a nonresident adjuster who holds a valid license from another state if the state has continuing education requirements substantially equivalent to the requirements for a license issued under this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4101.061. EXPIRATION; RENEWAL. Expiration and renewal of a license issued under this chapter are governed by Sections 4003.001 and 4004.055, rules adopted by the commissioner, and any applicable provision of this code or another insurance law of this state.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.
Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1172 (S.B. 876), Sec. 16, eff.
September 1, 2015.

Sec. 4101.062. ALTERNATIVE CONTINUING EDUCATION: CLAIMS CERTIFICATION. Notwithstanding Section 4004.051, the department shall accept as satisfaction of any continuing education requirement imposed on an adjuster under this chapter or Chapter 4004 a claims certification that the adjuster receives during a license period for which the continuing education is required if:

(1) the claims certification is issued by a national or state claims association with a certification program;

(2) the number of hours required to complete the certification program is not less than the number of hours of continuing education that an adjuster is required to complete during the license period under Sections 4004.053 and 4004.054;

(3) the content of the certification program:

(A) includes the content required under Section 4004.105; and

(B) is made available through an electronic portal maintained by the association for review and audit by the department;

(4) the association is approved by the department as a continuing education provider;

(5) the association reports the adjuster's completion of the certification program to the department through an electronic portal maintained by the department; and

(6) the association, through an electronic portal maintained by the association, provides the department access to the adjuster's transcript showing the adjuster's completion of the certification program.

Added by Acts 2019, 86th Leg., R.S., Ch. 442 (S.B. 1584), Sec. 1, eff. September 1, 2019.

SUBCHAPTER C. SPECIAL LICENSES

Sec. 4101.101. EMERGENCY LICENSE. (a) If a catastrophe or an emergency arises out of a disaster, act of God, riot, civil

commotion, conflagration, or other similar occurrence, the commissioner shall, on application, issue an emergency license to a person if the application is certified to the commissioner not later than the fifth day after the date on which the person begins work as an adjuster by:

(1) a person who holds a license under this chapter; or

(2) an insurer that maintains an office in this state and holds a certificate of authority to engage in the business of insurance in this state.

(b) The person or insurer that certifies an application under Subsection (a) is responsible for the loss or claims practices of the emergency license holder whom the person or insurer certifies.

(c) The commissioner may, after notice and hearing, revoke an emergency license on grounds specified by Section 4101.201.

(d) An emergency license is effective for a period not to exceed 90 days. The commissioner may extend the term of the emergency license for an additional period of 90 days.

(e) The commissioner shall establish a fee for an emergency license in an amount not to exceed \$20. A person issued an emergency license shall remit the fee to the department not later than the 30th day after the date on which the department issues the license.

(f) The commissioner may issue an emergency license to an applicant who meets the requirements of Subsection (a) regardless of whether the applicant is:

(1) a resident of this state; or

(2) an otherwise licensed adjuster.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4101.102. LIMITED LICENSE. (a) If considered necessary by the commissioner, the department may issue a limited license to an applicant in the manner otherwise provided for the issuance of a license under this chapter.

(b) The license shall specifically limit the kinds of insurance that may be handled by the person.

(c) The person may not adjust claims in a kind of insurance other than that for which the adjuster is specifically licensed.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

SUBCHAPTER D. POWERS AND DUTIES OF ADJUSTER

Sec. 4101.151. PLACE OF BUSINESS. (a) A licensed adjuster shall maintain a place of business that is:

- (1) located at the place at which the adjuster principally conducts transactions under the license; and
- (2) accessible to the public.

(b) A licensed adjuster shall promptly notify the commissioner if the adjuster changes the location of the adjuster's place of business.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4101.152. REFERRAL BY INSURER. (a) An insurer may not knowingly refer a claim or loss for adjustment in this state to a person purporting to be or acting as an adjuster unless the person holds a license under this chapter.

(b) Before referring a claim or loss for adjustment, an insurer must ascertain from the commissioner whether the person performing the adjustment holds a license under this chapter. Once the insurer has ascertained that the person holds a license, the insurer may refer the claim or loss to the person and may continue to refer claims or losses to the person until the insurer has knowledge or receives information from the commissioner that the person no longer holds a license.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

SUBCHAPTER E. ENFORCEMENT

Sec. 4101.201. GROUNDS FOR DISCIPLINARY ACTION. (a) The commissioner may discipline an adjuster or deny an application for a license under this chapter under a department rule or any applicable insurance law of this state.

(b) Department rules may specify grounds for discipline that are comparable to grounds for discipline of other license holders under this title.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4101.202. REINSTATEMENT OR REISSUANCE OF LICENSE. The commissioner may not reinstate or reissue the license of a license holder or former license holder whose license has been suspended, revoked, or refused renewal until the commissioner determines that the cause for a suspension, revocation, or refusal of a license issued under this chapter no longer exists.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4101.203. CRIMINAL PENALTY. A person commits an offense if the person violates Section 4101.051 or 4101.102(c). An offense under this section is a misdemeanor punishable by:

- (1) a fine of not more than \$500;
- (2) confinement in the county jail for not more than six months; or
- (3) both the fine and the confinement.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

SUBCHAPTER F. PROHIBITED CONDUCT

Sec. 4101.251. CERTAIN ROOFING-RELATED BUSINESS PROHIBITED.

(a) An insurance adjuster licensed under this chapter may not adjust a loss related to roofing damage on behalf of an insurer if the adjuster is a roofing contractor or otherwise provides roofing services or roofing products for compensation, or is a controlling person in a roofing-related business.

(b) A roofing contractor may not act as an adjuster or advertise to adjust claims for any property for which the contractor is providing or may provide roofing services, regardless of whether the contractor holds a license under this chapter.

(c) The commissioner shall adopt rules necessary to implement and enforce this section.

Added by Acts 2013, 83rd Leg., R.S., Ch. 903 (H.B. [1183](#)), Sec. 1, eff. September 1, 2013.

CHAPTER 4102. PUBLIC INSURANCE ADJUSTERS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 4102.001. DEFINITIONS. In this chapter:

(1) "License holder" means a person licensed under this chapter as a public insurance adjuster.

(2) "Person" includes an individual, firm, company, association, organization, partnership, limited liability company, or corporation.

(3) "Public insurance adjuster" means:

(A) a person who, for direct, indirect, or any other compensation:

(i) acts on behalf of an insured in negotiating for or effecting the settlement of a claim or claims for loss or damage under any policy of insurance covering real or personal property; or

(ii) on behalf of any other public insurance adjuster, investigates, settles, or adjusts or advises or assists an insured with a claim or claims for loss or damage under any policy of insurance covering real or personal property; or

(B) a person who advertises, solicits business, or holds himself or herself out to the public as an adjuster of claims for loss or damage under any policy of insurance covering real or personal property.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.082(a), eff. September 1, 2005.

Sec. 4102.002. GENERAL EXEMPTIONS. This chapter does not apply to:

(1) an officer or employee of the federal or state government or of a political subdivision of the state government while the officer or employee is engaged in the performance of official duties;

(2) an attorney engaged in the performance of the attorney's professional duties;

(3) insurers admitted to do business in the state and agents licensed by this state, engaged in the performance of their duties in connection with insurance transactions;

(4) the legal owner of personal property that has been sold under a conditional sales agreement or a mortgagee under the terms of a chattel mortgage;

(5) a salaried office employee who performs exclusively

clerical or administrative duties attendant to the disposition of the business regulated by this chapter;

(6) a photographer, estimator, appraiser, engineer, or arbitrator employed by a public insurance adjuster exclusively for the purpose of furnishing technical assistance to the licensed public insurance adjuster;

(7) a private investigator licensed under Chapter 1702, Occupations Code, while acting within the scope of that license; or

(8) a full-time salaried employee of a property owner or a property management company retained by a property owner who:

(A) does not hold the employee out as:

(i) a public insurance adjuster; or

(ii) a building, roofing, or other restoration contractor;

(B) has not been hired to handle a specific claim resulting from a fire or casualty loss; and

(C) acts at the sole discretion of the property owner or management company regarding a claim related to the owner's property.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.082(a), eff. September 1, 2005.

Sec. 4102.003. CERTAIN CONSTRUCTION REGARDING PRACTICE OF LAW PROHIBITED. This chapter may not be construed as entitling a person who is not licensed by the Supreme Court of Texas to practice law in this state.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.082(a), eff. September 1, 2005.

Sec. 4102.004. RULES. The commissioner may adopt reasonable and necessary rules to implement this chapter, including rules regarding:

(1) the qualifications of license holders, in addition to those prescribed by this chapter, that are necessary to promote and protect the public interest;

(2) the regulation of the conduct of license holders;

(3) the prescription of fees required by Section 4102.066;

and

(4) the regulation of advertisements under Section 4102.113 and the definition of "advertisement" as the term is used in that section.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.082(a), eff. September 1, 2005.

Sec. 4102.005. CODE OF ETHICS. The commissioner by rule shall adopt:

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

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

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

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.082(a), eff. September 1, 2005.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 1147 (H.B. 1951), Sec. 2.006, eff. September 1, 2011.

Sec. 4102.006. NOTICE TO LAST ADDRESS. Notice by registered mail, return receipt requested, sent to the last known address of an applicant for a license, a license holder, or another person to whom notice is required to be sent under this chapter, as reflected by the records of the department, constitutes sufficient notice under this chapter.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.082(a), eff. September 1, 2005.

Sec. 4102.007. RIGHT TO CONTRACT WITH LICENSE HOLDER. (a) Notwithstanding Sections 4001.002 and 4102.002, this section applies to a commercial or residential property insurance policy issued by an

insurer, including:

- (1) a capital stock insurance company;
- (2) a mutual insurance company;
- (3) a county mutual insurance company;
- (4) a Lloyd's plan;
- (5) a reciprocal or interinsurance exchange;
- (6) a farm mutual insurance company; and
- (7) an eligible surplus lines insurer if this state is the

insured's home state as defined by Section 981.002.

(b) An insurance policy, including any endorsement, to which this section applies may not include a provision that prohibits an insured from contracting with a public insurance adjuster for services provided under this chapter.

(c) An insured is not required to enter into a contract described by Subsection (b).

Added by Acts 2023, 88th Leg., R.S., Ch. 317 (H.B. 1706), Sec. 1, eff. September 1, 2023.

SUBCHAPTER B. LICENSE REQUIREMENTS

Sec. 4102.051. LICENSE REQUIRED; EXEMPTION. (a) A person may not act as a public insurance adjuster in this state or hold himself or herself out to be a public insurance adjuster in this state unless the person holds a license issued by the commissioner under Section 4102.053 or 4102.054.

(b) A license is not required for:

- (1) an attorney licensed to practice law in this state who has complied with Section 4102.053(a)(6); or
- (2) a person licensed as a general property and casualty agent or personal lines property and casualty agent under Chapter 4051 while acting for an insured concerning a loss under a policy issued by that agent.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.082(a), eff. September 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 548 (S.B. 1263), Sec. 2.31, eff. September 1, 2007.

Acts 2015, 84th Leg., R.S., Ch. 1178 (S.B. 1060), Sec. 1, eff. September 1, 2015.

Sec. 4102.052. APPLICATION. (a) An application for a license under this chapter must be on a form prescribed by the commissioner.

(b) The completed application must be notarized and be accompanied by a nonrefundable license application fee, as provided by Section 4102.066, for each application submitted.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.082(a), eff. September 1, 2005.

Sec. 4102.053. ISSUANCE OF LICENSE TO RESIDENT. (a) The commissioner shall issue a public insurance adjuster license to an applicant on determining that the application meets the requirements of this chapter, the license application fee has been paid, and the applicant is an individual who:

(1) is at least 18 years of age;

(2) is a citizen of the United States or has complied with all federal laws pertaining to employment or to the transaction of business in the United States;

(3) is a resident of this state;

(4) is trustworthy and of a moral character that reasonably ensures that the applicant will conduct the business of a public insurance adjuster fairly and in good faith without detriment to the public;

(5) has not been convicted of a felony in the 10 years preceding filing an application under this chapter or, if convicted of a felony in the 10 years preceding filing an application under this chapter, has received a full pardon from that conviction and is otherwise relieved from any disabilities connected with that conviction;

(6) has sufficient experience or training relating to the assessment of:

(A) real and personal property values; and

(B) physical loss of or damage to real or personal property that may be the subject of insurance and claims under insurance;

(7) is sufficiently informed as to the terms and effects of the types of insurance contracts that provide coverage on real and

personal property;

(8) possesses knowledge and experience adequate to enable the applicant to engage in the business of a public insurance adjuster fairly and without injury to the public or any member of the public with whom the applicant may have business as a public insurance adjuster;

(9) has successfully passed the license examination prescribed under Section 4102.057 or is exempt from the examination requirement under this chapter;

(10) has complied with the financial responsibility requirements imposed under Section 4102.105; and

(11) has complied with any other requirements under applicable state law, including provision of a complete set of fingerprints on request, as provided by Section 4001.103.

(b) The commissioner may issue a resident public insurance adjuster license to an applicant who has been convicted of a felony 11 or more years before filing an application under this chapter if the commissioner determines that the applicant is qualified to act as a public insurance adjuster and that the circumstances surrounding the applicant's conviction do not warrant the denial of a license issued under this chapter.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.082(a), eff. September 1, 2005.

Sec. 4102.054. ISSUANCE OF LICENSE TO NONRESIDENT. (a) The commissioner may issue a nonresident license to an applicant for a public insurance adjuster license who is not a permanent resident of this state on determining that the application meets the requirements of this chapter, the nonresident license application fee has been paid, and the applicant is an individual who:

(1) is at least 18 years of age;

(2) except as provided by Section 4102.058, has passed, to the satisfaction of the commissioner, an examination approved by the commissioner and of sufficient scope as prescribed by Section 4102.057;

(3) is self-employed as a public insurance adjuster or associated with or employed by a public insurance adjusting firm or other public insurance adjuster;

(4) is trustworthy and of a moral character that reasonably ensures that the applicant will conduct the business of a public insurance adjuster fairly and in good faith without detriment to the public;

(5) has never been convicted of a felony or, if convicted of a felony, has received a full pardon from that conviction and is otherwise relieved from any disabilities connected with that conviction;

(6) has sufficient experience or training relating to the assessment of:

(A) real and personal property values; and

(B) physical loss of or damage to real or personal property that may be the subject of insurance and claims under insurance;

(7) is sufficiently informed as to the terms and effects of the types of insurance contracts that provide coverage on real and personal property;

(8) possesses knowledge and experience adequate to enable the applicant to engage in the business of a public insurance adjuster fairly and without injury to the public or any member of the public with whom the applicant may have business as a public insurance adjuster;

(9) files proof of financial responsibility in accordance with Section 4102.105; and

(10) complies with any other requirements under applicable state law, including provision of a complete set of fingerprints on request, as provided by Section 4001.103.

(b) Repealed by Acts 2021, 87th Leg., R.S., Ch. 355 (H.B. 4030), Sec. 22(8), eff. September 1, 2021.

(c) Repealed by Acts 2021, 87th Leg., R.S., Ch. 355 (H.B. 4030), Sec. 22(8), eff. September 1, 2021.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.082(a), eff. September 1, 2005.

Amended by:

Acts 2021, 87th Leg., R.S., Ch. 355 (H.B. 4030), Sec. 21, eff. September 1, 2021.

Acts 2021, 87th Leg., R.S., Ch. 355 (H.B. 4030), Sec. 22(8), eff. September 1, 2021.

Sec. 4102.055. ISSUANCE OF LICENSE TO BUSINESS ENTITY ORGANIZED IN THIS STATE. (a) The commissioner shall adopt rules necessary to issue a public insurance adjuster license to a business entity organized under the laws of this state.

(b) Rules adopted by the commissioner under Subsection (a) must:

(1) be analogous to the provisions of Chapter 4001 that relate to licensure of corporations and partnerships; and

(2) contain qualifications for the issuance of a public insurance adjuster license analogous to the qualifications described by Section 4102.053.

(c) The commissioner may not issue a public insurance adjuster license to a business entity described by Subsection (a) unless at least one officer, active partner, or other managing individual of the business entity, and each individual performing acts of a public insurance adjuster on behalf of the business entity in this state, are individually licensed by the department under Section 4102.053 separately from the business entity.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.082(a), eff. September 1, 2005.

Sec. 4102.056. ISSUANCE OF LICENSE TO BUSINESS ENTITY NOT ORGANIZED IN THIS STATE. (a) The commissioner shall adopt rules necessary to issue a public insurance adjuster license to a business entity organized under the laws of another state or the United States.

(b) Rules adopted by the commissioner under Subsection (a) must:

(1) be analogous to the provisions of Chapter 4001 that relate to issuance of licenses to business entities; and

(2) contain:

(A) qualifications for the issuance of a public insurance adjuster license analogous to the qualifications described by Section 4102.054; and

(B) requirements for the performance of the duties and powers of a public insurance adjuster analogous to the requirements described by Section 4102.054.

(c) The department may not issue a public insurance adjuster

license to a business entity described by Subsection (a) unless at least one officer, active partner, or other managing individual of the business entity, and each individual performing acts of a public insurance adjuster on behalf of the business entity in this state, are individually licensed by the department under Section 4102.054 separately from the business entity.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.082(a), eff. September 1, 2005.

Sec. 4102.057. EXAMINATION REQUIRED. (a) Except as otherwise provided by this chapter, each applicant for a license as a public insurance adjuster must, before the issuance of the license, take and pass an examination to the satisfaction of the commissioner.

(b) The examination required by this section must be prescribed by the commissioner and must be of sufficient scope to reasonably test the applicant's:

(1) knowledge of basic insurance theory, essential elements of contracts, and claims ethics;

(2) technical competence in the handling of the types of claims for which the applicant is being tested; and

(3) knowledge of:

(A) Chapter 541;

(B) Subchapters A and B, Chapter 542;

(C) Chapter 547;

(D) the Deceptive Trade Practices-Consumer Protection Act (Subchapter E, Chapter 17, Business & Commerce Code);

(E) analogous laws as specified by the commissioner;

(F) statutory provisions related to the unauthorized practice of law contained in Subchapter G, Chapter 81, Government Code; and

(G) the duties and responsibilities of public insurance adjusters under the law.

(c) The commissioner shall, within a reasonable period not to exceed 30 days after the date of the examination, transmit the results of the examination and the action taken on the application to the applicant.

(d) An examination is not required for the renewal of a license issued under this chapter.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.082(a), eff. September 1, 2005.

Sec. 4102.058. EXEMPTION FROM EXAMINATION REQUIREMENT. The examination requirement imposed by Section 4102.057 does not apply to:

(1) an applicant who is licensed as a resident public insurance adjuster in the applicant's state of residence, if the state requires the passing of a written examination in order to obtain the license and a reciprocal agreement with the appropriate official of that state has been entered into by the department; or

(2) an applicant who is licensed as a nonresident public insurance adjuster in a state other than the applicant's state of residence, if the state of licensure requires the passing of a written examination in order to obtain the license and a reciprocal agreement with the appropriate official of the state of licensure has been entered into by the department.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.082(a), eff. September 1, 2005.

Sec. 4102.060. EXAMINATION FORM AND TIME. (a) The answers of an examinee to an examination required under this chapter shall be made by the examinee in writing. A written examination may be supplemented by oral examination.

(b) The examination shall be given at times and places within the state as the commissioner considers necessary to reasonably serve the convenience of both the commissioner and examinees.

(c) The commissioner may require a waiting period of reasonable duration before an examinee who fails the examination, but who is otherwise qualified, may be reexamined.

(d) The scheduling and administration of examinations required under Section 4102.057 shall be effected by persons approved by the commissioner.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.082(a), eff. September 1, 2005.

Sec. 4102.061. LICENSE FORM. The commissioner shall prescribe the form of the licenses issued under this chapter. Each license must contain:

- (1) the name of the public insurance adjuster and the address of the public insurance adjuster's place of business;
- (2) the date of issuance and the date of expiration of the license; and
- (3) if applicable, the name of the firm with which the public insurance adjuster is employed at the time the license is issued.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.082(a), eff. September 1, 2005.

Sec. 4102.062. EXPIRATION. A license issued under this chapter expires as provided by Chapter 4003 unless suspended or revoked by the commissioner.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.082(a), eff. September 1, 2005.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1172 (S.B. 876), Sec. 17, eff. September 1, 2015.

Sec. 4102.063. NOTICE OF EXPIRATION. At least 30 days before the expiration of a license, the department shall send written notice of the impending license expiration to the license holder at the license holder's last known mailing address according to the records of the department.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.082(a), eff. September 1, 2005.

Sec. 4102.064. RENEWAL OF UNEXPIRED LICENSE. (a) A license holder may renew a license that has not expired and has not been suspended or revoked by filing with the department a properly completed renewal application, in the form prescribed by the commissioner, that demonstrates continued compliance with the license

requirements imposed under this chapter or adopted by rule by the commissioner. The completed renewal application must be accompanied by:

(1) a renewal application fee in the amount determined by the commissioner under Section 4102.066(b); and

(2) evidence of compliance with the continuing education requirements imposed under Section 4102.109.

(b) A license holder must submit the completed renewal application, evidence of compliance with the continuing education requirements, and the renewal application fee to the commissioner not later than the 30th day before the second anniversary date of the license.

(c) On the filing of a completed renewal application, a renewal application fee, and, if applicable, evidence of compliance with the continuing education requirements, the original license continues in force until:

(1) the department issues the renewal license;

(2) the license is not renewed under Section 4004.055; or

(3) the commissioner issues an order revoking the license.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.082(a), eff. September 1, 2005.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1172 (S.B. 876), Sec. 18, eff. September 1, 2015.

Sec. 4102.065. RENEWAL OF EXPIRED LICENSE. (a) A person whose license has been expired for 90 days or less may renew the license by:

(1) submitting to the department:

(A) a completed renewal application in the form prescribed by the commissioner; and

(B) evidence of compliance with the continuing education requirements and eligibility for renewal under Section 4004.055; and

(2) paying to the department the required renewal application fee and an additional fee that is equal to one-half of the renewal application fee for the license.

(b) Except as provided by Section 4004.055, a person whose

license has been expired for more than 90 days but less than one year may not renew the license but is entitled to a new license without taking the applicable examination if the person submits to the department:

- (1) a new application;
- (2) evidence of compliance with the continuing education requirements;
- (3) the license application fee; and
- (4) an additional fee equal to one-half of the license application fee.

(c) A person whose license has been expired for one year or more may not renew the license. The person may obtain a new license by:

- (1) submitting to reexamination, if examination is required for original issuance of the license;
- (2) complying with the requirements and procedures for obtaining an original license; and
- (3) if applicable, submitting evidence of completion of any outstanding continuing education requirement and payment of any associated fine related to the expired license.

(d) The department may renew without reexamination an expired license of a person who was licensed in this state, moved to another state, and is currently licensed and has been in continual practice in the other state up to and including the date of the application. The person must pay to the department a fee that is equal to the license application fee.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.082(a), eff. September 1, 2005.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1172 (S.B. 876), Sec. 19, eff. September 1, 2015.

Sec. 4102.066. FEES. (a) The commissioner shall collect in advance the following nonrefundable fees:

- (1) for a public insurance adjuster license, an application fee in an amount to be determined by rule by the commissioner;
- (2) for a nonresident public insurance adjuster license, an application fee in an amount to be determined by rule by the

commissioner; and

(3) for each public insurance adjuster examination, a fee in an amount to be determined by rule by the commissioner.

(b) The amount of the fee for the renewal of a license issued under this chapter shall be determined by rule by the commissioner.

(c) The commissioner shall set the fees in amounts reasonable and necessary to implement this chapter.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.082(a), eff. September 1, 2005.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1178 (S.B. 1060), Sec. 2, eff. September 1, 2015.

Sec. 4102.067. USE OF FEES. (a) When collected, the fees authorized by this chapter shall be deposited with the comptroller to the credit of the Texas Department of Insurance operating account.

(b) The department may use any portion of the fees collected to:

(1) enforce this chapter;

(2) employ persons as the department considers necessary to investigate and make reports regarding alleged violations of this code and misconduct on the part of public insurance adjusters; and

(3) pay the salaries and expenses of persons and office employees and other expenses necessary to enforce this chapter.

(c) A person employed by the department under this section may examine under oath any person for the purpose of gathering information and evidence and may have the information and evidence reduced to writing.

(d) All expenses incurred under this section shall be paid from the fees collected under this chapter.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.082(a), eff. September 1, 2005.

Sec. 4102.068. LICENSE NOT ASSIGNABLE. A license issued under this chapter is not assignable.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.082(a),

eff. September 1, 2005.

SUBCHAPTER C. POWERS AND DUTIES

Sec. 4102.101. GENERAL AUTHORITY. (a) A license issued under this chapter authorizes the adjusting of claims on behalf of insureds for fire and allied coverages, burglary, flood, and all other property claims, both real and personal, including loss of income, but only when the client is an insured under the insurance policy.

(b) This chapter does not limit or diminish the authority of a license holder to investigate or adjust a loss to less than the authority for that purpose that may be exercised by an adjuster licensed under Chapter 4101.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.082(a), eff. September 1, 2005.

Sec. 4102.102. COMPLIANCE WITH INSURANCE CONTRACT. A license holder shall prepare each claim for an insured represented by the license holder in accordance with the terms and conditions of the contract of insurance under which recovery is sought.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.082(a), eff. September 1, 2005.

Sec. 4102.103. CONTRACT FOR SERVICES REQUIRED. (a) A license holder may not, directly or indirectly, act within this state as a public insurance adjuster without having first entered into a contract, in writing, on a form approved by the commissioner, executed in duplicate by the license holder and the insured or the insured's duly authorized representative. A license holder may not use any form of contract that is not approved by the commissioner.

(b) The contract must contain a provision allowing the client to rescind the contract by written notice to the license holder within 72 hours of signature, and must include a prominently displayed notice in 12-point boldface type that states "WE REPRESENT THE INSURED ONLY." The commissioner by rule may require additional prominently displayed notice requirements in the contract as the commissioner considers necessary.

(c) One copy of the contract shall be kept on file in this state by the license holder and must be available at all times for inspection, without notice, by the commissioner or the commissioner's duly authorized representative.

(d) A license holder may not enter into a contract with an insured and collect a commission as provided by Section 4102.104 without the intent to actually perform the services customarily provided by a licensed public insurance adjuster for the insured.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.082(a), eff. September 1, 2005.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1178 (S.B. 1060), Sec. 3, eff. September 1, 2015.

Sec. 4102.104. COMMISSIONS. (a) Except as provided by Subsection (b), a license holder may receive a commission for service provided under this chapter consisting of an hourly fee, a flat rate, a percentage of the total amount paid by an insurer to resolve a claim, or another method of compensation. The total commission received may not exceed 10 percent of the amount of the insurance settlement on the claim.

(b) A license holder may not receive a commission consisting of a percentage of the total amount paid by an insurer to resolve a claim on a claim on which the insurer, not later than 72 hours after the date on which the loss is reported to the insurer, either pays or commits in writing to pay to the insured the policy limit of the insurance policy in accordance with Section 862.053. The license holder is entitled to reasonable compensation from the insured for services provided by the license holder on behalf of the insured, based on the time spent on a claim that is subject to this subsection and expenses incurred by the license holder, until the claim is paid or the insured receives a written commitment to pay from the insurer.

(c) Except for the payment of a commission by the insured, all persons paying any proceeds of a policy of insurance or making any payment affecting an insured's rights under a policy of insurance must:

(1) include the insured as a payee on the payment draft or check; and

(2) require the written signature and endorsement of the insured on the payment draft or check.

(d) A public insurance adjuster may not accept any payment that violates the provisions of this section.

(e) Notwithstanding any authorization the insured may have given to a public insurance adjuster, a public insurance adjuster may not sign and endorse any payment draft or check on behalf of an insured.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.082(a), eff. September 1, 2005.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1178 (S.B. 1060), Sec. 4, eff. September 1, 2015.

Sec. 4102.105. FINANCIAL RESPONSIBILITY. (a) As a continuing condition of licensure, a public insurance adjuster must file proof of financial responsibility with respect to transactions with insureds under this chapter in an amount determined by the commissioner by rule. The financial responsibility must include the ability to pay sums the public insurance adjuster is obligated to pay under any judgment against the public insurance adjuster by an insured, based on an error, omission, fraud, negligent act, or unfair practice of the public insurance adjuster or any person for whose acts the public insurance adjuster is legally liable in the transaction of the public insurance adjuster's business under this code.

(b) In determining the amount of the financial responsibility requirement, the commissioner shall consider the nature of the obligation, other financial security requirements under this code, and financial security requirements adopted for public insurance adjusters in other states. In determining the types of financial responsibility required, the commissioner may consider a surety bond or a professional liability policy or similar policy or contract of professional liability coverage acceptable to the commissioner.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.082(a), eff. September 1, 2005.

Sec. 4102.106. PLACE OF BUSINESS. (a) Each license holder who is a resident of this state or a business entity organized under the laws of this state shall:

(1) maintain a place of business in this state that is accessible to the general public; and

(2) maintain in the place of business the records required by this chapter.

(b) The address of the place of business must appear on the face of the license.

(c) The license holder shall promptly notify the commissioner of any change in the address of the license holder's place of business.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.082(a), eff. September 1, 2005.

Sec. 4102.107. AGENT FOR SERVICE OF PROCESS. (a) Each nonresident license holder shall maintain an agent in this state for service of process.

(b) The name and address of the nonresident license holder's out-of-state business address and the name and address of the agent must appear on the face of the license.

(c) The nonresident license holder shall promptly notify the department of any change in the address of the license holder's place of business or in the agent for service of process.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.082(a), eff. September 1, 2005.

Sec. 4102.108. POSTING OF LICENSE. A license issued under this chapter must at all times be posted in a conspicuous place in the principal place of business of the license holder.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.082(a), eff. September 1, 2005.

Sec. 4102.109. CONTINUING EDUCATION. (a) Each license holder must complete at least 24 hours of continuing education during the

license period. The commissioner by rule shall prescribe the requirements for continuing education courses under this section.

(b) Notwithstanding Subsection (a), the commissioner may waive any continuing education requirement for a nonresident public insurance adjuster with a valid license from another state having continuing education requirements substantially equivalent to those of this state.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.082(a), eff. September 1, 2005.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1172 (S.B. 876), Sec. 20, eff. September 1, 2015.

Sec. 4102.110. RECORD MAINTENANCE. (a) A license holder shall keep a complete record in this state of each of the license holder's transactions as a public insurance adjuster. The records must include each of the following:

- (1) the name of the insured;
- (2) the date, location, and amount of the loss;
- (3) a copy of the contract between the license holder and the insured;
- (4) the name of the insurer and the amount, expiration date, and number of each policy under which the loss is covered;
- (5) an itemized statement of the recoveries by the insured from the sources known to the license holder;
- (6) the total compensation received for the adjustment; and
- (7) an itemized statement of disbursements made by the license holder from recoveries received on behalf of the insured.

(b) Records required to be kept under this section must be:

- (1) maintained in this state for at least five years after the termination of a transaction with the insured; and
- (2) open to examination by the commissioner.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.082(a), eff. September 1, 2005.

Sec. 4102.111. FIDUCIARY CAPACITY. (a) All funds received as claim proceeds by a license holder acting as a public insurance

adjuster are received and held by the license holder in a fiduciary capacity. A license holder may not divert or appropriate fiduciary funds received or held.

(b) An applicant for a license to act as a public insurance adjuster must, as part of the application, endorse an authorization for disclosure to the commissioner of all financial records of any funds the public insurance adjuster holds as a fiduciary. The authorization continues in force and effect for as long as the license holder continues to be licensed under this chapter.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.082(a), eff. September 1, 2005.

Sec. 4102.112. RELOCATION TO ANOTHER STATE. (a) Not later than the 30th day after moving from one state to another state, a nonresident or resident public insurance adjuster licensed in this state shall file with the department:

(1) the license holder's new address; and
(2) proof of authorization to engage in the business of public insurance adjuster in the new state of residence if that state requires licensure of public insurance adjusters.

(b) The department may not charge a fee or require a license application under Subsection (a).

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.082(a), eff. September 1, 2005.

Sec. 4102.113. ADVERTISEMENTS. Each advertisement by a license holder soliciting or advertising business must display the license holder's name, address, and license number as they appear in the records of the commissioner.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.082(a), eff. September 1, 2005.

Sec. 4102.114. DUTIES OF NONRESIDENT LICENSE HOLDER. (a) A nonresident license holder shall comply with all of the requirements of this chapter in performing any of the activities of a public

insurance adjuster in this state, including the requirements on record maintenance in Section 4102.110.

(b) The failure of a nonresident license holder, as determined by the commissioner after notice and an opportunity for a hearing, to properly maintain records in accordance with this chapter and make them available to the department on request constitutes grounds for the suspension of the nonresident license issued under this chapter, in accordance with Section 4102.201.

(c) Each individual who holds a nonresident license shall comply with all other laws and rules of this state applicable to public insurance adjusters, including the law governing the collection of state sales tax as appropriate for services performed under this chapter.

(d) Repealed by Acts 2021, 87th Leg., R.S., Ch. 355 (H.B. 4030), Sec. 22(9), eff. September 1, 2021.

(e) A nonresident license holder is subject to Section 4102.208(b), relating to failure to maintain the financial responsibility requirements.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.082(a), eff. September 1, 2005.

Amended by:

Acts 2021, 87th Leg., R.S., Ch. 355 (H.B. 4030), Sec. 22(9), eff. September 1, 2021.

SUBCHAPTER D. PROHIBITED CONDUCT

Sec. 4102.151. SOLICITATION PROHIBITED DURING NATURAL DISASTER. A license holder may not solicit or attempt to solicit a client for employment during the progress of a loss-producing natural disaster occurrence.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.082(a), eff. September 1, 2005.

Sec. 4102.152. SOLICITATION PROHIBITED DURING CERTAIN HOURS.
 (a) A license holder may not solicit or attempt to solicit business on a loss or a claim in person, by telephone, or in any other manner at any time except between the hours of 9 a.m. and 9 p.m. on a weekday or a Saturday and between noon and 9 p.m. on a Sunday.

(b) This section does not prohibit a license holder from accepting phone calls or personal visits during the prohibited hours from an insured on the insured's initiation.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.082(a), eff. September 1, 2005.

Sec. 4102.153. CERTAIN REPORTS AND DISCLOSURES PROHIBITED. A license holder may not knowingly make any false report to the license holder's employer or client and may not divulge to any other person, except as the law may require, any information obtained except at the direction of the employer or the client for whom the information is obtained.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.082(a), eff. September 1, 2005.

Sec. 4102.154. USE OF BADGE PROHIBITED. A license holder may not use a badge in connection with the official activities of the license holder's business.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.082(a), eff. September 1, 2005.

Sec. 4102.155. CERTAIN DELEGATION PROHIBITED. A license holder may not permit an employee or agent, in the employee's or agent's own name, to advertise, solicit or engage clients, furnish reports or present bills to clients, or in any manner conduct business for which a license is required under this chapter.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.082(a), eff. September 1, 2005.

Sec. 4102.156. PRACTICE OF LAW PROHIBITED. A license holder may not render services or perform acts that constitute the practice of law, including the giving of legal advice to any person in the license holder's capacity as a public insurance adjuster.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.082(a), eff. September 1, 2005.

Sec. 4102.157. CERTAIN BUSINESS PROHIBITED. A license holder may not solicit or attempt to solicit business, directly or indirectly, or act in any manner on a bodily injury loss covered by a life, health, or accident insurance policy or on any claim for which the client is not an insured under the insurance policy.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.082(a), eff. September 1, 2005.

Sec. 4102.158. CONFLICTS OF INTEREST PROHIBITED. (a) A license holder may not:

(1) participate directly or indirectly in the reconstruction, repair, or restoration of damaged property that is the subject of a claim adjusted by the license holder; or

(2) engage in any other activities that may reasonably be construed as presenting a conflict of interest, including soliciting or accepting any remuneration from, having a financial interest in, or deriving any direct or indirect financial benefit from, any salvage firm, repair firm, construction firm, or other firm that obtains business in connection with any claim the license holder has a contract or agreement to adjust.

(b) A license holder may not, without the knowledge and consent of the insured in writing, acquire an interest in salvaged property that is the subject of a claim adjusted by the license holder.

(c) A license holder may not represent an insured on a claim or charge a fee to an insured while representing the insurance carrier against which the claim is made.

(d) A license holder may not directly or indirectly solicit, as described by Chapter 38, Penal Code, employment for an attorney or enter into a contract with an insured for the primary purpose of referring an insured to an attorney and without the intent to actually perform the services customarily provided by a licensed public insurance adjuster. This section may not be construed to prohibit a license holder from recommending a particular attorney to an insured.

(e) A license holder may not act on behalf of an attorney in having an insured sign an attorney representation agreement.

(f) A license holder must become familiar with and at all times act in conformance with the criminal barratry statute set forth in Section 38.12, Penal Code.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.082(a), eff. September 1, 2005.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1178 (S.B. 1060), Sec. 5, eff. September 1, 2015.

Sec. 4102.159. MISREPRESENTATION PROHIBITED. A license holder may not use any misrepresentation to solicit a contract or agreement to adjust a claim.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.082(a), eff. September 1, 2005.

Sec. 4102.160. CERTAIN PAYMENTS PROHIBITED. A license holder may not:

(1) advance money to any potential client or insured; or
(2) pay, allow, or give, or offer to pay, allow, or give, directly or indirectly, to a person who is not a licensed public insurance adjuster a fee, commission, or other valuable consideration for the referral of an insured to the public insurance adjuster for purposes of the insured entering into a contract with that public insurance adjuster or for any other purpose.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.082(a), eff. September 1, 2005.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1178 (S.B. 1060), Sec. 6, eff. September 1, 2015.

Sec. 4102.161. CERTAIN REPRESENTATIONS PROHIBITED. A license holder may not use any letterhead, advertisement, or other printed matter, or use any other means, to represent that the license holder

is an instrumentality of the federal government, of a state, or of a political subdivision of a state.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.082(a), eff. September 1, 2005.

Sec. 4102.162. USE OF DIFFERENT NAME PROHIBITED. A license holder may not use a name different from the name under which the license holder is currently licensed in an advertisement, solicitation, or contract for business unless the name is used under a valid assumed name certificate as provided by Chapter 71, Business & Commerce Code.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.082(a), eff. September 1, 2005.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 836 (H.B. 2659), Sec. 1, eff. September 1, 2019.

Sec. 4102.163. CERTAIN CONTRACTOR BUSINESS PROHIBITED. (a) A contractor may not act as a public adjuster or advertise to adjust claims for any property for which the contractor is providing or may provide contracting services, regardless of whether the contractor:

(1) holds a license under this chapter; or

(2) is authorized to act on behalf of the insured under a power of attorney or other agreement.

(b) The commissioner shall adopt rules necessary to implement and enforce this section.

Added by Acts 2013, 83rd Leg., R.S., Ch. 903 (H.B. 1183), Sec. 2, eff. September 1, 2013.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 1100 (H.B. 2103), Sec. 1, eff. September 1, 2019.

Acts 2019, 86th Leg., R.S., Ch. 1100 (H.B. 2103), Sec. 2, eff. September 1, 2019.

Sec. 4102.164. ACCEPTANCE OF REFERRAL PAYMENTS PROHIBITED. (a)

A licensed public insurance adjuster may not accept a fee, commission, or other valuable consideration of any nature, regardless of form or amount, in exchange for the referral by a licensed public insurance adjuster of an insured to any third-party individual or firm, including an attorney, appraiser, umpire, construction company, contractor, or salvage company.

(b) The commissioner shall adopt rules necessary to implement and enforce this section.

Added by Acts 2015, 84th Leg., R.S., Ch. 1178 (S.B. 1060), Sec. 7, eff. September 1, 2015.

SUBCHAPTER E. ENFORCEMENT

Sec. 4102.201. DENIAL, SUSPENSION, OR REVOCATION OF LICENSE.

(a) The commissioner may deny an application for a license under this chapter or suspend or revoke a license issued under this chapter on the basis of:

- (1) a violation of this chapter or of any rule adopted by the commissioner under this chapter;
- (2) a cause that constitutes grounds for denial of an original license;
- (3) misrepresentation or fraud in obtaining a license;
- (4) failure to pass a required license examination;
- (5) the misappropriation or conversion of money required to be held in a fiduciary capacity;
- (6) material misrepresentation, with intent to deceive, of the terms of an insurance contract;
- (7) engaging in a fraudulent transaction;
- (8) demonstrated incompetence or untrustworthiness in the conduct of the license holder's affairs under the license, as determined by the commissioner;
- (9) conviction of a felony by a final judgment in a court of competent jurisdiction; or
- (10) material misrepresentation, with intent to deceive, of the person's status as a public insurance adjuster.

(b) If the department proposes to refuse to issue an original license under this chapter or to suspend, revoke, or refuse to renew a license under this chapter, the person affected is entitled to notice and hearing as provided by Section 4005.104.

(c) A final order entered as a result of a hearing under this section may be appealed to a court of competent jurisdiction as provided by Subchapter D, Chapter 36.

(d) An order suspending a license issued under this chapter must specify the period of the suspension not to exceed 12 months.

(e) The holder of a license that is revoked or suspended for cause shall surrender the license to the commissioner on demand.

(f) The commissioner may issue a license or reinstate a suspended or revoked license on a finding that the cause for suspension, revocation, or refusal no longer exists.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.082(a), eff. September 1, 2005.

Sec. 4102.202. APPLICATION FOR LICENSE AFTER SUSPENSION, DENIAL OF APPLICATION, OR REVOCATION OF LICENSE. (a) A person whose license is suspended under this chapter may apply for a new license only after the expiration of the period of suspension.

(b) A person whose license is revoked or whose application for a license is denied, except for a failure to submit a completed application, may not apply for a new license until the fifth anniversary of:

(1) the effective date of the denial or revocation; or

(2) if the applicant or license holder seeks judicial review of the department's action, the date of the final court order or decree affirming that action.

(c) The commissioner may deny a timely application filed under Subsection (b) if the applicant does not show good cause why the denial of the previous license application or the revocation of the license should not be considered a bar to the issuance of the new license.

(d) Subsection (c) does not apply to an applicant whose license application was denied for failure by the applicant to:

(1) pass the required written examination; or

(2) submit a properly completed license application.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.082(a), eff. September 1, 2005.

Sec. 4102.203. DISCIPLINARY PROCEEDING FOR CONDUCT COMMITTED BEFORE SURRENDER OR FORFEITURE OF LICENSE. (a) The department may institute a disciplinary proceeding against a former license holder for conduct that the license holder committed before the effective date of a voluntary surrender or automatic forfeiture of the license.

(b) In a proceeding under this section, the fact that the license holder has surrendered or forfeited the license does not affect the license holder's culpability for the conduct.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.082(a), eff. September 1, 2005.

Sec. 4102.204. ADMINISTRATIVE PENALTY. The commissioner, in lieu of suspending or revoking a license for a violation of this chapter or a rule adopted under this chapter, may impose on a license holder an administrative penalty in an amount not to exceed \$2,000 per violation if the commissioner determines that that action better serves the purposes of this chapter.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.082(a), eff. September 1, 2005.

Sec. 4102.205. AUTOMATIC FINES. Section 4005.109 applies to violations of this chapter.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.082(a), eff. September 1, 2005.

Sec. 4102.206. CRIMINAL PENALTY; SANCTIONS. (a) A person commits an offense if the person violates this chapter. An offense under this subsection is a Class B misdemeanor.

(b) If conduct that constitutes an offense under Subsection (a) also constitutes an offense under any other law, the person committing the offense may be prosecuted under this section or the other law.

(c) In addition to the criminal penalties imposed under Subsection (a), a person in violation of this chapter is subject to the sanctions provided by Sections 541.108-541.110, as if the person

had violated an order under those sections.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.082(a), eff. September 1, 2005.

Sec. 4102.207. INSURED OPTION TO VOID CONTRACT. (a) Any contract for services regulated by this chapter that is entered into by an insured with a person who is in violation of Section 4102.051 may be voided at the option of the insured.

(b) If a contract is voided under this section, the insured is not liable for the payment of any past services rendered, or future services to be rendered, by the violating person under that contract or otherwise.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.082(a), eff. September 1, 2005.

Sec. 4102.208. EMERGENCY CEASE AND DESIST ORDER. (a) If the commissioner believes that a person is engaging in acts or practices in violation of Section 4102.051, the commissioner ex parte may issue an emergency cease and desist order, in accordance with Subchapter B, Chapter 83, requiring the person to immediately cease and desist from engaging further in the acts or practices.

(b) In addition to any other remedy available under this code, if the commissioner believes that a person is committing a violation by failing to maintain the financial responsibility requirements of Section 4102.105, the commissioner ex parte may issue an emergency cease and desist order and suspend the person's license, in accordance with Subchapter B, Chapter 83, requiring the person to immediately cease and desist from engaging in the activities of a public insurance adjuster.

(c) A license suspended under Subsection (b) may be reinstated on the approval of an application for reinstatement filed with the commissioner, in the form prescribed by the commissioner, with proof that the financial responsibility requirements of Section 4102.105 have been met. The commissioner may deny the application for reinstatement:

(1) for any reason that would justify a refusal to issue, or a suspension or revocation of, a license; or

(2) for the performance by the applicant of any practice for which a license under this chapter is required while the applicant is under suspension for failure to keep the financial responsibility requirements in force.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.082(a), eff. September 1, 2005.

SUBTITLE D. OTHER PROFESSIONALS
CHAPTER 4151. THIRD-PARTY ADMINISTRATORS
SUBCHAPTER A. GENERAL PROVISIONS

Sec. 4151.001. DEFINITIONS. In this chapter:

(1) "Administrator" means a person who, in connection with annuities or life benefits, health benefits, accident benefits, pharmacy benefits, or workers' compensation benefits, collects premiums or contributions from or adjusts or settles claims for residents of this state. The term includes a delegated entity under Chapter 1272 and a workers' compensation health care network authorized under Chapter 1305 that administers a workers' compensation claim for an insurer, including an insurer that establishes or contracts with the network to provide health care services. The term does not include a person described by Section 4151.002.

(2) "Insurer" means a person who engages in the business of life, health, accident, or workers' compensation insurance under the law of this state. For purposes of this chapter only, the term also includes an "insurance carrier," as defined by Section 401.011(27), Labor Code, other than a governmental entity or a workers' compensation self-insurance group subject to regulation under Chapter 407A, Labor Code.

(3) "Person" means an individual, partnership, corporation, organization, government or governmental subdivision or agency, business trust, estate trust, association, or any other legal entity.

(4) "Plan" means a plan, fund, or program established, adopted, or maintained by a plan sponsor or insurer to the extent that the plan, fund, or program is established, adopted, or maintained to provide indemnification or expense reimbursement for any type of life, health, or accident benefit.

(5) "Plan sponsor" means a person, other than an insurer,

who establishes, adopts, or maintains a plan that covers residents of this state, including a plan established, adopted, or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, an association, a committee, a joint board of trustees, or any similar group of representatives who establish, adopt, or maintain a plan.

(6) "Workers' compensation benefits" means benefits provided under Title 5, Labor Code, or services provided through a certified workers' compensation health care network authorized under Chapter 1305.

(7) "Workers' compensation insurance coverage" means coverage subject to Subtitle E, Title 10. The term includes coverage described by Sections 401.011(44)(A) and (B), Labor Code.

(8) "Workers' compensation self-insurer" means a legal entity subject to regulation under Chapter 407, Labor Code.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 1176 (H.B. 472), Sec. 1.01, eff. September 1, 2007.

Sec. 4151.002. EXEMPTIONS. A person is not an administrator if the person is:

(1) an employer, other than a certified workers' compensation self-insurer, administering an employee benefit plan or the plan of an affiliated employer under common management and control;

(2) a union administering a benefit plan on behalf of its members;

(3) an insurer or a group hospital service corporation subject to Chapter 842 acting with respect to a policy lawfully issued and delivered by the insurer or corporation in and under the law of a state in which the insurer or corporation was authorized to engage in the business of insurance;

(4) a health maintenance organization that is authorized to operate in this state under Chapter 843 with respect to any activity that is specifically regulated under that chapter, Chapter 1271, 1272, or 1367, Subchapter A, Chapter 1452, or Subchapter B, Chapter 1507;

(5) an agent licensed under Subchapter B, Chapter 4051, Subchapter B, Chapter 4053, or Subchapter B, Chapter 4054, who receives commissions as an agent and is acting:

(A) under appointment on behalf of an insurer authorized to engage in the business of insurance in this state; and

(B) in the customary scope and duties of the person's authority as an agent;

(6) a creditor acting on behalf of its debtor with respect to insurance that covers a debt between the creditor and its debtor, if the creditor performs only the functions of a group policyholder or a creditor;

(7) a trust established in conformity with 29 U.S.C. Section 186 or a trustee or employee who is acting under the trust;

(8) a trust that is exempt from taxation under Section 501(a), Internal Revenue Code of 1986, or a trustee or employee acting under the trust;

(9) a custodian or a custodian's agent or employee who is acting under a custodian account that complies with Section 401(f), Internal Revenue Code of 1986;

(10) a bank, credit union, savings and loan association, or other financial institution that is subject to supervision or examination under federal or state law by a federal or state regulatory authority, if the institution is performing only those functions for which the institution holds a license under federal or state law;

(11) a company that advances and collects a premium or charge from its credit card holders on their authorization, if the company does not adjust or settle claims and acts only in the company's debtor-creditor relationship with its credit card holders;

(12) a person who adjusts or settles claims in the normal course of the person's practice or employment as a licensed attorney and who does not collect any premium or charge in connection with annuities or with life, health, accident, pharmacy, or workers' compensation benefits;

(13) an adjuster licensed under Subtitle C by the department who is engaged in the performance of the individual's powers and duties as an adjuster in the scope of the individual's license;

(14) a person who provides technical, advisory, utilization review, precertification, or consulting services to an insurer, plan,

or plan sponsor but does not make any management or discretionary decisions on behalf of the insurer, plan, or plan sponsor;

(15) an attorney in fact for a Lloyd's plan operating under Chapter 941 or for a reciprocal or interinsurance exchange operating under Chapter 942 who is acting in the capacity of attorney in fact under the applicable chapter;

(16) a joint fund, risk management pool, or self-insurance pool composed of political subdivisions of this state that participate in a fund or pool through interlocal agreements, any nonprofit administrative agency or governing body or other nonprofit entity that acts solely on behalf of a fund, pool, agency, or body, or any other fund, pool, agency, or body established under or for the purpose of implementing an interlocal governmental agreement;

(17) a self-insured political subdivision;

(18) a plan under which insurance benefits are provided exclusively by an insurer authorized to engage in the business of insurance in this state and the administrator of which is:

(A) a full-time employee of the plan's organizing or sponsoring association, trust, or other entity; or

(B) a trustee of the organizing or sponsoring trust;

(19) a parent of a wholly owned direct or indirect subsidiary insurer authorized to engage in the business of insurance in this state or a wholly owned direct or indirect subsidiary insurer that is a part of the parent's holding company system that, under an agreement regulated and approved under Chapter 823 or a similar statute of the domiciliary state if the parent or subsidiary insurer is a foreign insurer engaged in business in this state, on behalf of only itself or an affiliated insurer:

(A) collects premiums or contributions, if the parent or subsidiary insurer:

(i) prepares only billing statements and places those statements in the United States mail; and

(ii) causes all collected premiums to be deposited directly in a depository account of the particular affiliated insurer; or

(B) furnishes proof-of-loss forms, reviews claims, determines the amount of the liability for those claims, and negotiates settlements, if the parent or subsidiary insurer pays claims only from the funds of the particular subsidiary by checks or drafts of that subsidiary; or

(20) an affiliate, as described by Chapter 823.003, of a self-insurer certified under Chapter 407, Labor Code, and who:

(A) is performing the acts of an administrator on behalf of that certified self-insurer; and

(B) directly or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with that certified self-insurer, as the term "control" is described by Section 823.005.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.074(j), eff. September 1, 2005.

Acts 2007, 80th Leg., R.S., Ch. 1176 (H.B. 472), Sec. 1.02, eff. September 1, 2007.

Sec. 4151.0021. APPLICABILITY TO CERTAIN PROCESSING AGENTS.

(a) In this section, "processing agent" means a person described by Section 413.0111, Labor Code.

(b) A processing agent is not an administrator for purposes of this chapter if the processing agent is acting as an assignee of a pharmacy and if:

(1) the assignee has a written contract with the pharmacy to:

(A) act as the provider of licensed pharmacy services in lieu of the pharmacy; and

(B) purchase the pharmacy's claims at face value, or at a value expressly stated in the contract; and

(2) the contract specifically prohibits the assignee from performing any function of an administrator, as that term is defined in this chapter, unless the assignee holds a certificate of authority under this chapter.

Added by Acts 2007, 80th Leg., R.S., Ch. 1176 (H.B. 472), Sec. 1.03, eff. September 1, 2007.

Sec. 4151.0022. NONAPPLICABILITY. This chapter does not apply to a health care sharing ministry operated under Chapter 1681.

Added by Acts 2013, 83rd Leg., R.S., Ch. 455 (S.B. 874), Sec. 4, eff. June 14, 2013.

Sec. 4151.003. APPLICABILITY OF OTHER PROVISIONS OF CODE. An administrator is subject to Section 823.457, Subchapter H of Chapter 101, Chapter 541, Subchapter A of Chapter 542, and Chapter 804.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4151.0031. MARKET ANALYSIS. The commissioner may conduct market analyses and examinations of an administrator under Chapter 751.

Added by Acts 2007, 80th Leg., R.S., Ch. 1176 (H.B. 472), Sec. 1.03, eff. September 1, 2007.

Sec. 4151.004. APPLICABILITY TO CERTAIN INSURERS AND HEALTH MAINTENANCE ORGANIZATIONS. An insurer or health maintenance organization that is not exempt under Section 4151.002(3) or (4) is subject to all provisions of this chapter other than Sections 4151.005, 4151.051-4151.054, 4151.056, and 4151.206(a)(1).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4151.005. ADMINISTRATOR NOT INSURANCE AGENT. (a) An administrator licensed in any state who accepts an agent's commission for coverage for a risk located in this state and disburses that commission to an agent in this state is not considered an agent for purposes of this state's laws relating to the licensing of agents.

(b) The exemption provided by this section does not authorize an administrator to perform any other act for which a license as an agent is required by law.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4151.0051. REFERRAL TO ADJUSTER BY ADMINISTRATOR. (a) An

administrator may not knowingly refer a claim or loss for adjustment in this state to an individual purporting to be or acting as an adjuster unless the individual holds a license under Chapter 4101.

(b) Before first referring a claim or loss for adjustment, an administrator must ascertain from the commissioner whether the individual selected to perform the adjustment holds a license under Chapter 4101. After receipt of information from the department that the individual does hold an adjuster license, the administrator may refer claims or losses to the individual for adjustment until the administrator has actual knowledge or receives information from the department that the individual no longer holds an adjuster license under Chapter 4101. The department shall keep an updated list of individuals who hold adjuster licenses.

Added by Acts 2007, 80th Leg., R.S., Ch. 1176 (H.B. 472), Sec. 1.03, eff. September 1, 2007.

Sec. 4151.006. RULES. The commissioner may adopt, in the manner prescribed by Subchapter A, Chapter 36, rules that are fair, reasonable, and appropriate to augment and implement this chapter, including rules establishing financial standards, reporting requirements, and required contract provisions.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 1176 (H.B. 472), Sec. 1.04, eff. September 1, 2007.

SUBCHAPTER B. CERTIFICATE OF AUTHORITY

Sec. 4151.051. CERTIFICATE OF AUTHORITY REQUIRED. (a) An individual, corporation, organization, trust, partnership, or other legal entity may not act as or hold itself out as an administrator unless the entity is covered by and is engaging in business under a certificate of authority issued under this chapter.

(b) An administrator is required to hold only one certificate of authority issued under this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4151.052. APPLICATION. (a) An application for a certificate of authority to engage in business as an administrator must be in a form prescribed by the commissioner and must include the following:

(1) a copy of each basic organizational document of the applicant, including the articles of incorporation, bylaws, articles of association, trade name certificate, and any other similar document and a copy of any amendment to any of those documents;

(2) a description of the applicant and the applicant's services, facilities, and personnel;

(3) if the applicant is not domiciled in this state, a power of attorney executed by the applicant appointing the commissioner, the commissioner's successors in office, or the commissioner's appointed designee as the applicant's attorney in this state on whom process may be served in any legal action or proceeding based on a cause of action arising in this state against the applicant;

(4) an audited financial statement of the applicant covering the preceding three calendar years or any lesser period that the applicant and any predecessors of the applicant have been in existence, or if an audited financial statement is not available, an unaudited financial statement as of a date not earlier than the 120th day before the date the application is filed, accompanied by an affidavit or certification of the applicant that:

(A) the unaudited financial statement is true and correct, as of its date; and

(B) a material change in financial condition has not occurred from the date of the financial statement to the execution date of the affidavit or certification; and

(5) any other information the commissioner reasonably requires.

(b) An applicant for a certificate of authority or a certificate holder under this chapter shall notify the department in the manner prescribed by commissioner rule of a change of control in the applicant's or certificate holder's ownership not later than the 30th day after the effective date of the change and shall notify the department of any other fact or circumstance affecting the applicant's or certificate holder's qualifications for a certificate of authority in this state as required by commissioner rule.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 1176 (H.B. 472), Sec. 1.05, eff. September 1, 2007.

Sec. 4151.053. APPROVAL OF APPLICATION. The commissioner shall approve an application for a certificate of authority to engage in business in this state as an administrator if the commissioner is satisfied that:

(1) granting the application would not violate a federal or state law;

(2) the financial condition of the applicant or of each person who would operate or control the applicant is such that granting a certificate of authority would not be adverse to the public interest;

(3) the applicant has not attempted to obtain the certificate of authority through fraud or bad faith;

(4) the applicant has complied with this chapter and rules adopted by the commissioner under this chapter; and

(5) the name under which the applicant will engage in business in this state is not so similar to that of another administrator or insurer that it is likely to mislead the public.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4151.054. DENIAL OF APPLICATION. (a) If the commissioner is unable to approve an application for a certificate of authority, the commissioner shall:

(1) provide the applicant with written notice specifying each deficiency in the application; and

(2) offer the applicant the opportunity for a hearing to address each reason and circumstance for possible denial of the application.

(b) The commissioner must provide an opportunity for a hearing before the commissioner finally denies an application.

(c) At the hearing, the applicant has the burden to produce sufficient competent evidence on which the commissioner can make the determinations required by Section 4151.053.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4151.055. FIDELITY BOND REQUIRED. (a) If the commissioner approves an application for a certificate of authority, before the commissioner issues the certificate of authority, the applicant must:

(1) obtain and maintain a fidelity bond that complies with this section; and

(2) submit to the commissioner proof that the applicant has obtained the fidelity bond.

(b) The fidelity bond must protect against an act of fraud or dishonesty by the applicant in exercising the applicant's powers and duties as administrator.

(c) The fidelity bond may not be less than \$10,000 and may not be more than the lesser of:

(1) 10 percent of the amount of funds handled during the preceding year or, if no funds were handled during the preceding year, 10 percent of the amount of funds reasonably estimated to be handled by the administrator during the current calendar year; or

(2) \$500,000.

(d) On written request by an administrator for reduction of the amount of the fidelity bond for a particular year, the commissioner may authorize the reduction of the amount of the bond if the administrator presents evidence that the amount of funds to be handled during that year will be less than the amount handled during the preceding year.

(e) For purposes of this section, the amount of funds handled by a person in the person's capacity as administrator is either the total amount of premiums and contributions received by the administrator or the total amount of benefits paid by the administrator, whichever is greater, during the preceding calendar year in all jurisdictions in which the person acts as an administrator.

(f) Unless the administrator and the insurer or plan agree otherwise in writing, an administrator is required to obtain and maintain only one fidelity bond for all insurers and plans for which the administrator acts as administrator in this state.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4151.056. DURATION OF CERTIFICATE OF AUTHORITY. A certificate of authority issued to an administrator under this chapter is effective until it is suspended, canceled, or revoked. The issuance, denial, suspension, cancellation, or revocation of a certificate of authority to act as an administrator is subject to:

- (1) Subchapters B and C, Chapter 4005;
- (2) Chapter 82; and
- (3) Subchapter G.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 1176 (H.B. 472), Sec. 1.06, eff. September 1, 2007.

SUBCHAPTER C. POWERS AND DUTIES OF ADMINISTRATORS AND INSURERS

Sec. 4151.101. WRITTEN AGREEMENT WITH INSURER OR PLAN SPONSOR REQUIRED. (a) An administrator may provide services only under a written agreement with an insurer or plan sponsor.

(b) The commissioner by rule may prescribe provisions that must be included in the written agreement.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 1176 (H.B. 472), Sec. 1.08, eff. September 1, 2007.

Sec. 4151.102. CONTENTS OF WRITTEN AGREEMENT. (a) The written agreement must include each requirement prescribed by this subchapter except for a requirement that does not apply to any function the administrator performs.

(a-1) The written agreement must include a statement of the duties that the administrator is expected to perform on behalf of the insurer, and the lines, classes, or types of insurance that the administrator is authorized to administer. The agreement must include, as applicable, provisions regarding claims handling and other standards relating to the business underwritten by the insurer.

(b) If a policy or plan document is issued to a trustee, a copy

of the trust agreement and any amendment to that trust agreement becomes part of the written agreement.

(c) The written agreement may not contain a provision that unreasonably restricts the availability to a plan participant of an individual life, health, or accident policy or annuity through an agent selected by the plan participant.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 1176 (H.B. 472), Sec. 1.09, eff. September 1, 2007.

Sec. 4151.103. RETENTION OF WRITTEN AGREEMENT; INSPECTION BY COMMISSIONER. (a) The administrator and the insurer, plan, or plan sponsor shall retain a copy of the written agreement as part of their official records:

(1) during the term of the agreement; and

(2) until the fifth anniversary of the date on which the agreement expires.

(b) On written request by the commissioner, the administrator shall make the written agreement available for inspection by the commissioner or the commissioner's designee.

(c) Information the commissioner or the commissioner's designee obtains from the written agreement is confidential and may not be made available to the public. An employee of the department may examine the information in exercising powers and performing duties under this chapter.

(d) The commissioner shall adopt rules to address the transfer of records from one administrator to another.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 1176 (H.B. 472), Sec. 1.10, eff. September 1, 2007.

Sec. 4151.104. NOTICE OF USE OF ADMINISTRATOR'S SERVICES. (a) If an insurer, plan, or plan sponsor uses the services of an administrator, the administrator shall give written notice to each insured and injured employee of the administrator's identity and the

relationship among the administrator and the insurer, plan, or plan sponsor and the insured and injured employee. The insurer, plan, or plan sponsor must approve the notice before the notice is distributed.

(b) An administrator administering workers' compensation claims may satisfy the requirements of Subsection (a) by including the notice as part of, or in conjunction with, the notice required under Section 406.005(c), Labor Code.

(c) An administrator who fails to provide notice as required by Subsection (a) is subject to an administrative penalty in the manner provided by Chapter 84.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 1176 (H.B. 472), Sec. 1.11, eff. September 1, 2007.

Sec. 4151.1041. REFERRAL BY INSURER. (a) An insurer may not knowingly refer a claim or loss for administration in this state to a person purporting to be or acting as an administrator unless the person holds a certificate of authority under this chapter.

(b) Before first referring a claim or loss for administration, an insurer must ascertain from the commissioner whether the person performing the administration holds a certificate of authority under this chapter. Once the insurer has ascertained that the person holds a certificate of authority, the insurer may refer a claim to the person for administration and may continue to refer claims to the person until the insurer has knowledge or receives information from the commissioner that the person no longer holds a certificate of authority.

Added by Acts 2007, 80th Leg., R.S., Ch. 1176 (H.B. 472), Sec. 1.12, eff. September 1, 2007.

Sec. 4151.1042. RESPONSIBILITIES OF INSURER; SEMIANNUAL AUDIT. (a) If an insurer uses the services of an administrator, the insurer is responsible for determining the benefits, premium rates, reimbursement procedures, and claims payment procedures applicable to the coverage and for securing reinsurance, if any. The insurer shall

provide a copy of the written requirements relating to those matters to the administrator. The responsibilities of the administrator as to any of those matters must be set forth in the written agreement between the administrator and the insurer.

(b) An insurer shall ensure competent administration of its programs.

(c) If an administrator administers benefits for more than 100 certificate holders, injured employees, plan participants, or policyholders on behalf of an insurer, the insurer shall, at least semiannually, conduct a review of the operations of the administrator. At least biennially, the insurer shall conduct an on-site audit of the operations of the administrator.

Added by Acts 2007, 80th Leg., R.S., Ch. 1176 (H.B. 472), Sec. 1.12, eff. September 1, 2007.

Sec. 4151.105. PAYMENTS TO ADMINISTRATOR. (a) If an insurer, plan, or plan sponsor uses the services of an administrator:

(1) a payment of a premium or contribution to the administrator by or on behalf of an insured or plan participant is considered to have been received by the insurer, plan, or plan sponsor; and

(2) a payment of a return premium, contribution, or claim to the administrator by the insurer, plan, or plan sponsor is not considered payment to the insured, plan participant, or claimant until the insured, plan participant, or claimant receives the payment.

(b) This section does not limit a right of an insurer, plan, or plan sponsor against the administrator resulting from the administrator's failure to make a payment to an insured, plan participant, or claimant.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4151.106. CERTAIN FUNDS COLLECTED OR RECEIVED BY ADMINISTRATOR. (a) An administrator who collects funds must identify and state separately in writing the amount of any premium or contribution specified by the insurer, plan, or plan sponsor for the coverage and provide the information to any person who pays to the

administrator a premium or contribution.

(b) An administrator holds in a fiduciary capacity:

(1) a premium or contribution the administrator collects on behalf of an insurer, plan, or plan sponsor; and

(2) a return premium the administrator receives from an insurer, plan, or plan sponsor.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4151.107. DELIVERY OR DEPOSIT OF CERTAIN FUNDS RECEIVED BY ADMINISTRATOR. (a) On receiving a premium, contribution, or return premium, an administrator shall:

(1) timely deliver the funds to the person entitled to the funds according to terms of the written agreement; or

(2) promptly deposit the funds in a fiduciary bank account established and maintained by the administrator.

(b) If premiums or contributions deposited in a fiduciary bank account were collected on behalf of more than one insurer, plan, or plan sponsor, the administrator shall:

(1) maintain records that clearly record separately the deposits to and withdrawals from the account on behalf of each insurer, plan, or plan sponsor; and

(2) on request of an insurer, plan, or plan sponsor, provide to the insurer, plan, or plan sponsor a copy of the records relating to deposits and withdrawals on behalf of that insurer or plan.

(c) The requirements of Subsection (b):

(1) are in addition to requirements of any other federal or state law; and

(2) do not authorize the commingling of funds if otherwise prohibited by law.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4151.108. WITHDRAWALS FROM FIDUCIARY ACCOUNT. A withdrawal from a fiduciary bank account established under Section 4151.107 may be made only as provided in the written agreement for any of the following purposes:

(1) delivery to an insurer, plan, or plan sponsor entitled

to payment;

- (2) deposit in an account controlled and maintained in the name of the insurer, plan, or plan sponsor;
- (3) transfer to and deposit in a claims payment account for payment of a claim as provided by Section 4151.111;
- (4) payment to a group policyholder for delivery to the insurer entitled to payment;
- (5) payment to the administrator of the administrator's commission, fees, or charges;
- (6) delivery of a return premium to any person entitled to payment; or
- (7) payment of a premium for stop-loss or excess loss insurance.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4151.109. PAYMENT OF CLAIMS FROM FIDUCIARY ACCOUNT PROHIBITED. An administrator may not pay a claim from a fiduciary bank account established under Section 4151.107.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4151.110. UNDERWRITING STANDARDS. If an administrator has the authority to accept or reject a risk, the written agreement must address underwriting or other standards of the insurer or plan.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4151.111. ADJUDICATION OF CLAIMS. (a) An administrator shall adjudicate a claim not later than the 60th day after the date on which the administrator receives valid proof of loss in connection with the claim.

(b) The administrator shall pay each claim on a draft authorized by the insurer, plan, or plan sponsor in the written agreement.

(c) In the event of a conflict between this section and a provision of the Labor Code relating to time periods for adjudication and payment of workers' compensation claims, the Labor Code provision

prevails.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 1176 (H.B. 472), Sec. 1.13, eff. September 1, 2007.

Sec. 4151.112. MAINTENANCE OF BOOKS AND RECORDS. (a) An administrator shall maintain at the administrator's principal administrative office adequate books and records of each transaction in which the administrator engages with an insurer, plan, plan sponsor, insured, or plan participant.

(b) The administrator shall maintain the books and records:

(1) until the fifth anniversary of the end of the term of the written agreement to which the books and records relate; and

(2) in accordance with prudent standards of insurance recordkeeping.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4151.113. ACCESS TO BOOKS AND RECORDS. (a) For the purpose of examination, audit, and inspection, the administrator shall provide to the commissioner and the commissioner's designee access to the books and records maintained as required by Section 4151.112.

(b) A trade secret, including the identity and address of a policyholder, certificate holder, or injured employee, is confidential, except the commissioner may use that information in a proceeding against the administrator.

(c) An insurer, plan, or plan sponsor is entitled to continuing access to the books and records sufficient to permit the insurer, plan, or plan sponsor to fulfill a contractual obligation to an insured or plan participant. The right provided by this subsection is subject to any restriction included in the written agreement relating to the parties' proprietary rights to the books and records.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 1176 (H.B. 472), Sec. 1.14, eff.

September 1, 2007.

Sec. 4151.114. DISPOSITION OF BOOKS AND RECORDS ON TERMINATION OF WRITTEN AGREEMENT. On termination of the written agreement, an administrator may fulfill the requirements of Sections 4151.112 and 4151.113 by:

- (1) delivering the books and records:
 - (A) to a successor administrator; or
 - (B) if there is not a successor administrator, to the insurer, plan, or plan sponsor; and
- (2) giving written notice to the commissioner of the location of the books and records.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4151.115. CONFIDENTIALITY OF PERSONAL INFORMATION. (a) Information that identifies an individual covered by a plan is confidential.

(b) During the time information described by Subsection (a) is in an administrator's custody or control, the administrator shall take all reasonable precautions to prevent disclosure or use of the information for a purpose unrelated to administration of the plan.

(c) The administrator shall disclose information described by Subsection (a) only:

- (1) in response to a court order;
 - (2) for an examination conducted by the commissioner under this chapter;
 - (3) for an audit or investigation conducted under the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.);
 - (4) to or at the request of the insurer or plan sponsor;
- or
- (5) with the written consent of the identified individual or the individual's legal representative.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4151.116. ADVERTISING. Before an administrator uses

advertising relating to business underwritten by an insurer, plan, or plan sponsor, the insurer, plan, or plan sponsor must approve use of the advertising.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4151.117. COMPENSATION OF ADMINISTRATOR. (a) An administrator's compensation may be determined:

(1) as a percentage of the premiums or charges the administrator collects or the amount of claims the administrator pays or processes; or

(2) except as provided by Subsection (b), on another basis as specified in the written agreement.

(b) An insurer or plan sponsor may not permit or provide compensation or another thing of value to an administrator that is based on the savings accruing to the insurer or plan sponsor because of adverse determinations regarding claims for benefits, reductions of or limitations on benefits, or other analogous actions inconsistent with this chapter, that are made or taken by the administrator.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 1176 (H.B. 472), Sec. 1.15, eff. September 1, 2007.

SUBCHAPTER D. PHARMACY BENEFIT PLANS

Sec. 4151.151. DEFINITION. In this subchapter, "pharmacy benefit manager" means a person, other than a pharmacy or pharmacist, who acts as an administrator in connection with pharmacy benefits.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4151.152. IDENTIFICATION CARDS. (a) Except as provided by rules adopted by the commissioner, an administrator for a plan that provides pharmacy benefits shall issue an identification card to each individual covered by the plan. The administrator shall issue the identification card not later than the 30th day after the date

the administrator receives notice that the individual is eligible for the benefits.

(b) The commissioner by rule shall adopt standard information to be included on the identification card. The standard form identification card must include:

- (1) the name or logo of the entity administering the pharmacy benefits;
- (2) the international identification number assigned by the American National Standards Institute for the entity administering the pharmacy benefits;
- (3) the group number applicable to the covered individual;
- (4) the effective date of the coverage evidenced by the card;
- (5) a telephone number to be used to contact an appropriate person to obtain information relating to the pharmacy benefits provided under the coverage; and
- (6) copayment information for generic and brand-name prescription drugs.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4151.153. DISCLOSURE OF CERTAIN PATIENT INFORMATION PROHIBITED. (a) A pharmacy benefit manager may not sell a list of patients that contains information through which the identity of an individual patient is disclosed.

(b) A pharmacy benefit manager shall maintain all data that identifies a patient in a confidential manner that prevents disclosure to a third party unless the disclosure is otherwise authorized by law or by the patient.

(c) This section does not prohibit:

- (1) general advertising about a specific pharmaceutical product or service; or
- (2) the request and receipt by a person of information regarding:
 - (A) a specific pharmaceutical product or service;
 - (B) the person's own records or claims; or
 - (C) the person's dependent's records or claims.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4151.154. DISCOUNT HEALTH CARE PROGRAMS. A pharmacy benefit manager may not require a pharmacist or pharmacy to:

(1) accept or process a claim for prescription drugs under a discount health care program as defined by Section 7001.001 unless the pharmacist or pharmacy agrees in writing to accept or process the claim;

(2) participate in a specified provider network as a condition of processing a claim for prescription drugs under a discount health care program; or

(3) participate in, or process claims under, a discount health care program as a condition of participation in a provider network.

Added by Acts 2015, 84th Leg., R.S., Ch. 573 (H.B. 3028), Sec. 2, eff. September 1, 2015.

SUBCHAPTER E. DEPARTMENT REGULATION OF ADMINISTRATORS

Sec. 4151.201. EXAMINATION OF ADMINISTRATOR. (a) The commissioner may examine an administrator with regard to its business in this state.

(b) The commissioner may designate one or more employees to perform an examination.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4151.202. CONTENTS OF EXAMINATION; ON-SITE EVALUATION.

(a) An examination under Section 4151.201 must include a review of:

(1) each existing written agreement between the administrator and an insurer or plan sponsor; and

(2) the administrator's financial statements.

(b) The commissioner also may have examiners conduct an on-site evaluation of the administrator's personnel and facilities and any books and records of the administrator relating to the transaction of business by and the financial condition of the administrator.

(c) Before an examiner enters an administrator's property, the commissioner shall give notice to the administrator of the examiner's intent to conduct an on-site evaluation. The notice must:

(1) be in the form required by rule adopted by the commissioner; and

(2) include the date and estimated time that the examiner will enter the administrator's property.

(d) An examiner shall comply with operational rules of an administrator while on the administrator's property.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4151.203. COST OF EXAMINATION. The cost of an examination under Section 4151.201 shall be paid from the fee collected under Section 4151.206(a)(2) and with revenue from the maintenance tax levied under Chapter 259.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4151.204. EXAMINATION UNDER OATH. If necessary to make a complete evaluation of the activities and operations of an administrator, the commissioner may summon and examine under oath the administrator and the administrator's personnel.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4151.205. ANNUAL REPORT. (a) An administrator shall annually, not later than June 30, file with the commissioner a report on a form prescribed by the commissioner. The report must contain any information required by the commissioner and must be verified by at least two officers of the administrator.

(b) The annual report must cover the preceding calendar year.

(c) Except as provided by Subsection (f), the annual report must include an audited financial statement performed by an independent certified public accountant. An audited financial statement prepared on a consolidated basis must include a columnar consolidating or combining worksheet that shall be filed with the annual report and must comply with the following:

(1) amounts shown on the consolidated audited financial report must be shown on the worksheet;

(2) amounts for each entity must be stated separately; and

(3) explanations of consolidating and eliminating entries must be included.

(d) The annual report must include notes to the financial statement or attachments that reflect the complete name and address of each insurer in this state with which the administrator had an agreement during the preceding fiscal year.

(e) Information derived from an audited financial statement contained in an annual report under this section is confidential and is not subject to disclosure under Chapter 552, Government Code.

(f) An administrator who receives less than \$10 million annually as compensation for performing administrative services and operates under written agreements subject to this chapter with insurers or plan sponsors in this state is not required to file an audited financial statement under Subsection (c), but must file a financial statement certified in the manner prescribed by commissioner rule.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 1176 (H.B. 472), Sec. 1.17, eff. September 1, 2007.

Sec. 4151.206. FEES. (a) The commissioner shall collect and an applicant or administrator shall pay to the commissioner fees in an amount to be determined by the commissioner as follows:

(1) a filing fee not to exceed \$1,000 for processing an original application for a certificate of authority for an administrator;

(2) a fee not to exceed \$500 for an examination under Section 4151.201; and

(3) a filing fee not to exceed \$200 for an annual report.

(b) The commissioner shall deposit a fee collected under Subsection (a)(1) or (3) to the credit of the Texas Department of Insurance operating account.

(c) The commissioner shall deposit a fee collected under Subsection (a)(2) to the credit of the account described by Section 401.156(a).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.074, eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.074, eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 1176 (H.B. 472), Sec. 1.18, eff. September 1, 2007.

Acts 2011, 82nd Leg., R.S., Ch. 659 (S.B. 1291), Sec. 6, eff. September 1, 2011.

Sec. 4151.210. EFFECT OF REVOCATION OF OTHER CERTIFICATES. An officer or a director or a shareholder with a controlling interest of an entity whose certificate of authority to engage in the business of insurance or other analogous authorization has been revoked in this state or in any other state may not act as an officer, director, member, manager, or partner, or as a shareholder with a controlling interest, of an entity that holds a certificate of authority issued under this chapter unless the commissioner determines, for good cause shown, that it is in the public interest to permit the individual to act in that capacity.

Added by Acts 2007, 80th Leg., R.S., Ch. 1176 (H.B. 472), Sec. 1.19, eff. September 1, 2007.

Sec. 4151.211. RESTRICTIONS ON ACQUISITION OF OWNERSHIP INTEREST. (a) A person may not acquire an ownership interest in an entity that holds a certificate of authority under this chapter if the person is, or after the acquisition would be, directly or indirectly in control of the certificate holder, or otherwise acquire control of or exercise any control over the certificate holder, unless the person has filed with the department under oath:

(1) a biographical form for each person by whom or on whose behalf the acquisition of control is to be effected;

(2) a statement certifying that no person who is acquiring an ownership interest in or control of the certificate holder has been the subject of a disciplinary action taken by a financial or insurance regulator of this state, another state, or the United States;

(3) a statement certifying that, immediately on the change of control, the certificate holder will be able to satisfy the requirements for the issuance of a certificate of authority; and

(4) any additional information that the commissioner by rule may prescribe as necessary or appropriate to the public interest and the protection of the insurance consumers of this state.

(b) The department may require a partnership, syndicate, or other group that is required to file a statement under Subsection (a) to provide the information required under that subsection for each partner of the partnership, each member of the syndicate or group, and each person who controls the partner or member. If the partner, member, or person is a corporation or the person required to file the statement under Subsection (a) is a corporation, the department may require that the information required under that subsection be provided regarding:

(1) the corporation;

(2) each individual who is an executive officer or director of the corporation; and

(3) each person who is directly or indirectly the beneficial owner of more than 10 percent of the outstanding voting securities of the corporation.

(c) The department may disapprove an acquisition of control if, after notice and opportunity for hearing, the commissioner determines that:

(1) immediately on the change of control the certificate holder would not be able to satisfy the requirements for the certificate of authority;

(2) the competence, trustworthiness, experience, and integrity of the persons who would control the operation of the certificate holder are such that it would not be in the interest of the insurance consumers of this state to permit the acquisition of control; or

(3) the acquisition of control would violate this code or another law of this state, another state, or the United States.

(d) Notwithstanding Subsection (c), a change in control is considered approved if the commissioner has not proposed to deny the requested change before the 61st day after the date on which the department receives all information required by this section.

Added by Acts 2007, 80th Leg., R.S., Ch. 1176 (H.B. 472), Sec. 1.19, eff. September 1, 2007.

Sec. 4151.212. MAINTENANCE OF QUALIFICATIONS REQUIRED. The department may, in the manner prescribed by Section 4151.056 and by Subchapter G, revoke, suspend, or refuse to renew the certificate of authority of a certificate holder who does not maintain the qualifications necessary to obtain a certificate of authority issued under this chapter.

Added by Acts 2007, 80th Leg., R.S., Ch. 1176 (H.B. 472), Sec. 1.19, eff. September 1, 2007.

SUBCHAPTER F. WORKERS' COMPENSATION BENEFIT PLANS

Sec. 4151.251. DEFINITION. For purposes of this subchapter only, "insurance carrier" means:

- (1) an insurance company; or
- (2) a certified self-insurer for workers' compensation insurance, other than a certified self-insurance group under Chapter 407A, Labor Code, or a governmental entity that self-insures.

Added by Acts 2007, 80th Leg., R.S., Ch. 1176 (H.B. 472), Sec. 1.20, eff. September 1, 2007.

Sec. 4151.252. APPLICATION. (a) This subchapter applies to the administration of workers' compensation insurance coverage.

(b) This subchapter does not apply to an employer that does not elect under Subchapter A, Chapter 406, Labor Code, to obtain workers' compensation insurance coverage.

Added by Acts 2007, 80th Leg., R.S., Ch. 1176 (H.B. 472), Sec. 1.20, eff. September 1, 2007.

Sec. 4151.253. AGREEMENTS BETWEEN ADMINISTRATORS AND CARRIERS.

(a) An administrator shall enter into a contract in connection with workers' compensation benefits for collecting premium or contributions, adjusting claims, or settling claims with the insurance carrier responsible for those claims, including the insurance carrier responsible for claims arising under policies authorized under Section 2053.202(b). A contract required by this subsection may be in the form of a master services agreement.

(b) A contract required by Subsection (a) must provide that:

(1) the contract does not limit in any way the insurance carrier's authority or responsibility, including financial responsibility, to comply with each statutory or regulatory requirement; and

(2) the administrator shall comply with each statutory or regulatory requirement relating to a function assumed by or carried out by the administrator.

Added by Acts 2007, 80th Leg., R.S., Ch. 1176 (H.B. 472), Sec. 1.20, eff. September 1, 2007.

Sec. 4151.254. AGREEMENTS BETWEEN ADMINISTRATORS AND EMPLOYERS.

(a) In addition to the contract required by Section 4151.253, an administrator may also enter into a contract with an employer in connection with workers' compensation benefits for collecting premium or contributions, adjusting claims, or settling claims, including an employer purchasing a policy authorized under Section 2053.202(b).

(b) A contract entered into under Subsection (a) must provide that:

(1) the contract does not limit or modify in any way:

(A) the insurance carrier's authority or responsibility, including financial responsibility, to comply with each statutory or regulatory requirement; and

(B) the provisions of the contract entered into between the administrator and the insurance carrier under Section 4151.253; and

(2) the administrator shall comply with each statutory or regulatory requirement relating to a function assumed by or carried out by the administrator.

Added by Acts 2007, 80th Leg., R.S., Ch. 1176 (H.B. 472), Sec. 1.20, eff. September 1, 2007.

Sec. 4151.255. ADMINISTRATOR COMPENSATION. Except as provided by Section 4151.117, an administrator may accept compensation of any kind for the performance of administrative services in connection with workers' compensation claims from:

(1) an insurance carrier responsible for those claims;

(2) an employer with whom the administrator has entered into a contract; or

(3) both the insurance carrier and the employer.

Added by Acts 2007, 80th Leg., R.S., Ch. 1176 (H.B. 472), Sec. 1.20, eff. September 1, 2007.

Sec. 4151.256. LARGE DEDUCTIBLE POLICIES. An employer who enters into a contract with an insurance carrier under Section 2053.202(b) may not use or contract with an administrator to perform administrative services in connection with workers' compensation benefits unless the administrator has entered into a written agreement with the insurance carrier that:

(1) complies with all the provisions of this chapter; and

(2) provides that the insurance carrier is responsible for:

(A) setting standards used in the handling of claims;

and

(B) arranging for the payment of claims.

Added by Acts 2007, 80th Leg., R.S., Ch. 1176 (H.B. 472), Sec. 1.20, eff. September 1, 2007.

Sec. 4151.257. RULES. The commissioner shall adopt rules to implement the requirements of this subchapter, including rules prescribing requirements for contracts and master services agreements and requirements for the payment of claims. The rules must provide for compliance with the requirements of this chapter for any contract that takes effect or has an annual anniversary date on or after January 1, 2008.

Added by Acts 2007, 80th Leg., R.S., Ch. 1176 (H.B. 472), Sec. 1.20, eff. September 1, 2007.

SUBCHAPTER G. DISCIPLINARY ACTIONS; PENALTIES

Sec. 4151.301. GROUNDS FOR DENIAL, SUSPENSION, OR REVOCATION OF CERTIFICATE OF AUTHORITY. The department may deny an application for a certificate of authority or discipline the holder of a certificate of authority under this subchapter if the department determines that

the applicant or holder, individually, or through an officer, director, or shareholder:

- (1) has wilfully violated an insurance law of this state;
- (2) has intentionally made a material misstatement in the application for a certificate of authority;
- (3) has obtained or attempted to obtain a certificate of authority by fraud or misrepresentation;
- (4) has misappropriated, converted to the applicant's or holder's own use, or illegally withheld money belonging to:
 - (A) an insurance carrier, as that term is defined by Section 401.011, Labor Code;
 - (B) an insurer, as that term is defined by Section 4001.003;
 - (C) a health maintenance organization; or
 - (D) an insured, enrollee, injured employee, or beneficiary;
- (5) has engaged in fraudulent or dishonest acts or practices;
- (6) has materially misrepresented the terms and conditions of an insurance policy, certificate, evidence of coverage, or contract;
- (7) has been convicted of a felony;
- (8) is in a financial condition, or is operating or conducting business in a manner, that would render further transaction of business in this state hazardous or injurious to insured persons or the public;
- (9) has failed to comply with any judgment rendered against the applicant or holder before the 60th day after the date on which the judgment becomes final;
- (10) has wilfully violated a commissioner rule;
- (11) has refused to be examined or to produce accounts, records, and files for examination as required by this chapter or commissioner rule;
- (12) at any time fails to meet a qualification for which issuance of the certificate of authority could have been denied had the failure then existed and been known to the commissioner;
- (13) has had a certificate of authority, license, or other authority issued by this state, another state, or the United States suspended or revoked; or
- (14) has failed to timely file the annual report required

by Section 4151.205.

Added by Acts 2007, 80th Leg., R.S., Ch. 1176 (H.B. 472), Sec. 1.21, eff. September 1, 2007.

Sec. 4151.302. REMEDIES FOR VIOLATION OF INSURANCE LAWS OR COMMISSIONER RULES. In addition to any other remedy available under Chapter 82 for a violation of this code, another insurance law of this state, or a commissioner rule, the department may:

- (1) deny an application for a certificate of authority;
- (2) suspend or revoke a certificate of authority;
- (3) place on probation a person whose certificate of authority has been suspended;
- (4) assess an administrative penalty; or
- (5) reprimand a certificate of authority holder.

Added by Acts 2007, 80th Leg., R.S., Ch. 1176 (H.B. 472), Sec. 1.21, eff. September 1, 2007.

Sec. 4151.303. PROBATED SUSPENSION. If the suspension of a certificate of authority is probated, the commissioner may require the holder to:

- (1) report regularly to the department on any matter that is the basis of the probation; or
- (2) limit the holder's practice to the areas prescribed by the department.

Added by Acts 2007, 80th Leg., R.S., Ch. 1176 (H.B. 472), Sec. 1.21, eff. September 1, 2007.

Sec. 4151.304. HEARING. If the department proposes to deny an application for a certificate of authority, or to suspend or revoke a certificate of authority, the applicant or holder is entitled to notice and a hearing conducted by the State Office of Administrative Hearings as provided by Chapter 40.

Added by Acts 2007, 80th Leg., R.S., Ch. 1176 (H.B. 472), Sec. 1.21, eff. September 1, 2007.

Sec. 4151.305. APPLICATION FOR CERTIFICATE OF AUTHORITY AFTER DENIAL OR REVOCATION. (a) A person, or officer, director, or shareholder of a person, whose application has been denied or whose certificate of authority has been revoked under this subchapter may not apply for a certificate of authority before the fifth anniversary of:

(1) the effective date of the denial or revocation; or

(2) the date of a final court order affirming the denial or revocation if judicial review was sought.

(b) An application filed after the period required by Subsection (a) may be denied by the commissioner if the applicant fails to show good cause why the denial or revocation should not be a bar to the issuance of a new certificate.

(c) Subsection (b) does not apply to an applicant whose application was denied for failure by the applicant to submit a properly completed application for a certificate of authority.

Added by Acts 2007, 80th Leg., R.S., Ch. 1176 (H.B. 472), Sec. 1.21, eff. September 1, 2007.

Sec. 4151.306. DISCIPLINARY PROCEEDING FOR CONDUCT COMMITTED BEFORE SURRENDER OR FORFEITURE OF CERTIFICATE. (a) The department may institute a disciplinary proceeding against a former certificate holder, or officer, director, or shareholder of a former certificate holder, for conduct committed before the effective date of a voluntary surrender or automatic forfeiture of the certificate of authority.

(b) In a proceeding under this section, the fact that the certificate holder, or officer, director, or shareholder of a certificate holder, has surrendered or forfeited the certificate does not affect the former certificate holder's, or officer, director, or shareholder of a former certificate holder's, culpability for the conduct that is the subject of the proceeding.

Added by Acts 2007, 80th Leg., R.S., Ch. 1176 (H.B. 472), Sec. 1.21, eff. September 1, 2007.

Sec. 4151.307. EMERGENCY CERTIFICATE SUSPENSION. (a) The commissioner may suspend the certificate of an administrator without notice or hearing if the commissioner determines that:

- (1) the administrator is insolvent or impaired;
- (2) an order for receivership, conservatorship, rehabilitation, or any other delinquency regarding the administrator has been entered in any state; or
- (3) the financial condition or business practices of the administrator otherwise pose an imminent threat to the public health, safety, or welfare of the residents of this state.

(b) On determining that grounds exist under Subsection (a) to suspend the administrator's certificate of authority, the commissioner may issue an order suspending the certificate. The commissioner shall immediately serve notice of the suspension on the holder.

(c) The notice required by Subsection (b) must:

- (1) be personally served on the holder or be sent by registered or certified mail, return receipt requested, to the holder's last known address according to the department's records;
- (2) state the grounds for the suspension; and
- (3) inform the holder of the right to a hearing on the suspension order.

(d) An administrator whose certificate of authority is suspended under this section is entitled to request a hearing on the suspension not later than the 30th day after the date of receipt of notice of the suspension. Not later than the 10th day after the date a hearing is requested, the commissioner shall issue a notice of hearing.

(e) The hearing must be held not later than the 10th day after the date notice of hearing is issued, unless the parties agree to a later date.

(f) A hearing on a suspension order under this section is subject to Chapter 2001, Government Code, and to Subchapter A, Chapter 40. After the hearing, the administrative law judge shall recommend to the commissioner whether to uphold, vacate, or modify the suspension order.

(g) A suspension order issued under this section remains in effect until further action is taken by the commissioner.

Added by Acts 2007, 80th Leg., R.S., Ch. 1176 (H.B. 472), Sec. 1.21,

eff. September 1, 2007.

Sec. 4151.308. GENERAL ADMINISTRATIVE SANCTIONS. An administrator or other person who violates this chapter is subject to the sanctions provided by Chapter 82.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005. Renumbered from Insurance Code, Section 4151.207 and amended by Acts 2007, 80th Leg., R.S., Ch. 1176 (H.B. 472), Sec. 1.22, eff. September 1, 2007.

Sec. 4151.309. CRIMINAL PENALTY. (a) An administrator commits an offense if the administrator knowingly violates this chapter or a rule of the commissioner adopted under this chapter.

(b) An offense under this section is a misdemeanor punishable by a fine of not less than \$500 or more than \$5,000.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005. Renumbered from Insurance Code, Section 4151.208 and amended by Acts 2007, 80th Leg., R.S., Ch. 1176 (H.B. 472), Sec. 1.23, eff. September 1, 2007.

CHAPTER 4152. REINSURANCE INTERMEDIARIES

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 4152.001. DEFINITIONS. In this chapter:

(1) "Actuary" means a member in good standing of the American Academy of Actuaries.

(2) "Broker" means a person, other than an officer or employee of an insurer, who solicits, negotiates, or places reinsurance business on behalf of an insurer and who may not exercise the authority to bind reinsurance on behalf of that insurer.

(3) "Control" has the meaning described by Sections 823.005 and 823.151.

(4) "Insurer" means a commercially domiciled insurer or other person legally organized in this state to engage in the business of insurance as an insurance company, including:

- (A) a capital stock insurance company;
- (B) a mutual insurance company;

- (C) a title insurance company;
- (D) a fraternal benefit society;
- (E) a local mutual aid association;
- (F) a statewide mutual assessment company;
- (G) a county mutual insurance company;
- (H) a Lloyd's plan;
- (I) a reciprocal or interinsurance exchange;
- (J) a stipulated premium company;
- (K) a group hospital service corporation;
- (L) a farm mutual insurance company; and
- (M) a risk retention group.

(5) "Manager" means a person who has the authority to bind reinsurance or who manages all or part of the reinsurance business of an insurer, including the management of a separate division, department, or underwriting office, and who acts as an agent for that insurer. The term does not include:

- (A) an employee of the insurer;
- (B) a manager of the United States branch of an alien insurer;
- (C) an underwriting manager who, under a contract, manages all of the reinsurance operations of an insurer, who is under common control with the insurer under Chapter 823, and whose compensation is not based on the volume of premiums written; or
- (D) a manager of a group, association, pool, or other organization of insurers who engages in joint underwriting or joint reinsurance and who is subject to examination by the insurance commissioner or other appropriate officer of the state in which the manager's principal business office is located.

(6) "Person" means an individual or a corporation, partnership, association, or other private legal entity.

(7) "Qualified United States financial institution" means an institution that is:

- (A) organized or, in the case of a United States office of a foreign banking organization, licensed under the laws of the United States or a state; and
- (B) regulated, supervised, and examined by United States federal or state authorities who have regulatory authority over banks and trust companies.

(8) "Reinsurance" means a written contract that for consideration transfers an insurance risk of loss between insurers

and indemnifies a ceding insurer against all or part of the loss that the ceding insurer may sustain under an insurance policy the ceding insurer has issued or assumed. The term does not include a contract for the bulk sale, transfer, and assumption of direct insurance policy liability to the insureds.

(9) "Reinsurance intermediary" means a broker or manager.

(10) "Reinsurer" means an insurer who has the authority to assume reinsurance, including retrocessions. The term includes a retrocessionaire.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4152.002. CLASSIFICATION AS COMMERCIALY DOMICILED INSURER. (a) For purposes of this chapter, a foreign or alien insurer authorized to engage in the business of insurance in this state is a commercially domiciled insurer if during the period described by Subsection (b) the average of the gross premiums written by the insurer in this state is:

(1) more than the average of the gross premiums written by the insurer in the insurer's state of domicile; and

(2) 20 percent or more of the total gross premiums written by the insurer in the United States, as reported in the insurer's three most recent annual statements.

(b) The period applicable to Subsection (a) is:

(1) the three most recent fiscal years of the insurer that precede the fiscal year in which the determination under this section is made; or

(2) if the insurer has been authorized to engage in the business of insurance in this state for less than the period described by Subdivision (1), the period for which the insurer has been authorized to engage in the business of insurance in this state.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4152.003. RIGHTS OF THIRD PARTIES NOT AFFECTED. This chapter does not restrict the rights of or confer any additional rights on a policyholder, claimant, creditor, or other third party.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4152.004. RULES. The commissioner may adopt reasonable rules as necessary to implement this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

SUBCHAPTER B. LICENSE REQUIREMENTS

Sec. 4152.051. LICENSE REQUIRED. (a) A person may not act as a broker or manager in this state for an insurer engaged in the business of insurance or reinsurance in this state unless the person holds an appropriate license under this chapter.

(b) A person who holds a manager license is not required to obtain a broker license but must comply with Subchapter D to act as a broker.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4152.052. QUALIFICATIONS. The commissioner may establish qualifications for a reinsurance intermediary license as reasonably necessary to fulfill the requirements of this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4152.053. APPLICATION. (a) An application for a reinsurance intermediary license may not be accepted unless the application shows on its face that the applicant has been engaged in the business of insurance or reinsurance for at least three years.

(b) Each person authorized under Section 4152.057 to act as a reinsurance intermediary under a reinsurance intermediary license issued to an entity must be named in the application and any supplement to the application.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4152.054. SERVICE OF NOTICE, ORDERS, AND PROCESS. (a) An applicant for a reinsurance intermediary license who is not a

resident of this state must:

(1) designate the commissioner as agent for service of process in the manner, and with the same legal effect, as provided by Chapter 804 for service of process on unauthorized insurers; and

(2) provide the commissioner with the name and address of a resident of this state on whom a notice or order of the commissioner or process affecting the applicant may be served.

(b) A license holder who is a nonresident shall notify the commissioner in writing of each change in the license holder's designated agent under Subsection (a)(2) not later than the 30th day after the date on which the license holder makes the change. The change does not take effect until acknowledged by the commissioner.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4152.055. FEES. (a) The department shall collect a nonrefundable licensing fee from each reinsurance intermediary who applies for an original or renewal license in this state.

(b) The commissioner shall set the fees for original, renewal, and reciprocal licenses in amounts that are reasonable and necessary to cover the costs of the licensing program.

(c) The fees shall be deposited to the credit of the Texas Department of Insurance operating account. Money deposited in the account under this subsection may be used by the department only to enforce this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4152.056. LICENSE ISSUANCE. The commissioner shall issue a reinsurance intermediary license to a person who complies with this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4152.057. PERSONS AUTHORIZED TO ACT UNDER LICENSE. (a) A reinsurance intermediary license issued to a firm or association authorizes each member of the firm or association and any designated employee to act as a reinsurance intermediary under the license.

(b) A reinsurance intermediary license issued to a corporation authorizes each officer and any designated employee or director of the corporation to act as a reinsurance intermediary under the license.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4152.058. BOND OR ERRORS AND OMISSIONS POLICY. (a) The commissioner may require a reinsurance intermediary to:

- (1) file a bond with the commissioner for the protection of all insurers represented; or
- (2) maintain an errors and omissions policy.

(b) The issuer of the bond or the errors and omissions policy must be acceptable to the commissioner. The bond or the policy must be in an amount determined by the commissioner to be customary and adequate under the circumstances.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4152.059. LICENSE EXPIRATION AND RENEWAL. (a) A reinsurance intermediary license is valid for two years from the date of issuance and may be renewed for two-year terms.

(b) The commissioner may adopt standards for the renewal of a reinsurance intermediary license.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

SUBCHAPTER C. EXAMINATION OF REINSURANCE INTERMEDIARIES

Sec. 4152.101. EXAMINATION BY COMMISSIONER. (a) A reinsurance intermediary is subject to examination by the commissioner of the reinsurance intermediary's:

- (1) financial condition; and
- (2) compliance with the laws of this state affecting the conduct of the reinsurance intermediary's business.

(b) A manager may be examined as if the manager were an insurer.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4152.102. ACCESS TO AND MAINTENANCE OF BOOKS, BANK ACCOUNTS, AND RECORDS. (a) The commissioner is entitled to access to all books, bank accounts, and records of a reinsurance intermediary.

(b) A reinsurance intermediary shall maintain books, bank accounts, and records in a form usable by the commissioner.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4152.103. CONDUCT OF EXAMINATION. The commissioner, one or more commissioned examiners, a certified public accountant, or another person qualified to perform the examination shall conduct an examination under this subchapter as the commissioner considers necessary.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4152.104. EXAMINATION EXPENSE. (a) A reinsurance intermediary who is examined under this subchapter shall pay an amount for the expense of the examination that the commissioner certifies as just and reasonable.

(b) Expenses relating to an examination conducted under this subchapter may be charged to the person examined in accordance with Sections 401.151, 401.152, 401.155, and 401.156.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 2J.005, eff. April 1, 2009.

SUBCHAPTER D. REQUIREMENTS RELATING TO BROKERS

Sec. 4152.151. CONTRACT BETWEEN BROKER AND INSURER. (a) A broker and an insurer represented by the broker may enter into a transaction only under a written contract that:

(1) is executed by a responsible officer of both the broker and the insurer; and

(2) specifies the responsibilities of each party.

(b) At a minimum, a contract entered into under this section must:

(1) authorize the insurer to terminate the broker's authority in writing at any time;

(2) require the broker to:

(A) provide accounts to the insurer at least quarterly that accurately detail all material transactions, including information necessary to support all commissions, charges, and other fees received by or owing to the broker;

(B) pay all money due the insurer not later than the 30th day after the date of receipt;

(C) hold all money collected for the insurer's account in a fiduciary capacity in a bank that is a qualified United States financial institution; and

(D) if premiums or contributions are collected on behalf of or for more than one insurer:

(i) maintain records to identify the ownership interest of each insurer in money held in a fiduciary capacity; and

(ii) provide to each insurer on request a copy of the records relating to deposits and withdrawals on behalf of or for that insurer;

(3) state that the broker will:

(A) comply with:

(i) Section 4152.153; and

(ii) the written standards established by the insurer for the cession or retrocession of risks ceded;

(B) disclose to the insurer any relationship with a reinsurer to which business will be ceded or retroceded; and

(C) provide annually to each insurer with whom the broker transacts business an audited statement of the broker's financial condition prepared by a certified public accountant;

(4) identify:

(A) the name and address of the insurer;

(B) the kinds of insurance to be reinsured or retroceded;

(C) the type of reinsurance or retrocessions; and

(D) the limits of coverage; and

(5) state the effective date and expiration date of the contract.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4152.152. PLACEMENT OF REINSURANCE WITH UNAUTHORIZED REINSURER. Unless the ceding insurer releases the broker in writing from the broker's obligations under this section, a broker who places reinsurance on behalf of an authorized ceding insurer with a reinsurer that is not authorized, accredited, or trusted in this state under Chapter 493 shall:

- (1) exercise due diligence in inquiring into the financial condition of the reinsurer;
- (2) disclose to the ceding insurer the broker's findings in connection with the inquiry under Subdivision (1); and
- (3) make available to the ceding insurer a copy of the current financial statement of the reinsurer.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2J.006, eff. April 1, 2009.

Acts 2017, 85th Leg., R.S., Ch. 594 (S.B. 1070), Sec. 3.14, eff. September 1, 2017.

Sec. 4152.153. TRANSACTION RECORDS. (a) For at least 10 years after the expiration of each contract of reinsurance transacted by a broker, the broker shall maintain a complete record for each transaction that contains:

- (1) the type of contract, limits, underwriting restrictions, classes of risks, and territory;
- (2) the period of coverage, including effective and expiration dates, cancellation provisions, and notice requirements regarding cancellation;
- (3) reporting and settlement requirements regarding balances;
- (4) the rate used to compute the reinsurance premium;
- (5) the name and address of each ceding or assuming insurer;
- (6) the rates of all reinsurance commissions, including the commissions on any retrocessions handled by the broker;

- (7) related correspondence and memoranda;
- (8) proof of placement;
- (9) details regarding retrocessions handled by the broker, including the identity and address of each retrocessionaire and the respective percentage of each contract assumed or ceded;
- (10) financial records, including premium and loss accounts; and
- (11) if the broker procures a reinsurance contract on behalf of an authorized ceding insurer:
 - (A) written evidence that the assuming insurer has agreed to assume the risk if the contract is procured directly from an assuming insurer; or
 - (B) written evidence that the reinsurer has delegated binding authority to the representative who has agreed to assume the risk and that the representative is qualified to act as a manager under this chapter if the contract is procured through a representative of the assuming insurer, other than an employee.

(b) Each insurer subject to a contract of reinsurance transacted by a broker is entitled to access to the information maintained by the broker under Subsection (a) and may copy and audit all accounts and records maintained by the broker related to the insurer's business. The broker shall maintain the information in a form usable by the insurer.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4152.154. EMPLOYMENT OF PERSON BY INSURER AND BROKER. A person may not be employed by an insurer and a broker with whom the insurer transacts business unless the broker is:

- (1) under common control with the insurer; and
- (2) subject to Chapter 823.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

SUBCHAPTER E. REQUIREMENTS RELATING TO MANAGERS

Sec. 4152.201. CONTRACT BETWEEN MANAGER AND INSURER. (a) A manager and an insurer represented by the manager may enter into a transaction only under a written contract that:

- (1) is executed by a responsible officer of both the

manager and the insurer;

(2) is approved by the insurer's board of directors or attorney in fact;

(3) specifies the responsibilities of each party;

(4) identifies the rate, terms, and purpose of each commission, charge, or other fee the manager may assess the insurer; and

(5) at a minimum, incorporates the requirements of Sections 4152.202-4152.214.

(b) Not later than the 30th day before the date the insurer assumes or cedes business through the manager, a copy of the executed contract must be filed with the commissioner for approval.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4152.202. TERMINATION OF CONTRACT. An insurer may:

(1) terminate a contract entered into under Section 4152.201 for cause on written notice to the manager by certified mail, return receipt requested; and

(2) suspend the authority of the manager to assume or cede business during any dispute regarding the cause for termination.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4152.203. ACCOUNTING FOR TRANSACTIONS. A manager who enters into a contract with an insurer under Section 4152.201 shall provide accounts to the insurer at least quarterly that accurately detail all material transactions, including information necessary to support all commissions, charges, and other fees received by or owing to the manager.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4152.204. MANAGEMENT OF MONEY. (a) A manager shall pay an insurer at least monthly all money due the insurer under a contract entered into under Section 4152.201.

(b) The manager must hold all money collected for the insurer's account in a fiduciary capacity in a bank that is a qualified United

States financial institution. The manager may not retain more than three months of estimated claims payments and allocated loss adjustment expenses.

(c) If premiums or contributions are collected on behalf of or for more than one insurer, the manager shall:

- (1) keep a separate account for each insurer;
- (2) maintain a copy of the records for each account; and
- (3) provide to each insurer on request a copy of the records relating to deposits and withdrawals on behalf of or for that insurer.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4152.205. TRANSACTION RECORDS. (a) For at least 10 years after the expiration of each reinsurance contract transacted by a manager, the manager shall maintain a complete record for each transaction that contains:

- (1) the type of contract, limits, underwriting restrictions, classes of risks, and territory;
- (2) the period of coverage, including effective and expiration dates, cancellation provisions and notice requirements regarding cancellation, and disposition of outstanding reserves on covered risks;
- (3) reporting and settlement requirements regarding balances;
- (4) the rate used to compute the reinsurance premium;
- (5) the name and address of each ceding or assuming insurer;
- (6) the rates of all reinsurance commissions, including the commissions on any retrocessions handled by the manager;
- (7) related correspondence and memoranda;
- (8) proof of placement;
- (9) details regarding retrocessions handled by the manager, as permitted by Section 4152.254, including the identity and address of each retrocessionaire and the respective percentage of each contract assumed;
- (10) financial records, including premium and loss accounts; and
- (11) if the manager procures a reinsurance contract on

behalf of a ceding insurer:

(A) written evidence that the assuming insurer has agreed to assume the risk if the contract is procured directly from an assuming insurer; or

(B) written evidence that the reinsurer has delegated binding authority to the representative who has agreed to assume the risk and that the representative is qualified to act as a manager under this chapter if the contract is procured through a representative of the assuming insurer, other than an employee.

(b) Each insurer is entitled to access to the information maintained by the manager and may copy all accounts and records maintained by the manager related to the insurer's business. The manager shall maintain the information in a form usable by the insurer.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4152.206. CONTRACT ASSIGNMENT PROHIBITED. A manager may not assign in whole or in part a contract entered into under Section 4152.201.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4152.207. COMPLIANCE WITH UNDERWRITING AND RATING STANDARDS OF INSURER. A manager shall comply with the written underwriting and rating standards established by an insurer with whom the manager has entered into a contract under Section 4152.201 for the acceptance, rejection, or cession of all risks.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4152.208. SETTLEMENT OF CLAIMS. (a) This section applies only to a contract entered into under Section 4152.201 that permits a manager to settle claims on behalf of an insurer.

(b) All claims must be reported to the insurer at least quarterly.

(c) The manager shall send a copy of the claim file to the insurer at the insurer's request or as soon as it is known that the

claim:

- (1) has the potential to exceed the lesser of:
 - (A) an amount determined by the commissioner; or
 - (B) the limit set by the insurer;
- (2) involves a coverage dispute;
- (3) may exceed the manager's claims settlement authority;
- (4) has been open for more than six months; or
- (5) has been closed by payment of the lesser of:
 - (A) an amount determined by the commissioner; or
 - (B) the limit set by the insurer.

(d) A claim file is the joint property of the insurer and manager, except that on an order of liquidation of the insurer the file becomes the sole property of the insurer or the insurer's estate. The manager is entitled to reasonable access to the claim file and may copy the file on a timely basis.

(e) Any settlement authority granted to the manager may be terminated for cause on the insurer's written notice by certified mail, return receipt requested, to the manager or on the termination of the contract. The insurer may suspend the settlement authority during any dispute regarding the cause of termination.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4152.209. PAYMENT OF INTERIM PROFITS. If a contract entered into under Section 4152.201 provides for the sharing of interim profits by the manager, interim profits may not be paid until:

- (1) the first anniversary of the end of each underwriting period for property business, the fifth anniversary of the end of each underwriting period for casualty business, or the expiration of the period set by the executive director for those or other specified kinds of insurance; and
- (2) the adequacy of reserves on remaining claims has been verified under Section 4152.213.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4152.210. AUDITED STATEMENT OF MANAGER'S FINANCIAL CONDITION. (a) A manager shall provide annually to each insurer and

reinsurer with whom the manager transacts business an audited statement of the manager's financial condition.

(b) The statement must be prepared by an independent certified public accountant in a form acceptable to the commissioner.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4152.211. DISCLOSURE OF RELATIONSHIPS WITH OTHER INSURERS. Before ceding or assuming any business on behalf of an insurer under a contract entered into under Section 4152.201, a manager shall disclose to the insurer any relationship the manager has with another insurer.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4152.212. ACTS OF MANAGER CONSIDERED ACTS OF INSURER. The acts of a manager are considered to be the acts of the insurer on whose behalf the manager is acting.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4152.213. ACTUARY'S OPINION ON ADEQUACY OF LOSS RESERVES. In addition to any other required loss reserve certification, a manager who establishes loss reserves shall provide annually, or more frequently as required by other law, an opinion from an actuary attesting to the adequacy of the loss reserves established for losses incurred and outstanding on business produced by the manager.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4152.214. PLACEMENT OF REINSURANCE WITH UNAUTHORIZED REINSURER. (a) Unless the ceding insurer releases the manager in writing from the manager's obligations under this section, a manager who places reinsurance on behalf of an authorized ceding insurer with a reinsurer that is not authorized, accredited, or trusted in this state under Chapter 493 shall:

(1) exercise due diligence in inquiring into the financial

condition of the reinsurer;

(2) disclose to the ceding insurer the manager's findings in connection with the inquiry under Subdivision (1); and

(3) make available to the ceding insurer a copy of the current financial statement of the reinsurer.

(b) A ceding insurer that releases a manager from the manager's obligations under Subsection (a) assumes those obligations.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2J.007, eff. April 1, 2009.

Acts 2017, 85th Leg., R.S., Ch. 594 (S.B. 1070), Sec. 3.15, eff. September 1, 2017.

Sec. 4152.215. PROHIBITIONS. (a) A reinsurance intermediary acting as a manager may not:

(1) bind retrocessions on behalf of an insurer, except that the manager may bind facultative retrocessions under obligatory retrocessional agreements if the contract entered into with the insurer under Section 4152.201 contains reinsurance underwriting guidelines for those retrocessions that include:

(A) a list of reinsurers with whom those automatic agreements are in effect; and

(B) for each reinsurer:

(i) the coverages and amounts or percentages that may be reinsured; and

(ii) commission schedules;

(2) commit an insurer to participate in a reinsurance syndicate;

(3) appoint or contract with a broker without ensuring that the broker is qualified to act as a manager under this chapter;

(4) without prior approval of the insurer, pay or commit an insurer to pay a claim that exceeds the lesser of:

(A) an amount specified by the insurer; or

(B) one percent of the insurer's policyholders' surplus as of December 31 of the last complete calendar year; or

(5) collect a payment from a retrocessionaire or commit an insurer to a claim settlement with a retrocessionaire without prior

approval of the insurer.

(b) If prior approval is given as provided by Subsection (a)(5), a report must be forwarded to the reinsurer as provided by Section 4152.203.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4152.216. EMPLOYMENT OF PERSON BY INSURER AND MANAGER. A person may not be employed by an insurer and a manager with whom the insurer transacts business unless the manager is:

- (1) under common control with the insurer; and
- (2) subject to Chapter 823.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

SUBCHAPTER F. REQUIREMENTS RELATING TO INSURERS

Sec. 4152.251. ENGAGEMENT OF SERVICES OF UNLICENSED BROKER OR MANAGER. (a) Except as provided by Subsection (b), an insurer may not engage the services of a person to act as a broker or manager on the insurer's behalf unless the person holds a license if required by Section 4152.051.

(b) An insurer, or an employee, attorney, or actuary of an insurer, may negotiate and obtain reinsurance for that insurer without holding a broker or manager license or without using the services of a broker or manager if that insurer, employee, attorney, or actuary does not otherwise hold the person out as a broker or manager or perform the duties or provide the services of a broker or manager.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4152.252. AUDITED STATEMENT OF MANAGER'S FINANCIAL CONDITION. An insurer shall obtain annually an audited statement as provided by Section 4152.210 of the financial condition of each manager with whom the insurer transacts business.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4152.253. REVIEW OF UNDERWRITING AND CLAIMS PROCESSING OPERATIONS. An insurer shall conduct at least semiannually an on-site review of the underwriting and claims processing operations of a manager with whom the insurer enters into a contract under Section 4152.201.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4152.254. AUTHORITY FOR RETROCESSIONAL CONTRACTS OR PARTICIPATION IN REINSURANCE SYNDICATES. Binding authority for all retrocessional contracts or participation in reinsurance syndicates rests with an officer of the insurer. That officer may not be affiliated with a manager acting for the insurer.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4152.255. NOTIFICATION OF TERMINATION OF MANAGER'S CONTRACT. (a) Not later than the 30th day after the date an insurer terminates a manager's contract, the insurer shall provide written notice to the commissioner of the termination, including the reasons for termination.

(b) The notice is a privileged communication and is not subject to public disclosure or admission into evidence in any proceeding.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4152.256. APPOINTMENT OF CERTAIN PERSONS TO BOARD OF DIRECTORS PROHIBITED. (a) This section does not apply to a relationship governed by Chapter 823.

(b) An insurer may not appoint to the insurer's board of directors an officer, director, employee, controlling shareholder, or submanager of a manager acting for that insurer.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

SUBCHAPTER G. DISCIPLINE AND ENFORCEMENT

Sec. 4152.301. GROUNDS FOR LICENSE DENIAL OR DISCIPLINARY

ACTION. The department may deny an application for a license or discipline a license holder under Subchapter C, Chapter 4005, if the department determines that the applicant or license holder, or a person who would be authorized to act on behalf of the applicant or license holder under Section 4152.057, has:

- (1) wilfully violated or participated in the violation of this chapter or another insurance law of this state;
- (2) intentionally made a material misstatement in the license application;
- (3) obtained or attempted to obtain the license by fraud or misrepresentation;
- (4) misappropriated, converted to the person's own use, or illegally withheld money required to be held in a fiduciary capacity;
- (5) materially misrepresented the terms or effect of any contract of insurance or reinsurance, or engaged in any fraudulent transaction; or
- (6) been convicted of a felony or of a misdemeanor of which criminal fraud is an essential element.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4152.302. IMPOSITION OF SANCTIONS. (a) The commissioner may impose or seek any sanction authorized by law, including the penalties authorized by Chapters 82 and 83, against a reinsurance intermediary, insurer, or reinsurer who the commissioner determines, after notice and hearing as provided by this code, has violated this chapter.

(b) The commissioner may impose or seek any sanction authorized by law, including the penalties authorized by Chapter 101, against a nonlicensed reinsurance intermediary who violates this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

CHAPTER 4153. RISK MANAGERS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 4153.001. DEFINITION. In this chapter, "risk manager" means a person who:

- (1) represents to the public that the person is a risk manager; and

(2) for compensation examines or evaluates risks for and provides advice regarding reduction of risks to a person seeking to obtain or renew property and casualty insurance coverage in this state.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4153.002. EXEMPTIONS. This chapter does not apply to a person who is employed as a risk manager by:

- (1) a liability insurance company authorized to engage in business in this state;
- (2) a single employer; or
- (3) a public self-insurance pool.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4153.003. RULES. The commissioner may adopt rules necessary to carry out this chapter and to regulate risk managers.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

SUBCHAPTER B. LICENSE REQUIREMENTS

Sec. 4153.051. LICENSE REQUIRED. A person may not act as or represent that the person is a risk manager in this state unless the person:

- (1) meets the requirements prescribed by this chapter and department rules; and
- (2) holds a license issued by the department.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4153.052. APPLICATION. (a) To obtain a license to act as a risk manager in this state, an applicant must submit to the department an application on forms prescribed by the commissioner and provided by the department.

(b) An application must be accompanied by the license fee required by Section 4153.057 and include:

(1) information the department requires relating to the applicant's identity, personal history, experience, and business record; and

(2) any other information the department requires.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4153.053. QUALIFICATIONS. To qualify for a risk manager's license, an applicant must:

(1) be at least 18 years of age;

(2) maintain a place of business in this state;

(3) meet the application requirements prescribed by this chapter and department rules;

(4) take and pass the examination required by this chapter;

and

(5) pay the examination and license fees.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4153.054. EXAMINATION. (a) Except as provided by Sections 4153.055 and 4153.058, an applicant for a risk manager's license must personally take and pass an examination to the satisfaction of the commissioner under this chapter and department rules.

(b) The commissioner shall prescribe the examination for a risk manager's license. The examination must:

(1) be designed to test the qualifications and competency of the applicant to be a risk manager; and

(2) be of sufficient scope to reasonably test the applicant's knowledge of risk management and the duties and responsibilities of a risk manager under the laws of this state and department rules.

(c) The department shall:

(1) determine the times and places for examinations; and

(2) give reasonable public notice of the examinations in the manner provided by department rules.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4153.055. EXEMPTIONS FROM EXAMINATION AND CONTINUING EDUCATION REQUIREMENT. (a) An applicant is not required to take an examination to obtain a risk manager's license if the applicant holds the designation of:

(1) chartered property casualty underwriter (CPCU) from the American Institute for Chartered Property Casualty Underwriters;

(2) certified insurance counselor (CIC) from the national Society of Certified Insurance Counselors;

(3) associate in risk management (ARM) from the Insurance Institute of America; or

(4) Certified Risk Manager (CRM) from The National Alliance for Insurance Education & Research.

(b) A license holder who has held a designation described by Subsection (a)(2), (3), or (4) for a period of not less than 30 years is exempt from continuing education requirements established under this title.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.
Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1172 (S.B. 876), Sec. 21, eff. September 1, 2015.

Sec. 4153.056. REEXAMINATION. (a) An applicant who fails the examination may retake the examination on payment of an additional examination fee.

(b) The commissioner may require the applicant to wait for a reasonable period determined by the commissioner before the applicant may retake the examination.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4153.057. FEES. (a) The commissioner shall set and collect in advance a nonrefundable fee, in an amount not to exceed \$50, for:

(1) an examination required by this chapter if the department administers the examination;

(2) a risk manager's license; and

(3) the renewal of a risk manager's license.

(b) A fee collected under this section shall be deposited to

the credit of the Texas Department of Insurance operating account.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4153.058. RECIPROCAL LICENSE. On submission of an application and the license fee required by Section 4153.057, a person may receive a risk manager's license without examination if the person is licensed as a risk manager by another state, the licensing requirements of which were, on the date the license was issued, substantially equivalent to the requirements prescribed by this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4153.059. LICENSE EXPIRATION. Except as otherwise provided by a staggered renewal system adopted under Section 4003.002, a risk manager's license expires on the second anniversary of the date the license was issued.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4153.060. LICENSE RENEWAL. (a) A license holder may renew an unexpired license by:

(1) filing with the department a completed renewal application; and

(2) paying the nonrefundable renewal fee.

(b) The commissioner shall issue a renewal certificate to the license holder if the commissioner determines the license holder continues to be eligible for the license.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

SUBCHAPTER C. POWERS AND DUTIES OF RISK MANAGERS

Sec. 4153.101. PLACE OF BUSINESS. A license holder shall maintain a place of business in this state that is:

(1) accessible to the public; and

(2) located at the place at which the license holder

principally conducts business.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4153.102. NOTIFICATION OF CHANGE OF PLACE OF BUSINESS. A license holder who changes the address of the license holder's place of business from the address that appears on the license shall notify the department of that change as provided by department rules.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

SUBCHAPTER D. DISCIPLINARY ACTION

Sec. 4153.151. GROUNDS FOR DISCIPLINARY ACTION. The department may discipline a license holder or deny an applicant a license under Subchapter C, Chapter 4005:

(1) for any cause for which, if known by the department, issuance of the license could have been refused; or

(2) if the license holder or applicant:

(A) wilfully or knowingly violates this chapter, an insurance law of this state, or a department rule;

(B) obtains or attempts to obtain a license through wilful misrepresentation or fraud;

(C) fails the examination required by this chapter; or

(D) is convicted on final judgment of a felony.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4153.152. LICENSE SUSPENSION. (a) An order suspending a license must specify the duration of the suspension period. The department may not suspend a license for a period of more than 12 months.

(b) A license holder whose license is revoked or suspended shall surrender the license to the commissioner at the commissioner's request.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

Sec. 4153.153. REINSTATEMENT OR REISSUANCE OF LICENSE. The commissioner may not reinstate the license of or reissue a license to a person whose license is suspended or revoked or to whom the department refuses to issue a renewal certificate until the first anniversary of the date of the suspension, revocation, or refusal to renew.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 7, eff. April 1, 2005.

TITLE 14. UTILIZATION REVIEW AND INDEPENDENT REVIEW
CHAPTER 4201. UTILIZATION REVIEW AGENTS
SUBCHAPTER A. GENERAL PROVISIONS

Sec. 4201.001. PURPOSE. The purpose of this chapter is to:

- (1) promote the delivery of quality health care in a cost-effective manner;
- (2) ensure that a utilization review agent adheres to reasonable standards for conducting utilization review;
- (3) foster greater coordination and cooperation between a health care provider and utilization review agent;
- (4) improve communications and knowledge of benefits among all parties concerned before an expense is incurred; and
- (5) ensure that a utilization review agent maintains the confidentiality of medical records in accordance with applicable law.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4201.002. DEFINITIONS. In this chapter:

- (1) "Adverse determination" means a determination by a utilization review agent that health care services provided or proposed to be provided to a patient are not medically necessary or are experimental or investigational.
- (2) "Emergency care" means health care services provided in a hospital emergency facility or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the individual's condition, sickness, or injury is of such a nature that failure to get immediate medical care could:

- (A) place the individual's health in serious jeopardy;
- (B) result in serious impairment to bodily functions;
- (C) result in serious dysfunction of a bodily organ or part;
- (D) result in serious disfigurement; or
- (E) for a pregnant woman, result in serious jeopardy to the health of the fetus.

(3) "Enrollee" means an individual covered by a health insurance policy or health benefit plan. The term includes an individual who is covered as an eligible dependent of another individual.

(4) "Health benefit plan" means a plan of benefits, other than a health insurance policy, that:

- (A) defines the coverage provisions for health care for enrollees; and
- (B) is offered or provided by a public or private organization.

(5) "Health care provider" means a person, corporation, facility, or institution that is:

- (A) licensed by a state to provide or is otherwise lawfully providing health care services; and
- (B) eligible for independent reimbursement for those health care services.

(6) "Health insurance policy" means an insurance policy, including a policy written by a corporation subject to Chapter 842, that provides coverage for medical or surgical expenses incurred as a result of accident or sickness.

(7) "Life-threatening" means a disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

(8) "Nurse" means a professional or registered nurse, a licensed vocational nurse, or a licensed practical nurse.

(9) "Patient" means the enrollee or an eligible dependent of the enrollee under a health benefit plan or health insurance policy.

(10) "Payor" means:

- (A) an insurer that writes health insurance policies;
- (B) a preferred provider organization, health maintenance organization, or self-insurance plan; or
- (C) any other person or entity that provides, offers to

provide, or administers hospital, outpatient, medical, or other health benefits to a person treated by a health care provider in this state under a policy, plan, or contract.

(11) "Physician" means a licensed doctor of medicine or a doctor of osteopathy.

(12) "Provider of record" means the physician or other health care provider with primary responsibility for the health care services provided to or requested on behalf of an enrollee or the physician or other health care provider that has provided or has been requested to provide the health care services to the enrollee. The term includes a health care facility where the health care services are provided on an inpatient or outpatient basis.

(13) "Utilization review" includes a system for prospective, concurrent, or retrospective review of the medical necessity and appropriateness of health care services and a system for prospective, concurrent, or retrospective review to determine the experimental or investigational nature of health care services. The term does not include a review in response to an elective request for clarification of coverage.

(14) "Utilization review agent" means an entity that conducts utilization review for:

(A) an employer with employees in this state who are covered under a health benefit plan or health insurance policy;

(B) a payor; or

(C) an administrator holding a certificate of authority under Chapter 4151.

(15) "Utilization review plan" means the screening criteria and utilization review procedures of a utilization review agent.

(16) "Working day" means a weekday that is not a legal holiday.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. [2017](#)), Sec. 4, eff. April 1, 2007.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1330 (H.B. [4290](#)), Sec. 7, eff. September 1, 2009.

Acts 2019, 86th Leg., R.S., Ch. 1218 (S.B. [1742](#)), Sec. 3.01, eff. September 1, 2019.

Sec. 4201.003. RULES. (a) The commissioner may adopt rules to implement this chapter.

(b) A rule adopted under this chapter relates only to a person or entity subject to this chapter.

(c) Repealed by Acts 2011, 82nd Leg., R.S., Ch. 1147, Sec. 2.008(11), eff. September 1, 2011.

(d) Repealed by Acts 2011, 82nd Leg., R.S., Ch. 1147, Sec. 2.008(11), eff. September 1, 2011.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 1147 (H.B. 1951), Sec. 2.008(11), eff. September 1, 2011.

Sec. 4201.004. TELEPHONE ACCESS. (a) A utilization review agent shall:

(1) have appropriate personnel reasonably available, by toll-free telephone at least 40 hours per week during normal business hours in this state, to discuss patients' care and allow response to telephone review requests;

(2) have a telephone system capable, during hours other than normal business hours, of accepting or recording incoming telephone calls or of providing instructions to a caller; and

(3) respond to a call made during hours other than normal business hours not later than the second working day after the later of:

(A) the date the call was received; or

(B) the date the details necessary to respond have been received from the caller.

(b) A utilization review agent must provide to the commissioner a written description of the procedures to be used when responding with respect to poststabilization care subsequent to emergency treatment as requested by a treating physician or other health care provider.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

SUBCHAPTER B. APPLICABILITY OF CHAPTER

Sec. 4201.051. PERSONS PROVIDING INFORMATION ABOUT SCOPE OF COVERAGE OR BENEFITS. This chapter does not apply to a person who:

(1) provides information to an enrollee about scope of coverage or benefits provided under a health insurance policy or health benefit plan; and

(2) does not determine whether a particular health care service provided or to be provided to an enrollee is:

- (A) medically necessary or appropriate; or
- (B) experimental or investigational.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1330 (H.B. 4290), Sec. 8, eff. September 1, 2009.

Sec. 4201.052. CERTAIN CONTRACTS WITH FEDERAL GOVERNMENT. This chapter does not apply to a contract with the federal government to provide utilization review with respect to a patient who is eligible for services under Title XVIII or XIX of the Social Security Act (42 U.S.C. Section 1395 et seq. or Section 1396 et seq.).

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4201.053. MEDICAID AND OTHER STATE HEALTH OR MENTAL HEALTH PROGRAMS. (a) Except as provided by Section 4201.057, this chapter does not apply to:

- (1) the state Medicaid program;
- (2) the services program for children with special health care needs under Chapter 35, Health and Safety Code;
- (3) a program administered under Title 2, Human Resources Code;
- (4) a program of the Department of State Health Services relating to mental health services;
- (5) a program of the Department of Aging and Disability Services relating to intellectual disability services; or
- (6) a program of the Texas Department of Criminal Justice.

Text of subsection effective until April 1, 2025

(b) Sections 4201.303(c), 4201.304(b), 4201.357(a-1), and 4201.3601 do not apply to:

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

(2) the Employees Retirement System of Texas or another entity issuing or administering a coverage plan under Chapter 1551;

(3) the Teacher Retirement System of Texas or another entity issuing or administering a plan under Chapter 1575 or 1579;

(4) The Texas A&M University System or The University of Texas System or another entity issuing or administering coverage under Chapter 1601; and

(5) a managed care organization providing a Medicaid managed care plan under Chapter 533, Government Code.

Text of subsection effective on April 1, 2025

(b) Sections 4201.303(c), 4201.304(b), 4201.357(a-1), and 4201.3601 do not apply to:

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

(2) the Employees Retirement System of Texas or another entity issuing or administering a coverage plan under Chapter 1551;

(3) the Teacher Retirement System of Texas or another entity issuing or administering a plan under Chapter 1575 or 1579;

(4) The Texas A&M University System or The University of Texas System or another entity issuing or administering coverage under Chapter 1601; and

(5) a managed care organization providing a Medicaid managed care plan under Chapter 540 or 540A, Government Code, as applicable.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. [2017](#)), Sec. 4, eff. April 1, 2007.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1037 (H.B. [1621](#)), Sec. 1, eff. September 1, 2015.

Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. [4611](#)), Sec. 2.139, eff. April 1, 2025.

Sec. 4201.054. WORKERS' COMPENSATION BENEFITS. (a) Except as provided by this section, this chapter applies to utilization review of a health care service provided to a person eligible for workers' compensation medical benefits under Title 5, Labor Code. The commissioner of workers' compensation shall regulate as provided by this chapter a person who performs utilization review of a medical benefit provided under Title 5, Labor Code.

(b) Sections 4201.303(c), 4201.304(b), 4201.357(a-1), and 4201.3601 do not apply to utilization review of a health care service provided to a person eligible for workers' compensation benefits under Title 5, Labor Code.

(c) Title 5, Labor Code, prevails in the event of a conflict between this chapter and Title 5, Labor Code.

(d) The commissioner of workers' compensation may adopt rules as necessary to implement this section.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 134 (H.B. 1006), Sec. 7(a), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 134 (H.B. 1006), Sec. 7(b), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.075(a), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.075(b), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.075(a), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.075(b), eff. September 1, 2007.

Acts 2015, 84th Leg., R.S., Ch. 1037 (H.B. 1621), Sec. 2, eff. September 1, 2015.

Sec. 4201.055. HEALTH CARE SERVICE PROVIDED UNDER AUTOMOBILE INSURANCE POLICY. This chapter does not apply to utilization review of a health care service provided under an automobile insurance policy or contract that is authorized under Chapter 2301 or Article 5.13-2 or that is issued under Chapter 981.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4201.056. EMPLOYEE WELFARE BENEFIT PLANS. This chapter does not apply to the terms or benefits of an employee welfare benefit plan defined by Section 3(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1002(1)).

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4201.057. HEALTH MAINTENANCE ORGANIZATIONS. (a) In this section, "health maintenance organization" includes a health maintenance organization that contracts with the Health and Human Services Commission or with an agency operating part of the state Medicaid managed care program to provide health care services to recipients of medical assistance under Chapter 32, Human Resources Code.

(b) This chapter applies to a health maintenance organization except as expressly provided by this section.

(c) As a condition of holding a certificate of authority to engage in the business of a health maintenance organization, a health maintenance organization that performs utilization review must:

(1) comply with this chapter, except Subchapter C; and
(2) submit to assessment of a maintenance tax under Chapter 258 to cover the costs of administering compliance with this subsection.

(d) The commissioner shall adopt rules for appropriate verification and enforcement of compliance with Subsection (c).

(e) Notwithstanding Subsection (c)(1), a health maintenance organization that performs utilization review for a person or entity subject to this chapter, other than a person or entity for which the health maintenance organization is the payor, must obtain a certificate of registration under Subchapter C and shall comply with all of the provisions of this chapter.

(f) This chapter does not prohibit or limit the distribution of a portion of the savings from the reduction or elimination of unnecessary medical services, treatment, supplies, confinements, or

days of confinement in a health care facility through profit sharing, bonus, or withholding arrangements to a participating physician or participating health care provider for providing health care services to an enrollee.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4201.058. INSURERS. (a) This chapter applies to an insurer subject to this code that delivers or issues for delivery a health insurance policy in this state except as expressly provided by this section. As a condition of holding a certificate of authority to engage in the business of insurance, an insurer that performs utilization review shall comply with this chapter, except Subchapter C. The insurer is subject to assessment of a maintenance tax under Chapter 257 to cover the costs of administering compliance with this subsection.

(b) The commissioner shall adopt rules for appropriate verification and enforcement of compliance with Subsection (a).

(c) Notwithstanding Subsection (a), an insurer subject to this code that performs utilization review for a person or entity subject to this chapter, other than a person or entity for which the insurer is the payor, must obtain a certificate of registration under Subchapter C and shall comply with all of the provisions of this chapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

SUBCHAPTER C. CERTIFICATION

Sec. 4201.101. CERTIFICATE OF REGISTRATION REQUIRED. A utilization review agent may not conduct utilization review unless the commissioner issues a certificate of registration to the agent under this subchapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4201.102. REQUIREMENTS FOR CERTIFICATION. (a) The commissioner may issue a certificate of registration only to an applicant who has met all the requirements of this chapter and all applicable rules adopted by the commissioner.

(b) As a condition of holding a certificate of registration or renewal of a certificate, a utilization review agent must maintain compliance with Subchapters D, E, and F.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4201.103. CERTIFICATE RENEWAL. Certification may be renewed biennially by filing, not later than March 1, a renewal form with the commissioner accompanied by a fee in an amount set by the commissioner.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4201.104. CERTIFICATION AND RENEWAL FORMS. (a) The commissioner shall promulgate forms to be filed under this subchapter for initial certification and for a renewal certificate of registration. The form for initial certification must require:

(1) the utilization review agent's name, address, telephone number, and normal business hours;

(2) the name and address of an agent for service of process in this state;

(3) a summary of the utilization review plan;

(4) information concerning the categories of personnel who will perform utilization review for the agent;

(5) a copy of the procedures established under Subchapter H for the appeal of an adverse determination;

(6) a certification that the agent will comply with this chapter; and

(7) a copy of the procedures for resolving oral or written complaints initiated by enrollees, patients, or health care providers as required by Section 4201.204.

(b) The commissioner may not require that the summary of the utilization review plan include proprietary details.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4201.105. FEES. The commissioner shall establish, administer, and enforce the fees for initial certification and certification renewal in amounts that do not exceed the amounts necessary to cover the cost of administering this chapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4201.106. CERTIFICATE NOT TRANSFERABLE. A certificate of registration is not transferable.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4201.107. REPORTING MATERIAL CHANGES. A utilization review agent shall report any material change to the information disclosed in a form filed under this subchapter not later than the 30th day after the date the change takes effect.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4201.108. LIST OF UTILIZATION REVIEW AGENTS. (a) The commissioner shall maintain and update monthly a list of each utilization review agent to whom a certificate of registration has been issued and the renewal date of the certificate.

(b) The commissioner shall provide the list at cost to each individual or organization requesting the list.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

SUBCHAPTER D. UTILIZATION REVIEW: GENERAL STANDARDS

Sec. 4201.151. UTILIZATION REVIEW PLAN. A utilization review agent's utilization review plan, including reconsideration and appeal requirements, must be reviewed by a physician licensed to practice medicine in this state and conducted in accordance with standards developed with input from appropriate health care providers and approved by a physician licensed to practice medicine in this state.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 1218 (S.B. 1742), Sec. 3.02, eff. September 1, 2019.

Sec. 4201.152. UTILIZATION REVIEW UNDER PHYSICIAN. A utilization review agent shall conduct utilization review under the direction of a physician licensed to practice medicine in this state.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 1218 (S.B. 1742), Sec. 3.02, eff. September 1, 2019.

Sec. 4201.153. SCREENING CRITERIA AND REVIEW PROCEDURES. (a) A utilization review agent shall use written medically acceptable screening criteria and review procedures that are established and periodically evaluated and updated with appropriate involvement from physicians, including practicing physicians, dentists, and other health care providers.

(b) A utilization review determination shall be made in accordance with currently accepted medical or health care practices, taking into account special circumstances of the case that may require deviation from the norm stated in the screening criteria.

(c) Screening criteria must be:

- (1) objective;
- (2) clinically valid;
- (3) compatible with established principles of health care;

and

- (4) flexible enough to allow a deviation from the norm when

justified on a case-by-case basis.

(d) Screening criteria must be used to determine only whether to approve the requested treatment. A denial of requested treatment must be referred to an appropriate physician, dentist, or other health care provider to determine medical necessity.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4201.154. REVIEW AND INSPECTION OF SCREENING CRITERIA AND REVIEW PROCEDURES. (a) A utilization review agent's written screening criteria and review procedures shall be made available for:

(1) review and inspection to determine appropriateness and compliance as considered necessary by the commissioner; and
(2) copying as necessary for the commissioner to accomplish the commissioner's duties under this code.

(b) Any information obtained or acquired under the authority of this section, Section 4201.153, and this chapter is confidential and privileged and is not subject to Chapter 552, Government Code, or to subpoena except to the extent necessary for the commissioner to enforce this chapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4201.155. LIMITATION ON NOTICE REQUIREMENTS AND REVIEW PROCEDURES. (a) A utilization review agent may not establish or impose a notice requirement or other review procedure that is contrary to the requirements of the health insurance policy or health benefit plan.

(b) This section may not be construed to release a health insurance policy or health benefit plan from full compliance with this chapter or other applicable law.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 1218 (S.B. 1742), Sec. 3.03, eff. September 1, 2019.

**SUBCHAPTER E. UTILIZATION REVIEW: RELATIONS WITH PATIENTS AND
HEALTH CARE PROVIDERS**

Sec. 4201.201. REPETITIVE CONTACTS WITH HEALTH CARE PROVIDER OR PATIENT; FREQUENCY OF REVIEWS. A utilization review agent:

- (1) may not engage in unnecessary or unreasonable repetitive contacts with a health care provider or patient; and
- (2) shall base the frequency of contacts or reviews on the severity or complexity of the patient's condition or on necessary treatment and discharge planning activity.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4201.202. OBSERVING OR PARTICIPATING IN PATIENT'S CARE.

(a) Unless approved for an individual patient by the provider of record or modified by contract, a utilization review agent shall be prohibited from observing, participating in, or otherwise being present during a patient's examination, treatment, procedure, or therapy.

(b) This subchapter, Subchapters D and F, and Section 4201.102(b) may not be construed to otherwise limit or deny contact with a patient for purposes of conducting utilization review unless otherwise specifically prohibited by law.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4201.203. MENTAL HEALTH THERAPY. (a) A utilization review agent may not require, as a condition of treatment approval or for any other reason, the observation of a psychotherapy session or the submission or review of a mental health therapist's process or progress notes.

(b) Notwithstanding this section, a utilization review agent may require submission of a patient's medical record summary.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4201.204. COMPLAINT SYSTEM. (a) A utilization review agent shall establish and maintain a complaint system that provides reasonable procedures for the resolution of oral or written complaints initiated by enrollees, patients, or health care providers concerning the utilization review.

(b) The complaint procedure must include a requirement that the utilization review agent provide a written response to the complainant within 30 days.

(c) Repealed by Acts 2015, 84th Leg., R.S., Ch. 42 , Sec. 3.01(7), eff. September 1, 2015.

(d) A utilization review agent shall maintain a record of each complaint until the third anniversary of the date the complainant filed the complaint.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 42 (S.B. 784), Sec. 3.01(7), eff. September 1, 2015.

Sec. 4201.205. DESIGNATED INITIAL CONTACT. (a) A health care provider may designate one or more individuals as the initial contact or contacts for a utilization review agent seeking routine information or data.

(b) A designation made under this section may not preclude a utilization review agent or medical advisor from contacting a health care provider or the provider's employees who are not designated under this section under circumstances in which:

- (1) a review might otherwise be unreasonably delayed; or
- (2) the designated individual is unable to provide the necessary data or information that the agent requests.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4201.206. OPPORTUNITY TO DISCUSS TREATMENT BEFORE ADVERSE DETERMINATION. (a) Subject to Subsection (b) and the notice

requirements of Subchapter G, before an adverse determination is issued by a utilization review agent who questions the medical necessity, the appropriateness, or the experimental or investigational nature of a health care service, the agent shall provide the health care provider who ordered, requested, provided, or is to provide the service a reasonable opportunity to discuss with a physician licensed to practice medicine in this state the patient's treatment plan and the clinical basis for the agent's determination.

(b) If the health care service described by Subsection (a) was ordered, requested, or provided, or is to be provided by a physician, the opportunity described by that subsection must be with a physician licensed to practice medicine in this state and who has the same or similar specialty as the physician.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1330 (H.B. 4290), Sec. 9, eff. September 1, 2009.

Acts 2019, 86th Leg., R.S., Ch. 1218 (S.B. 1742), Sec. 3.03, eff. September 1, 2019.

Acts 2021, 87th Leg., R.S., Ch. 1018 (H.B. 3459), Sec. 4, eff. September 1, 2021.

Sec. 4201.207. CHARGES BY HEALTH CARE PROVIDER FOR PROVIDING MEDICAL INFORMATION. (a) Unless precluded or modified by contract, a utilization review agent shall reimburse a health care provider for the reasonable costs of providing medical information in writing, including the costs of copying and transmitting requested patient records or other documents.

(b) A health care provider's charges for providing medical information to a utilization review agent may not:

(1) exceed the cost of copying records regarding a workers' compensation claim as set by rules adopted by the commissioner of workers' compensation; or

(2) include any costs otherwise recouped as part of the charges for health care.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 134 (H.B. 1006), Sec. 8(a), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.076(a), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.076(a), eff. September 1, 2007.

SUBCHAPTER F. UTILIZATION REVIEW: PERSONNEL

Sec. 4201.251. DELEGATION OF UTILIZATION REVIEW. A utilization review agent may delegate utilization review to qualified personnel in the hospital or other health care facility in which the health care services to be reviewed were or are to be provided. The delegation does not release the agent from the full responsibility for compliance with this chapter or other applicable law, including the conduct of those to whom utilization review has been delegated.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 1218 (S.B. 1742), Sec. 3.03, eff. September 1, 2019.

Sec. 4201.252. PERSONNEL. (a) Personnel employed by or under contract with a utilization review agent to perform utilization review must be appropriately trained and qualified and meet the requirements of this chapter and other applicable law, including applicable licensing requirements.

(b) Personnel, other than a physician licensed to practice medicine, who obtain oral or written information directly from a patient's physician or other health care provider regarding the patient's specific medical condition, diagnosis, or treatment options or protocols must be a nurse, physician assistant, or other health care provider qualified to provide the requested service.

(c) This section may not be interpreted to require personnel who perform clerical or administrative tasks to have the qualifications prescribed by this section.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April

1, 2007.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 1218 (S.B. 1742), Sec. 3.04, eff. September 1, 2019.

Sec. 4201.253. PROHIBITED BASES FOR EMPLOYMENT, COMPENSATION, EVALUATIONS, OR PERFORMANCE STANDARDS. A utilization review agent may not permit or provide compensation or another thing of value to an employee or agent of the utilization review agent, condition employment of the agent's employees or agent evaluations, or set employee or agent performance standards, based on the amount of volume of adverse determinations, reductions of or limitations on lengths of stay, benefits, services, or charges, or the number or frequency of telephone calls or other contacts with health care providers or patients, that are inconsistent with this chapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

SUBCHAPTER G. NOTICE OF DETERMINATIONS

Sec. 4201.301. GENERAL DUTY TO NOTIFY. A utilization review agent shall provide notice of a determination made in a utilization review to:

- (1) the enrollee's provider of record; and
- (2) the enrollee or a person acting on the enrollee's behalf.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4201.302. GENERAL TIME FOR NOTICE. A utilization review agent must mail or otherwise transmit the notice required by this subchapter not later than the second working day after the date of the request for utilization review and the agent receives all information necessary to complete the review.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4201.303. ADVERSE DETERMINATION: CONTENTS OF NOTICE. (a) Notice of an adverse determination must include:

- (1) the principal reasons for the adverse determination;
- (2) the clinical basis for the adverse determination;
- (3) a description of or the source of the screening criteria used as guidelines in making the adverse determination; and
- (4) a description of the procedure for the complaint and appeal process, including notice to the enrollee of the enrollee's right to appeal an adverse determination to an independent review organization and of the procedures to obtain that review.

(b) For an enrollee who has a life-threatening condition, the notice required by Subsection (a)(4) must include a description of the enrollee's right to an immediate review by an independent review organization and of the procedures to obtain that review.

(c) For an enrollee who is denied the provision of prescription drugs or intravenous infusions for which the patient is receiving benefits under the health insurance policy, the notice required by Subsection (a)(4) must include a description of the enrollee's right to an immediate review by an independent review organization and of the procedures to obtain that review.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1037 (H.B. 1621), Sec. 3, eff. September 1, 2015.

Sec. 4201.304. TIME FOR NOTICE OF ADVERSE DETERMINATION. (a) Subject to Subsection (b), a utilization review agent shall provide notice of an adverse determination required by this subchapter as follows:

- (1) with respect to a patient who is hospitalized at the time of the adverse determination, within one working day by either telephone or electronic transmission to the provider of record, followed by a letter within three working days notifying the patient and the provider of record of the adverse determination;

- (2) with respect to a patient who is not hospitalized at

the time of the adverse determination, within three working days in writing to the provider of record and the patient; or

(3) within the time appropriate to the circumstances relating to the delivery of the services to the patient and to the patient's condition, provided that when denying poststabilization care subsequent to emergency treatment as requested by a treating physician or other health care provider, the agent shall provide the notice to the treating physician or other health care provider not later than one hour after the time of the request.

(b) A utilization review agent shall provide notice of an adverse determination for a concurrent review of the provision of prescription drugs or intravenous infusions for which the patient is receiving health benefits under the health insurance policy not later than the 30th day before the date on which the provision of prescription drugs or intravenous infusions will be discontinued.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1037 (H.B. 1621), Sec. 4, eff. September 1, 2015.

Sec. 4201.305. NOTICE OF ADVERSE DETERMINATION FOR RETROSPECTIVE UTILIZATION REVIEW. (a) Notwithstanding Sections 4201.302 and 4201.304, if a retrospective utilization review is conducted, the utilization review agent shall provide notice of an adverse determination under the retrospective utilization review in writing to the provider of record and the patient within a reasonable period, but not later than 30 days after the date on which the claim is received.

(b) The period under Subsection (a) may be extended once by the utilization review agent for a period not to exceed 15 days, if the utilization review agent:

(1) determines that an extension is necessary due to matters beyond the utilization review agent's control; and

(2) notifies the provider of record and the patient before the expiration of the initial 30-day period of the circumstances requiring the extension and the date by which the utilization review agent expects to make a determination.

(c) If the extension under Subsection (b) is required because of the failure of the provider of record or the patient to submit information necessary to reach a determination on the request, the notice of extension must:

- (1) specifically describe the required information necessary to complete the request; and
- (2) give the provider of record and the patient at least 45 days from the date of receipt of the notice of extension to provide the specified information.

(d) If the period for making the determination under this section is extended because of the failure of the provider of record or the patient to submit the information necessary to make the determination, the period for making the determination is tolled from the date on which the utilization review agent sends the notification of the extension to the provider of record or the patient until the earlier of:

- (1) the date on which the provider of record or the patient responds to the request for additional information; or
- (2) the date by which the specified information was to have been submitted.

(e) If the periods for retrospective utilization review provided by this section conflict with the time limits concerning or related to payment of claims established under Subchapter J, Chapter 843, the time limits established under Subchapter J, Chapter 843, control.

(f) If the periods for retrospective utilization review provided by this section conflict with the time limits concerning or related to payment of claims established under Subchapters C and C-1, Chapter 1301, the time limits established under Subchapters C and C-1, Chapter 1301, control.

(g) If the periods for retrospective utilization review provided by this section conflict with the time limits concerning or related to payment of claims established under Section 408.027, Labor Code, the time limits established under Section 408.027, Labor Code, control.

Added by Acts 2009, 81st Leg., R.S., Ch. 1330 (H.B. [4290](#)), Sec. 10, eff. September 1, 2009.

SUBCHAPTER H. APPEAL OF ADVERSE DETERMINATION

Sec. 4201.351. COMPLAINT AS APPEAL. For purposes of this subchapter, a complaint filed concerning dissatisfaction or disagreement with an adverse determination constitutes an appeal of that adverse determination.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4201.352. WRITTEN DESCRIPTION OF APPEAL PROCEDURES. A utilization review agent shall maintain and make available a written description of the procedures for appealing an adverse determination.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4201.353. APPEAL PROCEDURES MUST BE REASONABLE. The procedures for appealing an adverse determination must be reasonable.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4201.354. PERSONS OR ENTITIES WHO MAY APPEAL. The procedures for appealing an adverse determination must provide that the adverse determination may be appealed orally or in writing by:

- (1) an enrollee;
- (2) a person acting on the enrollee's behalf; or
- (3) the enrollee's physician or other health care provider.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4201.355. ACKNOWLEDGMENT OF APPEAL. (a) The procedures for appealing an adverse determination must provide that, within five working days from the date the utilization review agent receives the appeal, the agent shall send to the appealing party a letter acknowledging the date of receipt.

(b) The letter must also include a list of:

- (1) the procedures required by this subchapter; and
- (2) the documents that the appealing party must submit for

review.

(c) When a utilization review agent receives an oral appeal of an adverse determination, the agent shall send a one-page appeal form to the appealing party.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4201.356. DECISION BY PHYSICIAN REQUIRED; SPECIALTY REVIEW. (a) The procedures for appealing an adverse determination must provide that a physician licensed to practice medicine makes the decision on the appeal, except as provided by Subsection (b).

(b) If not later than the 10th working day after the date an appeal is requested or denied the enrollee's health care provider requests a particular type of specialty provider review the case, a health care provider who is of the same or a similar specialty as the health care provider who would typically manage the medical or dental condition, procedure, or treatment under consideration for review shall review the denial or the decision denying the appeal. The specialty review must be completed within 15 working days of the date the health care provider's request for specialty review is received.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 1218 (S.B. 1742), Sec. 3.05, eff. September 1, 2019.

Sec. 4201.357. EXPEDITED APPEAL FOR DENIAL OF EMERGENCY CARE, CONTINUED HOSPITALIZATION, PRESCRIPTION DRUGS OR INTRAVENOUS INFUSIONS. (a) The procedures for appealing an adverse determination must include, in addition to the written appeal, a procedure for an expedited appeal of a denial of emergency care, a denial of continued hospitalization, or a denial of another service if the requesting health care provider includes a written statement with supporting documentation that the service is necessary to treat

a life-threatening condition or prevent serious harm to the patient. That procedure must include a review by a health care provider who:

(1) has not previously reviewed the case; and

(2) is of the same or a similar specialty as the health care provider who would typically manage the medical or dental condition, procedure, or treatment under review in the appeal.

(a-1) The procedures for appealing an adverse determination must include, in addition to the written appeal and the appeal described by Subsection (a), a procedure for an expedited appeal of a denial of prescription drugs or intravenous infusions for which the patient is receiving benefits under the health insurance policy.

That procedure must include a review by a health care provider who:

(1) has not previously reviewed the case; and

(2) is of the same or a similar specialty as the health care provider who would typically manage the medical or dental condition, procedure, or treatment under review in the appeal.

(a-2) An adverse determination under Section 1369.0546 is entitled to an expedited appeal. The physician or, if appropriate, other health care provider deciding the appeal must consider atypical diagnoses and the needs of atypical patient populations.

(b) The time for resolution of an expedited appeal under this section shall be based on the medical or dental immediacy of the condition, procedure, or treatment under review, provided that the resolution of the appeal may not exceed one working day from the date all information necessary to complete the appeal is received.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1037 (H.B. 1621), Sec. 5, eff. September 1, 2015.

Acts 2015, 84th Leg., R.S., Ch. 1037 (H.B. 1621), Sec. 6, eff. September 1, 2015.

Acts 2017, 85th Leg., R.S., Ch. 103 (S.B. 680), Sec. 3, eff. September 1, 2017.

Acts 2019, 86th Leg., R.S., Ch. 1218 (S.B. 1742), Sec. 3.06, eff. September 1, 2019.

Sec. 4201.358. RESPONSE LETTER TO INTERESTED PERSONS. The

procedures for appealing an adverse determination must provide that, after the utilization review agent has sought review of the appeal, the agent shall issue a response letter explaining the resolution of the appeal to:

- (1) the patient or a person acting on the patient's behalf;
- and
- (2) the patient's physician or other health care provider.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4201.359. NOTICE OF APPEAL. (a) The procedures for appealing an adverse determination must require written notice to the appealing party of the determination of the appeal as soon as practicable, but not later than the 30th calendar day, after the date the utilization review agent receives the appeal.

(b) If the appeal is denied, the notice must include a clear and concise statement of:

- (1) the clinical basis for the denial;
- (2) the specialty of the physician or other health care provider making the denial; and
- (3) the appealing party's right to seek review of the denial by an independent review organization under Subchapter I and the procedures for obtaining that review.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4201.360. IMMEDIATE APPEAL TO INDEPENDENT REVIEW ORGANIZATION IN LIFE-THREATENING CIRCUMSTANCES. Notwithstanding any other law, in a circumstance involving an enrollee's life-threatening condition, the enrollee is:

- (1) entitled to an immediate appeal to an independent review organization as provided by Subchapter I; and
- (2) not required to comply with procedures for an internal review of the utilization review agent's adverse determination.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4201.3601. IMMEDIATE APPEAL TO INDEPENDENT REVIEW ORGANIZATION FOR DENIAL OF PRESCRIPTION DRUGS OR INTRAVENOUS INFUSIONS. Notwithstanding any other law, in a circumstance involving the provision of prescription drugs or intravenous infusions for which the patient is receiving benefits under the health insurance policy, the enrollee is:

- (1) entitled to an immediate appeal to an independent review organization as provided by Subchapter I; and
- (2) not required to comply with procedures for an internal review of the utilization review agent's adverse determination.

Added by Acts 2015, 84th Leg., R.S., Ch. 1037 (H.B. 1621), Sec. 7, eff. September 1, 2015.

SUBCHAPTER I. INDEPENDENT REVIEW OF ADVERSE DETERMINATION

Sec. 4201.401. REVIEW BY INDEPENDENT REVIEW ORGANIZATION; COMPLIANCE WITH INDEPENDENT DETERMINATION. (a) A utilization review agent shall allow any party whose appeal of an adverse determination is denied by the agent to seek review of that determination by an independent review organization assigned to the appeal in accordance with Chapter 4202.

(b) The utilization review agent shall comply with the independent review organization's determination regarding the medical necessity or appropriateness of health care items and services for an enrollee.

(c) The utilization review agent shall comply with the independent review organization's determination regarding the experimental or investigational nature of health care items and services for an enrollee.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1330 (H.B. 4290), Sec. 11, eff. September 1, 2009.

Sec. 4201.402. INFORMATION PROVIDED TO INDEPENDENT REVIEW

ORGANIZATION. (a) Not later than the third business day after the date a utilization review agent receives a request for independent review, the agent shall provide to the appropriate independent review organization:

(1) a copy of:

(A) any medical records of the enrollee that are relevant to the review;

(B) any documents used by the plan in making the determination to be reviewed;

(C) the written notification described by Section 4201.359; and

(D) any documents and other written information submitted to the agent in support of the appeal; and

(2) a list of each physician or other health care provider who:

(A) has provided care to the enrollee; and

(B) may have medical records relevant to the appeal.

(b) A utilization review agent may provide confidential information in the custody of the agent to an independent review organization, subject to rules and standards adopted by the commissioner under Chapter 4202.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4201.403. PAYMENT FOR INDEPENDENT REVIEW. A utilization review agent shall pay for an independent review conducted under this subchapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

SUBCHAPTER J. SPECIALTY UTILIZATION REVIEW AGENTS

Sec. 4201.451. DEFINITION. For purposes of this subchapter, "specialty utilization review agent" means a utilization review agent who conducts utilization review for a specialty health care service, including dentistry, chiropractic services, or physical therapy.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April

1, 2007.

Sec. 4201.452. INAPPLICABILITY OF CERTAIN OTHER LAW. A specialty utilization review agent is not subject to Section 4201.151, 4201.152, 4201.206, 4201.252, or 4201.356.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4201.453. UTILIZATION REVIEW PLAN. A specialty utilization review agent's utilization review plan, including reconsideration and appeal requirements, must be:

(1) reviewed by a health care provider of the appropriate specialty who is licensed or otherwise authorized to provide the specialty health care service in this state; and

(2) conducted in accordance with standards developed with input from a health care provider of the appropriate specialty who is licensed or otherwise authorized to provide the specialty health care service in this state.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 1218 (S.B. 1742), Sec. 3.07, eff. September 1, 2019.

Sec. 4201.454. UTILIZATION REVIEW UNDER DIRECTION OF PROVIDER OF SAME SPECIALTY. A specialty utilization review agent shall conduct utilization review under the direction of a health care provider who is of the same specialty as the agent and who is licensed or otherwise authorized to provide the specialty health care service in this state.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 1218 (S.B. 1742), Sec. 3.07, eff. September 1, 2019.

Sec. 4201.455. PERSONNEL. (a) Personnel who are employed by or under contract with a specialty utilization review agent to perform utilization review must be appropriately trained and qualified and meet the requirements of this chapter and other applicable law of this state, including applicable licensing laws.

(b) Personnel who obtain oral or written information directly from a physician or other health care provider must be a nurse, physician assistant, or other health care provider of the same specialty as the agent and who are licensed or otherwise authorized to provide the specialty health care service by a state licensing agency in the United States.

(c) This section does not require personnel who perform only clerical or administrative tasks to have the qualifications prescribed by this section.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 1218 (S.B. 1742), Sec. 3.08, eff. September 1, 2019.

Sec. 4201.456. OPPORTUNITY TO DISCUSS TREATMENT BEFORE ADVERSE DETERMINATION. Subject to the notice requirements of Subchapter G, before an adverse determination is issued by a specialty utilization review agent who questions the medical necessity, the appropriateness, or the experimental or investigational nature of a health care service, the agent shall provide the health care provider who ordered, requested, or is to provide the service a reasonable opportunity to discuss the patient's treatment plan and the clinical basis for the agent's determination with a health care provider who is of the same specialty as the agent.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1330 (H.B. 4290), Sec. 12, eff. September 1, 2009.

Acts 2019, 86th Leg., R.S., Ch. 1218 (S.B. 1742), Sec. 3.09, eff.

September 1, 2019.

Sec. 4201.457. APPEAL DECISIONS. A specialty utilization review agent shall comply with the requirement that a physician or other health care provider who makes the decision in an appeal of an adverse determination must be of the same or a similar specialty as the health care provider who would typically manage the specialty condition, procedure, or treatment under review in the appeal.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

SUBCHAPTER L. CONFIDENTIALITY OF INFORMATION; ACCESS TO OTHER INFORMATION

Sec. 4201.551. GENERAL CONFIDENTIALITY REQUIREMENT. (a) A utilization review agent shall preserve the confidentiality of individual medical records to the extent required by law.

(b) This chapter does not authorize a utilization review agent to take any action that violates a state or federal law or regulation concerning confidentiality of patient records.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4201.552. CONSENT REQUIREMENTS. (a) A utilization review agent may not disclose individual medical records, personal information, or other confidential information about a patient obtained in the performance of utilization review without the patient's prior written consent or except as otherwise required by law.

(b) If the prior written consent is submitted by anyone other than the patient who is the subject of the personal or confidential information requested, the consent must:

- (1) be dated; and
- (2) contain the patient's signature.

(c) The patient's signature for purposes of Subsection (b)(2) must have been obtained one year or less before the date the disclosure is sought or the consent is invalid.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4201.553. PROVIDING INFORMATION TO AFFILIATED ENTITIES. A utilization review agent may provide confidential information to a third party under contract with or affiliated with the agent solely to perform or assist with utilization review. Information provided to a third party under this section remains confidential.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4201.554. PROVIDING INFORMATION TO COMMISSIONER. Notwithstanding this subchapter, a utilization review agent shall provide to the commissioner on request individual medical records or other confidential information to enable the commissioner to determine compliance with this chapter. The information is confidential and privileged and is not subject to Chapter 552, Government Code, or to subpoena, except to the extent necessary to enable the commissioner to enforce this chapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4201.555. ACCESS TO RECORDED PERSONAL INFORMATION. (a) If an individual submits a written request to a utilization review agent for access to recorded personal information concerning the individual, the agent shall, within 10 business days from the date the agent receives the request:

(1) inform the requesting individual in writing of the nature and substance of the recorded personal information; and
(2) allow the individual, at the individual's discretion, to:

(A) view and copy, in person, the recorded personal information concerning the individual; or

(B) obtain a copy of the information by mail.

(b) If the information requested under this section is in coded form, the utilization review agent shall provide in writing an

accurate translation of the information in plain language.

(c) A utilization review agent's charges for providing a copy of information requested under this section shall be reasonable, as determined by rule adopted by the commissioner. The charges may not include any costs otherwise recouped as part of the charges for utilization review.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4201.556. PUBLISHING INFORMATION IDENTIFIABLE TO HEALTH CARE PROVIDER. (a) A utilization review agent may not publish data that identifies a particular physician or other health care provider, including data in a quality review study or performance tracking data, without providing prior written notice to the physician or other provider.

(b) The prohibition under this section does not apply to internal systems or reports used by the utilization review agent.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4201.557. REQUIREMENT TO MAINTAIN DATA IN CONFIDENTIAL MANNER. A utilization review agent shall maintain all data concerning a patient or physician or other health care provider in a confidential manner that prevents unauthorized disclosure to a third party.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4201.558. DESTRUCTION OF CERTAIN CONFIDENTIAL DOCUMENTS. When a utilization review agent determines a document in the custody of the agent that contains confidential patient information or confidential physician or other health care provider financial data is no longer needed, the document shall be destroyed by a method that ensures the complete destruction of the information.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

SUBCHAPTER M. ENFORCEMENT

Sec. 4201.601. NOTICE OF SUSPECTED VIOLATION; COMPELLING PRODUCTION OF INFORMATION. If the commissioner believes that a person or entity conducting utilization review is in violation of this chapter or applicable rules, the commissioner:

- (1) shall notify the utilization review agent, health maintenance organization, or insurer of the alleged violation; and
- (2) may compel the production of documents or other information as necessary to determine whether a violation has occurred.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4201.602. ENFORCEMENT PROCEEDING. (a) The commissioner may initiate a proceeding under this subchapter.

(b) A proceeding under this chapter is a contested case for purposes of Chapter 2001, Government Code.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4201.603. REMEDIES AND PENALTIES FOR VIOLATION. If the commissioner determines that a utilization review agent, health maintenance organization, insurer, or other person or entity conducting utilization review has violated or is violating this chapter, the commissioner may:

- (1) impose a sanction under Chapter 82;
- (2) issue a cease and desist order under Chapter 83; or
- (3) assess an administrative penalty under Chapter 84.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

SUBCHAPTER N. EXEMPTION FROM PREAUTHORIZATION REQUIREMENTS FOR PHYSICIANS AND PROVIDERS PROVIDING CERTAIN HEALTH CARE SERVICES

Sec. 4201.651. DEFINITIONS. (a) In this subchapter, "preauthorization" means a determination by a health maintenance organization, insurer, or person contracting with a health maintenance organization or insurer that health care services proposed to be provided to a patient are medically necessary and appropriate.

(b) In this subchapter, terms defined by Section 843.002, including "health care services," "physician," and "provider," have the meanings assigned by that section.

Added by Acts 2021, 87th Leg., R.S., Ch. 1018 (H.B. [3459](#)), Sec. 5, eff. September 1, 2021.

Text of section effective until April 1, 2025

Sec. 4201.652. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to:

(1) a health benefit plan offered by a health maintenance organization operating under Chapter 843, except that this subchapter does not apply to:

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

(B) the state Medicaid program, including the Medicaid managed care program operated under Chapter 533, Government Code;

(2) a preferred provider benefit plan or exclusive provider benefit plan offered by an insurer under Chapter 1301; and

(3) a person who contracts with a health maintenance organization or insurer to issue preauthorization determinations or perform the functions described in this subchapter for a health benefit plan to which this subchapter applies.

Added by Acts 2021, 87th Leg., R.S., Ch. 1018 (H.B. [3459](#)), Sec. 5, eff. September 1, 2021.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. [4611](#)), Sec. 2.140, eff. April 1, 2025.

Text of section effective on April 1, 2025

Sec. 4201.652. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to:

(1) a health benefit plan offered by a health maintenance organization operating under Chapter 843, except that this subchapter does not apply to:

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

(B) the state Medicaid program, including the Medicaid managed care program operated under Chapter 540 or 540A, Government Code, as applicable;

(2) a preferred provider benefit plan or exclusive provider benefit plan offered by an insurer under Chapter 1301; and

(3) a person who contracts with a health maintenance organization or insurer to issue preauthorization determinations or perform the functions described in this subchapter for a health benefit plan to which this subchapter applies.

Added by Acts 2021, 87th Leg., R.S., Ch. 1018 (H.B. 3459), Sec. 5, eff. September 1, 2021.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 2.140, eff. April 1, 2025.

Sec. 4201.653. EXEMPTION FROM PREAUTHORIZATION REQUIREMENTS FOR PHYSICIANS AND PROVIDERS PROVIDING CERTAIN HEALTH CARE SERVICES. (a) A health maintenance organization or an insurer that uses a preauthorization process for health care services may not require a physician or provider to obtain preauthorization for a particular health care service if, in the most recent six-month evaluation period, as described by Subsection (b), the health maintenance organization or insurer has approved or would have approved not less than 90 percent of the preauthorization requests submitted by the physician or provider for the particular health care service.

(b) Except as provided by Subsection (c), a health maintenance organization or insurer shall evaluate whether a physician or provider qualifies for an exemption from preauthorization requirements under Subsection (a) once every six months.

(c) A health maintenance organization or insurer may continue an exemption under Subsection (a) without evaluating whether the physician or provider qualifies for the exemption under Subsection (a) for a particular evaluation period.

(d) A physician or provider is not required to request an exemption under Subsection (a) to qualify for the exemption.

Added by Acts 2021, 87th Leg., R.S., Ch. 1018 (H.B. 3459), Sec. 5, eff. September 1, 2021.

Sec. 4201.654. DURATION OF PREAUTHORIZATION EXEMPTION. (a) A physician's or provider's exemption from preauthorization requirements under Section 4201.653 remains in effect until:

(1) the 30th day after the date the health maintenance organization or insurer notifies the physician or provider of the health maintenance organization's or insurer's determination to rescind the exemption under Section 4201.655, if the physician or provider does not appeal the health maintenance organization's or insurer's determination; or

(2) if the physician or provider appeals the determination, the fifth day after the date the independent review organization affirms the health maintenance organization's or insurer's determination to rescind the exemption.

(b) If a health maintenance organization or insurer does not finalize a rescission determination as specified in Subsection (a), then the physician or provider is considered to have met the criteria under Section 4201.653 to continue to qualify for the exemption.

Added by Acts 2021, 87th Leg., R.S., Ch. 1018 (H.B. 3459), Sec. 5, eff. September 1, 2021.

Sec. 4201.655. DENIAL OR RESCISSION OF PREAUTHORIZATION EXEMPTION. (a) A health maintenance organization or insurer may rescind an exemption from preauthorization requirements under Section 4201.653 only:

(1) during January or June of each year;

(2) if the health maintenance organization or insurer makes a determination, on the basis of a retrospective review of a random sample of not fewer than five and no more than 20 claims submitted by

the physician or provider during the most recent evaluation period described by Section 4201.653(b), that less than 90 percent of the claims for the particular health care service met the medical necessity criteria that would have been used by the health maintenance organization or insurer when conducting preauthorization review for the particular health care service during the relevant evaluation period; and

(3) if the health maintenance organization or insurer complies with other applicable requirements specified in this section, including:

(A) notifying the physician or provider not less than 25 days before the proposed rescission is to take effect; and

(B) providing with the notice under Paragraph (A):

(i) the sample information used to make the determination under Subdivision (2); and

(ii) a plain language explanation of how the physician or provider may appeal and seek an independent review of the determination.

(b) A determination made under Subsection (a)(2) must be made by an individual licensed to practice medicine in this state. For a determination made under Subsection (a)(2) with respect to a physician, the determination must be made by an individual licensed to practice medicine in this state who has the same or similar specialty as that physician.

(c) A health maintenance organization or insurer may deny an exemption from preauthorization requirements under Section 4201.653 only if:

(1) the physician or provider does not have the exemption at the time of the relevant evaluation period; and

(2) the health maintenance organization or insurer provides the physician or provider with actual statistics and data for the relevant preauthorization request evaluation period and detailed information sufficient to demonstrate that the physician or provider does not meet the criteria for an exemption from preauthorization requirements for the particular health care service under Section 4201.653.

Added by Acts 2021, 87th Leg., R.S., Ch. 1018 (H.B. 3459), Sec. 5, eff. September 1, 2021.

Sec. 4201.656. INDEPENDENT REVIEW OF EXEMPTION DETERMINATION.

(a) A physician or provider has a right to a review of an adverse determination regarding a preauthorization exemption be conducted by an independent review organization. A health maintenance organization or insurer may not require a physician or provider to engage in an internal appeal process before requesting a review by an independent review organization under this section.

(b) A health maintenance organization or insurer shall pay:

(1) for any appeal or independent review of an adverse determination regarding a preauthorization exemption requested under this section; and

(2) a reasonable fee determined by the Texas Medical Board for any copies of medical records or other documents requested from a physician or provider during an exemption rescission review requested under this section.

(c) An independent review organization must complete an expedited review of an adverse determination regarding a preauthorization exemption not later than the 30th day after the date a physician or provider files the request for a review under this section.

(d) A physician or provider may request that the independent review organization consider another random sample of not less than five and no more than 20 claims submitted to the health maintenance organization or insurer by the physician or provider during the relevant evaluation period for the relevant health care service as part of its review. If the physician or provider makes a request under this subsection, the independent review organization shall base its determination on the medical necessity of claims reviewed by the health maintenance organization or insurer under Section 4201.655 and reviewed under this subsection.

Added by Acts 2021, 87th Leg., R.S., Ch. 1018 (H.B. 3459), Sec. 5, eff. September 1, 2021.

Sec. 4201.657. EFFECT OF APPEAL OR INDEPENDENT REVIEW

DETERMINATION. (a) A health maintenance organization or insurer is bound by an appeal or independent review determination that does not affirm the determination made by the health maintenance organization or insurer to rescind a preauthorization exemption.

(b) A health maintenance organization or insurer may not retroactively deny a health care service on the basis of a rescission of an exemption, even if the health maintenance organization's or insurer's determination to rescind the preauthorization exemption is affirmed by an independent review organization.

(c) If a determination of a preauthorization exemption made by the health maintenance organization or insurer is overturned on review by an independent review organization, the health maintenance organization or insurer:

(1) may not attempt to rescind the exemption before the end of the next evaluation period that occurs; and

(2) may only rescind the exemption after if the health maintenance organization or insurer complies with Sections 4201.655 and 4201.656.

Added by Acts 2021, 87th Leg., R.S., Ch. 1018 (H.B. [3459](#)), Sec. 5, eff. September 1, 2021.

Sec. 4201.658. ELIGIBILITY FOR PREAUTHORIZATION EXEMPTION FOLLOWING FINALIZED EXEMPTION RESCISSION OR DENIAL. After a final determination or review affirming the rescission or denial of an exemption for a specific health care service under Section 4201.653, a physician or provider is eligible for consideration of an exemption for the same health care service after the six-month evaluation period that follows the evaluation period which formed the basis of the rescission or denial of an exemption.

Added by Acts 2021, 87th Leg., R.S., Ch. 1018 (H.B. [3459](#)), Sec. 5, eff. September 1, 2021.

Sec. 4201.659. EFFECT OF PREAUTHORIZATION EXEMPTION. (a) A health maintenance organization or insurer may not deny or reduce payment to a physician or provider for a health care service for which the physician or provider has qualified for an exemption from preauthorization requirements under Section 4201.653 based on medical necessity or appropriateness of care unless the physician or provider:

(1) knowingly and materially misrepresented the health care service in a request for payment submitted to the health maintenance

organization or insurer with the specific intent to deceive and obtain an unlawful payment from the health maintenance organization or insurer; or

(2) failed to substantially perform the health care service.

(b) A health maintenance organization or an insurer may not conduct a retrospective review of a health care service subject to an exemption except:

(1) to determine if the physician or provider still qualifies for an exemption under this subchapter; or

(2) if the health maintenance organization or insurer has a reasonable cause to suspect a basis for denial exists under Subsection (a).

(c) For a retrospective review described by Subsection (b)(2), nothing in this subchapter may be construed to modify or otherwise affect:

(1) the requirements under or application of Section 4201.305, including any timeframes specified by that section; or

(2) any other applicable law, except to prescribe the only circumstances under which:

(A) a retrospective utilization review may occur as specified by Subsection (b)(2); or

(B) payment may be denied or reduced as specified by Subsection (a).

(d) Not later than five days after qualifying for an exemption from preauthorization requirements under Section 4201.653, a health maintenance organization or insurer must provide to a physician or provider a notice that includes:

(1) a statement that the physician or provider qualifies for an exemption from preauthorization requirements under Section 4201.653;

(2) a list of the health care services and health benefit plans to which the exemption applies; and

(3) a statement of the duration of the exemption.

(e) If a physician or provider submits a preauthorization request for a health care service for which the physician or provider qualifies for an exemption from preauthorization requirements under Section 4201.653, the health maintenance organization or insurer must promptly provide a notice to the physician or provider that includes:

(1) the information described by Subsection (d); and

(2) a notification of the health maintenance organization's or insurer's payment requirements.

(f) Nothing in this subchapter may be construed to:

(1) authorize a physician or provider to provide a health care service outside the scope of the provider's applicable license issued under Title 3, Occupations Code; or

(2) require a health maintenance organization or insurer to pay for a health care service described by Subdivision (1) that is performed in violation of the laws of this state.

Added by Acts 2021, 87th Leg., R.S., Ch. 1018 (H.B. [3459](#)), Sec. 5, eff. September 1, 2021.

CHAPTER 4202. INDEPENDENT REVIEW ORGANIZATIONS

Sec. 4202.001. DEFINITION. In this chapter, "payor" has the meaning assigned by Section 4201.002.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. [2017](#)), Sec. 4, eff. April 1, 2007.

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

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

(2) the suspension and revocation of the certification.

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

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

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

(3) the qualifications and independence of each physician or other health care provider making a review determination for an independent review organization;

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

(5) the timely notice to an enrollee of the results of an

independent review, including the clinical basis for the review determination.

(c) In addition to the standards described by Subsection (b), the commissioner shall adopt standards and rules that:

(1) prohibit:

(A) more than one independent review organization from operating out of the same office or other facility;

(B) an individual or entity from owning more than one independent review organization;

(C) an individual from owning stock in or serving on the board of more than one independent review organization;

(D) an individual who has served on the board of an independent review organization whose certification was revoked for cause from serving on the board of another independent review organization before the fifth anniversary of the date on which the revocation occurred;

(E) an individual who serves as an officer, director, manager, executive, or supervisor of an independent review organization from serving as an officer, director, manager, executive, supervisor, employee, agent, or independent contractor of another independent review organization; and

(F) an independent review organization from:

(i) publicly disclosing patient information protected by the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. Section 1320d et seq.); or

(ii) transmitting the information to a subcontractor involved in the independent review process that has not signed an agreement similar to the business associate agreement required by regulations adopted under the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. Section 1320d et seq.); and

(2) require:

(A) an independent review organization to:

(i) maintain a physical address and a mailing address in this state;

(ii) be incorporated in this state;

(iii) be in good standing with the comptroller; and

(iv) be based and certified in this state and to locate the organization's primary offices in this state;

(B) an independent review organization to surrender the

organization's certification as part of an agreed order; and

(C) an independent review organization to:

(i) notify the department of an agreement to sell the organization or shares in the organization;

(ii) not later than the 60th day before the date of the sale, submit the name of the purchaser and a complete and legible set of fingerprints for each officer of the purchaser and for each owner or shareholder of the purchaser or, if the purchaser is publicly held, each owner or shareholder described by Section 4202.004(a)(1), and any additional information necessary to comply with Section 4202.004(d); and

(iii) complete the transfer of ownership after the department has sent written confirmation in accordance with Subsection (d) that the requirements of this chapter have been satisfied.

(d) The department shall send the written confirmation required by Subsection (c)(2)(C)(iii) not later than the expiration of the fourth week after the date the department determines the requirements are satisfied.

(e) Standards to ensure the confidentiality of medical records transmitted to an independent review organization under Subsection (b)(2) must require organizations and utilization review agents to transmit and store records in compliance with the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. Section 1320d et seq.) and the regulations and standards adopted under that Act.

(f) The commissioner shall adopt standards requiring that:

(1) on application for certification, an officer of the organization attest that the office is located at a physical address;

(2) the office be equipped with a computer system capable of:

(A) processing requests for independent review; and

(B) accessing all electronic records related to the review and the independent review process;

(3) all records be maintained electronically and made available to the department on request; and

(4) in the case of an office located in a residence, the working office be located in a room set aside for independent review business purposes and in a manner to ensure confidentiality in accordance with Subsection (e).

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1332 (H.B. 4519), Sec. 1, eff. September 1, 2009.

Acts 2013, 83rd Leg., R.S., Ch. 1024 (H.B. 2645), Sec. 1, eff. September 1, 2013.

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

(1) for a life-threatening condition as defined by Section 4201.002, the provision of prescription drugs or intravenous infusions for which the patient is receiving benefits under the health insurance policy, or a review of a step therapy protocol exception request under Section 1369.0546, not later than the earlier of the third day after the date the organization receives the information necessary to make the determination or, with respect to:

(A) a review of a health care service provided to a person with a life-threatening condition eligible for workers' compensation medical benefits, the eighth day after the date the organization receives the request that the determination be made; or

(B) a review of a health care service other than a service described by Paragraph (A), the third day after the date the organization receives the request that the determination be made; or

(2) for a situation other than a situation described by Subdivision (1), not later than the earlier of:

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

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

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 1024 (H.B. 2645), Sec. 2, eff. September 1, 2013.

Acts 2015, 84th Leg., R.S., Ch. 1037 (H.B. 1621), Sec. 8, eff.

September 1, 2015.

Acts 2017, 85th Leg., R.S., Ch. 103 (S.B. 680), Sec. 4, eff. September 1, 2017.

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

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

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

(3) the name and type of business of each corporation or other organization described by Subdivision (4) that the applicant controls or is affiliated with and the nature and extent of the control or affiliation;

(4) the name and a biographical sketch of each director, officer, and executive of the applicant and of any entity listed under Subdivision (3) and a description of any relationship the applicant or the named individual has with:

(A) a health benefit plan;

(B) a health maintenance organization;

(C) an insurer;

(D) a utilization review agent;

(E) a nonprofit health corporation;

(F) a payor;

(G) a health care provider;

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

(I) any other independent review organization in the state;

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

(6) a description of:

(A) the areas of expertise of the physicians or other health care providers making review determinations for the applicant;

(B) the procedures used by the applicant to verify

physician and provider credentials, including the computer processes, electronic databases, and records, if any, used; and

(C) the software used by the credentialing manager for managing the processes, databases, and records described by Paragraph (B);

(7) the procedures to be used by the applicant in making independent review determinations under Subchapter I, Chapter 4201; and

(8) a description of the applicant's use of communications, records, and computer processes to manage the independent review process.

(b) The commissioner shall establish certifications for independent review of health care services provided to persons eligible for workers' compensation medical benefits and other health care services after considering accreditation, if any, by a nationally recognized accrediting organization that imposes requirements for accreditation that are the same as, substantially similar to, or more stringent than the department's requirements for accreditation.

(c) The department shall make available to applicants applications for certification to review health care services provided to persons eligible for workers' compensation medical benefits and other health care services.

(d) The commissioner shall require that each officer of the applicant and each owner or shareholder of the applicant or, if the purchaser is publicly held, each owner or shareholder described by Subsection (a)(1) submit a complete and legible set of fingerprints to the department for the purpose of obtaining criminal history record information from the Department of Public Safety and the Federal Bureau of Investigation. The department shall conduct a criminal history check of each applicant using information:

(1) provided under this section; and

(2) made available to the department by the Department of Public Safety, the Federal Bureau of Investigation, and any other criminal justice agency under Chapter 411, Government Code.

(e) An application for certification for review of health care services must require an organization that is accredited by an organization described by Subsection (b) to provide the department evidence of the accreditation. The commissioner shall consider the evidence if the accrediting organization published and made available

to the commissioner the organization's requirements for and methods used in the accreditation process. An independent review organization that is accredited by an organization described by Subsection (b) may request that the department expedite the application process.

(f) A certified independent review organization that becomes accredited by an organization described by Subsection (b) may provide evidence of that accreditation to the department that shall be maintained in the department's file related to the independent review organization's certification.

(g) Certification must be renewed biennially.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 1024 (H.B. 2645), Sec. 3, eff. September 1, 2013.

Sec. 4202.005. PERIODIC REPORTING OF INFORMATION; BIENNIAL DESIGNATION; UPDATES AND INSPECTION. (a) An independent review organization shall biennially submit the information required in an application for certification under Section 4202.004. Anytime there is a material change in the information the organization included in the application, the organization shall submit updated information to the commissioner.

(b) The commissioner shall designate biennially each organization that meets the standards for an independent review organization adopted under Section 4202.002.

(c) Information regarding a material change must be submitted on a form adopted by the commissioner not later than the 30th day after the date the material change occurs. If the material change is a relocation of the organization:

(1) the organization must inform the department that the location is available for inspection before the date of the relocation by the department; and

(2) on request of the department, an officer shall attend the inspection.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 1024 (H.B. 2645), Sec. 4, eff. September 1, 2013.

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

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4202.007. OVERSIGHT. The commissioner shall provide ongoing oversight of the independent review organizations to ensure continued compliance with this chapter and the standards and rules adopted under this chapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4202.008. PROHIBITED OWNERSHIP OR CONTROL OF INDEPENDENT REVIEW ORGANIZATION. An independent review organization may not be a subsidiary of, or in any way owned or controlled by, a payor or a trade or professional association of payors.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

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

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4202.010. IMMUNITY FROM LIABILITY. (a) An independent

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

(b) This section does not apply to an act or omission of the independent review organization that is made in bad faith or that involves gross negligence.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4202.012. REFERRAL. The commissioner by rule shall require referral by random assignment of adverse determinations under Subchapter I, Chapter 4201, to independent review organizations. On referral of a determination, the commissioner shall notify:

- (1) the utilization review agent;
- (2) the payor;
- (3) the independent review organization;
- (4) the patient, as defined by Section 4201.002, or the patient's representative; and
- (5) the provider of record as defined by Section 4201.002.

Added by Acts 2013, 83rd Leg., R.S., Ch. 1024 (H.B. 2645), Sec. 5, eff. September 1, 2013.

Sec. 4202.013. PRIMARY OFFICE IN THIS STATE REQUIRED. An independent review organization operating under this chapter must maintain the organization's primary office in this state.

Added by Acts 2013, 83rd Leg., R.S., Ch. 1024 (H.B. 2645), Sec. 5, eff. September 1, 2013.

Sec. 4202.014. PREEMPTION. The commissioner shall suspend enforcement of any provision of this chapter that the commissioner determines to be preempted by 42 U.S.C. Section 300gg-19.

Added by Acts 2013, 83rd Leg., R.S., Ch. 1024 (H.B. 2645), Sec. 5, eff. September 1, 2013.

CHAPTER 4203. PROHIBITED CONSULTANT ACTIVITIES

Sec. 4203.001. DEFINITION. In this chapter, "consultant" means a person who, for compensation and at the request of an insurer, business, individual, or utilization review agent:

(1) reviews, assesses, or evaluates a claim, charge, or service of another chiropractor to determine whether the claim, charge, or service is:

(A) medically necessary, reasonable, or appropriate; or

(B) recommended for payment or nonpayment; or

(2) advises an insurer or utilization review agent regarding a chiropractic charge or service or recommends to that insurer or agent guidelines for a chiropractic charge or service.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Sec. 4203.002. PROHIBITED CONSULTANT ACTIVITIES. A member or employee of the Texas Board of Chiropractic Examiners may not act as a consultant or perform any consultant activities for an insurer or business, individual, or utilization review agent that audits chiropractic claims, charges, or services.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

TITLE 15. INTERSTATE INSURANCE COMPACTS**CHAPTER 5001. INTERSTATE INSURANCE PRODUCT REGULATION COMPACT**

Sec. 5001.001. ADOPTION OF COMPACT; REPRESENTATIVE TO COMMISSION. Pursuant to the terms and conditions of this chapter, the state joins with other states that have adopted the Interstate Insurance Product Regulation Compact to establish and become a member of the Interstate Insurance Product Regulation Commission. The commissioner is the state's representative to that commission.

Added by Acts 2005, 79th Leg., Ch. 1132 (H.B. 2613), Sec. 1, eff. September 1, 2005.

Sec. 5001.002. TERMS OF COMPACT.

ARTICLE I. PURPOSES

The purposes of this Compact are, through means of joint and cooperative action among the Compacting States:

1. To promote and protect the interest of consumers of individual and group annuity, life insurance, disability income and long-term care insurance products;
2. To develop uniform standards for insurance products covered under the Compact;
3. To establish a central clearinghouse to receive and provide prompt review of insurance products covered under the Compact and in certain cases, advertisements related thereto, submitted by insurers authorized to do business in one or more Compacting States;
4. To give appropriate regulatory approval to those product filings and advertisements satisfying the applicable uniform standard;
5. To improve coordination of regulatory resources and expertise between state insurance departments regarding the setting of uniform standards and review of insurance products covered under the Compact;
6. To create the Interstate Insurance Product Regulation Commission; and
7. To perform these and such other related functions as may be consistent with the state regulation of the business of insurance.

ARTICLE II. DEFINITIONS

For purposes of this Compact:

1. "Advertisement" means any material designed to create public interest in a Product, or induce the public to purchase, increase, modify, reinstate, borrow on, surrender, replace or retain a policy, as more specifically defined in the Rules and Operating Procedures of the Commission.
2. "Bylaws" mean those bylaws established by the Commission for its governance, or for directing or controlling the Commission's actions or conduct.
3. "Compacting State" means any State which has enacted this Compact legislation and which has not withdrawn pursuant to Article XIV, Section 1, or been terminated pursuant to Article XIV, Section 2.
4. "Commission" means the "Interstate Insurance Product Regulation Commission" established by this Compact.
5. "Commissioner" means the chief insurance regulatory

official of a State including, but not limited to commissioner, superintendent, director or administrator.

6. "Domiciliary State" means the state in which an Insurer is incorporated or organized; or, in the case of an alien Insurer, its state of entry.

7. "Insurer" means any entity licensed by a State to issue contracts of insurance for any of the lines of insurance covered by this Act.

8. "Member" means the person chosen by a Compacting State as its representative to the Commission, or his or her designee.

9. "Non-compacting State" means any State which is not at the time a Compacting State.

10. "Operating Procedures" mean procedures promulgated by the Commission implementing a Rule, Uniform Standard or a provision of this Compact.

11. "Product" means the form of a policy or contract, including any application, endorsement, or related form which is attached to and made a part of the policy or contract, and any evidence of coverage or certificate, for an individual or group annuity, life insurance, disability income or long-term care insurance product that an Insurer is authorized to issue.

12. "Rule" means a statement of general or particular applicability and future effect promulgated by the Commission, including a Uniform Standard developed pursuant to Article VII of this Compact, designed to implement, interpret, or prescribe law or policy or describing the organization, procedure, or practice requirements of the Commission, which shall have the force and effect of law in the Compacting States.

13. "State" means any state, district or territory of the United States of America.

14. "Third-Party Filer" means an entity that submits a Product filing to the Commission on behalf of an Insurer.

15. "Uniform Standard" means a standard adopted by the Commission for a Product line, pursuant to Article VII of this Compact, and shall include all of the Product requirements in aggregate; provided, that each Uniform Standard shall be construed, whether express or implied, to prohibit the use of any inconsistent, misleading or ambiguous provisions in a Product and the form of the Product made available to the public shall not be unfair, inequitable or against public policy as determined by the Commission.

ARTICLE III. ESTABLISHMENT OF THE COMMISSION AND VENUE

1. The Compacting States hereby create and establish a joint public agency known as the "Interstate Insurance Product Regulation Commission." Pursuant to Article IV, the Commission will have the power to develop Uniform Standards for Product lines, receive and provide prompt review of Products filed therewith, and give approval to those Product filings satisfying applicable Uniform Standards; provided, it is not intended for the Commission to be the exclusive entity for receipt and review of insurance product filings. Nothing herein shall prohibit any Insurer from filing its product in any State wherein the Insurer is licensed to conduct the business of insurance; and any such filing shall be subject to the laws of the State where filed.

2. The Commission is a body corporate and politic, and an instrumentality of the Compacting States.

3. The Commission is solely responsible for its liabilities except as otherwise specifically provided in this Compact.

4. Venue is proper and judicial proceedings by or against the Commission shall be brought solely and exclusively in a Court of competent jurisdiction where the principal office of the Commission is located.

ARTICLE IV. POWERS OF THE COMMISSION

The Commission shall have the following powers:

1. To promulgate Rules, pursuant to Article VII of this Compact, which shall have the force and effect of law and shall be binding in the Compacting States to the extent and in the manner provided in this Compact;

2. To exercise its rule-making authority and establish reasonable Uniform Standards for Products covered under the Compact, and Advertisement related thereto, which shall have the force and effect of law and shall be binding in the Compacting States, but only for those Products filed with the Commission, provided, that a Compacting State shall have the right to opt out of such Uniform Standard pursuant to Article VII, to the extent and in the manner provided in this Compact, and, provided further, that any Uniform Standard established by the Commission for long-term care insurance products may provide the same or greater protections for consumers as, but shall not provide less than, those protections set forth in the National Association of Insurance Commissioners' Long-Term Care Insurance Model Act and Long-Term Care Insurance Model Regulation,

respectively, adopted as of 2001. The Commission shall consider whether any subsequent amendments to the NAIC Long-Term Care Insurance Model Act or Long-Term Care Insurance Model Regulation adopted by the NAIC require amending of the Uniform Standards established by the Commission for long-term care insurance products;

3. To receive and review in an expeditious manner Products filed with the Commission, and rate filings for disability income and long-term care insurance Products, and give approval of those Products and rate filings that satisfy the applicable Uniform Standard, where such approval shall have the force and effect of law and be binding on the Compacting States to the extent and in the manner provided in the Compact;

4. To receive and review in an expeditious manner Advertisement relating to long-term care insurance products for which Uniform Standards have been adopted by the Commission, and give approval to all Advertisement that satisfies the applicable Uniform Standard. For any product covered under this Compact, other than long-term care insurance products, the Commission shall have the authority to require an insurer to submit all or any part of its Advertisement with respect to that product for review or approval prior to use, if the Commission determines that the nature of the product is such that an Advertisement of the product could have the capacity or tendency to mislead the public. The actions of Commission as provided in this section shall have the force and effect of law and shall be binding in the Compacting States to the extent and in the manner provided in the Compact;

5. To exercise its rule-making authority and designate Products and Advertisement that may be subject to a self-certification process without the need for prior approval by the Commission;

6. To promulgate Operating Procedures, pursuant to Article VII of this Compact, which shall be binding in the Compacting States to the extent and in the manner provided in this Compact;

7. To bring and prosecute legal proceedings or actions in its name as the Commission; provided, that the standing of any state insurance department to sue or be sued under applicable law shall not be affected;

8. To issue subpoenas requiring the attendance and testimony of witnesses and the production of evidence;

9. To establish and maintain offices;

10. To purchase and maintain insurance and bonds;
11. To borrow, accept or contract for services of personnel, including, but not limited to, employees of a Compacting State;
12. To hire employees, professionals or specialists, and elect or appoint officers, and to fix their compensation, define their duties and give them appropriate authority to carry out the purposes of the Compact, and determine their qualifications; and to establish the Commission's personnel policies and programs relating to, among other things, conflicts of interest, rates of compensation and qualifications of personnel;
13. To accept any and all appropriate donations and grants of money, equipment, supplies, materials and services, and to receive, utilize and dispose of the same; provided that at all times the Commission shall strive to avoid any appearance of impropriety;
14. To lease, purchase, accept appropriate gifts or donations of, or otherwise to own, hold, improve or use, any property, real, personal or mixed; provided that at all times the Commission shall strive to avoid any appearance of impropriety;
15. To sell, convey, mortgage, pledge, lease, exchange, abandon or otherwise dispose of any property, real, personal or mixed;
16. To remit filing fees to Compacting States as may be set forth in the Bylaws, Rules or Operating Procedures;
17. To enforce compliance by Compacting States with Rules, Uniform Standards, Operating Procedures and Bylaws;
18. To provide for dispute resolution among Compacting States;
19. To advise Compacting States on issues relating to Insurers domiciled or doing business in Non-compacting jurisdictions, consistent with the purposes of this Compact;
20. To provide advice and training to those personnel in state insurance departments responsible for product review, and to be a resource for state insurance departments;
21. To establish a budget and make expenditures;
22. To borrow money;
23. To appoint committees, including advisory committees comprising Members, state insurance regulators, state legislators or their representatives, insurance industry and consumer representatives, and such other interested persons as may be

designated in the Bylaws;

24. To provide and receive information from, and to cooperate with law enforcement agencies;

25. To adopt and use a corporate seal; and

26. To perform such other functions as may be necessary or appropriate to achieve the purposes of this Compact consistent with the state regulation of the business of insurance.

ARTICLE V. ORGANIZATION OF THE COMMISSION

1. Membership, Voting and Bylaws

a. Each Compacting State shall have and be limited to one Member. Each Member shall be qualified to serve in that capacity pursuant to applicable law of the Compacting State. Any Member may be removed or suspended from office as provided by the law of the State from which he or she shall be appointed. Any vacancy occurring in the Commission shall be filled in accordance with the laws of the Compacting State wherein the vacancy exists. Nothing herein shall be construed to affect the manner in which a Compacting State determines the election or appointment and qualification of its own Commissioner.

b. Each Member shall be entitled to one vote and shall have an opportunity to participate in the governance of the Commission in accordance with the Bylaws. Notwithstanding any provision herein to the contrary, no action of the Commission with respect to the promulgation of a Uniform Standard shall be effective unless two-thirds (2/3) of the Members vote in favor thereof.

c. The Commission shall, by a majority of the Members, prescribe Bylaws to govern its conduct as may be necessary or appropriate to carry out the purposes, and exercise the powers, of the Compact, including, but not limited to:

i. Establishing the fiscal year of the Commission;

ii. Providing reasonable procedures for appointing and electing members, as well as holding meetings, of the Management Committee;

iii. Providing reasonable standards and procedures: (i) for the establishment and meetings of other committees, and (ii) governing any general or specific delegation of any authority or function of the Commission;

iv. Providing reasonable procedures for calling and conducting meetings of the Commission that consist of a majority of Commission members, ensuring reasonable advance notice of each such

meeting and providing for the right of citizens to attend each such meeting with enumerated exceptions designed to protect the public's interest, the privacy of individuals, and insurers' proprietary information, including trade secrets. The Commission may meet in camera only after a majority of the entire membership votes to close a meeting en toto or in part. As soon as practicable, the Commission must make public (i) a copy of the vote to close the meeting revealing the vote of each Member with no proxy votes allowed, and (ii) votes taken during such meeting;

v. Establishing the titles, duties and authority and reasonable procedures for the election of the officers of the Commission;

vi. Providing reasonable standards and procedures for the establishment of the personnel policies and programs of the Commission. Notwithstanding any civil service or other similar laws of any Compacting State, the Bylaws shall exclusively govern the personnel policies and programs of the Commission;

vii. Promulgating a code of ethics to address permissible and prohibited activities of commission members and employees; and

viii. Providing a mechanism for winding up the operations of the Commission and the equitable disposition of any surplus funds that may exist after the termination of the Compact after the payment and/or reserving of all of its debts and obligations.

d. The Commission shall publish its bylaws in a convenient form and file a copy thereof and a copy of any amendment thereto, with the appropriate agency or officer in each of the Compacting States.

2. Management Committee, Officers and Personnel

a. A Management Committee comprising no more than fourteen (14) members shall be established as follows:

i. One (1) member from each of the six (6) Compacting States with the largest premium volume for individual and group annuities, life, disability income and long-term care insurance products, determined from the records of the NAIC for the prior year;

ii. Four (4) members from those Compacting States with at least two percent (2%) of the market based on the premium volume described above, other than the six (6) Compacting States with the largest premium volume, selected on a rotating basis as provided in

the Bylaws; and

iii. Four (4) members from those Compacting States with less than two percent (2%) of the market, based on the premium volume described above, with one (1) selected from each of the four (4) zone regions of the NAIC as provided in the Bylaws.

b. The Management Committee shall have such authority and duties as may be set forth in the Bylaws, including but not limited to:

i. Managing the affairs of the Commission in a manner consistent with the Bylaws and purposes of the Commission;

ii. Establishing and overseeing an organizational structure within, and appropriate procedures for, the Commission to provide for the creation of Uniform Standards and other Rules, receipt and review of product filings, administrative and technical support functions, review of decisions regarding the disapproval of a product filing, and the review of elections made by a Compacting State to opt out of a Uniform Standard; provided that a Uniform Standard shall not be submitted to the Compacting States for adoption unless approved by two-thirds (2/3) of the members of the Management Committee;

iii. Overseeing the offices of the Commission; and

iv. Planning, implementing, and coordinating communications and activities with other state, federal and local government organizations in order to advance the goals of the Commission.

c. The Commission shall elect annually officers from the Management Committee, with each having such authority and duties, as may be specified in the Bylaws.

d. The Management Committee may, subject to the approval of the Commission, appoint or retain an executive director for such period, upon such terms and conditions and for such compensation as the Commission may deem appropriate. The executive director shall serve as secretary to the Commission, but shall not be a Member of the Commission. The executive director shall hire and supervise such other staff as may be authorized by the Commission.

3. Legislative and Advisory Committees

a. A legislative committee comprising state legislators or their designees shall be established to monitor the operations of, and make recommendations to, the Commission, including the Management Committee; provided that the manner of selection and term of any

legislative committee member shall be as set forth in the Bylaws. Prior to the adoption by the Commission of any Uniform Standard, revision to the Bylaws, annual budget or other significant matter as may be provided in the Bylaws, the Management Committee shall consult with and report to the legislative committee.

b. The Commission shall establish two (2) advisory committees, one of which shall comprise consumer representatives independent of the insurance industry, and the other comprising insurance industry representatives.

c. The Commission may establish additional advisory committees as its Bylaws may provide for the carrying out of its functions.

4. Corporate Records of the Commission

The Commission shall maintain its corporate books and records in accordance with the Bylaws.

5. Qualified Immunity, Defense and Indemnification

a. The Members, officers, executive director, employees and representatives of the Commission shall be immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities; provided, that nothing in this paragraph shall be construed to protect any such person from suit and/or liability for any damage, loss, injury or liability caused by the intentional or willful and wanton misconduct of that person.

b. The Commission shall defend any Member, officer, executive director, employee or representative of the Commission in any civil action seeking to impose liability arising out of any actual or alleged act, error or omission that occurred within the scope of Commission employment, duties or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities; provided, that nothing herein shall be construed to prohibit that person from retaining his or her own counsel; and provided further, that the actual or alleged act, error or omission did not result from that person's intentional or willful and wanton misconduct.

c. The Commission shall indemnify and hold harmless any Member, officer, executive director, employee or representative of the Commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error or omission that occurred within the scope of Commission employment, duties or responsibilities, or that such person had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities, provided, that the actual or alleged act, error or omission did not result from the intentional or willful and wanton misconduct of that person.

ARTICLE VI. MEETINGS AND ACTS
OF THE COMMISSION

1. The Commission shall meet and take such actions as are consistent with the provisions of this Compact and the Bylaws.

2. Each Member of the Commission shall have the right and power to cast a vote to which that Compacting State is entitled and to participate in the business and affairs of the Commission. A Member shall vote in person or by such other means as provided in the Bylaws. The Bylaws may provide for Members' participation in meetings by telephone or other means of communication.

3. The Commission shall meet at least once during each calendar year. Additional meetings shall be held as set forth in the Bylaws.

ARTICLE VII. RULES AND OPERATING PROCEDURES:

RULEMAKING FUNCTIONS OF THE COMMISSION
AND OPTING OUT OF UNIFORM STANDARDS

1. Rulemaking Authority. The Commission shall promulgate reasonable Rules, including Uniform Standards, and Operating Procedures in order to effectively and efficiently achieve the purposes of this Compact. Notwithstanding the foregoing, in the event the Commission exercises its rulemaking authority in a manner that is beyond the scope of the purposes of this Act, or the powers granted hereunder, then such an action by the Commission shall be invalid and have no force and effect.

2. Rulemaking Procedure. Rules and Operating Procedures shall be made pursuant to a rulemaking process that conforms to the Model State Administrative Procedure Act of 1981 as amended, as may be appropriate to the operations of the Commission. Before the Commission adopts a Uniform Standard, the Commission shall give written notice to the relevant state legislative committee(s) in each Compacting State responsible for insurance issues of its intention to

adopt the Uniform Standard. The Commission in adopting a Uniform Standard shall consider fully all submitted materials and issue a concise explanation of its decision.

3. Effective Date and Opt Out of a Uniform Standard. A Uniform Standard shall become effective ninety (90) days after its promulgation by the Commission or such later date as the Commission may determine; provided, however, that a Compacting State may opt out of a Uniform Standard as provided in this Article. "Opt out" shall be defined as any action by a Compacting State to decline to adopt or participate in a promulgated Uniform Standard. All other Rules and Operating Procedures, and amendments thereto, shall become effective as of the date specified in each Rule, Operating Procedure or amendment.

4. Opt Out Procedure. A Compacting State may opt out of a Uniform Standard, either by legislation or regulation duly promulgated by the Insurance Department under the Compacting State's Administrative Procedure Act. If a Compacting State elects to opt out of a Uniform Standard by regulation, it must (a) give written notice to the Commission no later than ten (10) business days after the Uniform Standard is promulgated, or at the time the State becomes a Compacting State and (b) find that the Uniform Standard does not provide reasonable protections to the citizens of the State, given the conditions in the State. The Commissioner shall make specific findings of fact and conclusions of law, based on a preponderance of the evidence, detailing the conditions in the State which warrant a departure from the Uniform Standard and determining that the Uniform Standard would not reasonably protect the citizens of the State. The Commissioner must consider and balance the following factors and find that the conditions in the State and needs of the citizens of the State outweigh: (i) the intent of the legislature to participate in, and the benefits of, an interstate agreement to establish national uniform consumer protections for the Products subject to this Act; and (ii) the presumption that a Uniform Standard adopted by the Commission provides reasonable protections to consumers of the relevant Product.

Notwithstanding the foregoing, a Compacting State may, at the time of its enactment of this Compact, prospectively opt out of all Uniform Standards involving long-term care insurance products by expressly providing for such opt out in the enacted Compact, and such an opt out shall not be treated as a material variance in the offer

or acceptance of any State to participate in this Compact. Such an opt out shall be effective at the time of enactment of this Compact by the Compacting State and shall apply to all existing Uniform Standards involving long-term care insurance products and those subsequently promulgated.

5. Effect of Opt Out. If a Compacting State elects to opt out of a Uniform Standard, the Uniform Standard shall remain applicable in the Compacting State electing to opt out until such time the opt out legislation is enacted into law or the regulation opting out becomes effective.

Once the opt out of a Uniform Standard by a Compacting State becomes effective as provided under the laws of that State, the Uniform Standard shall have no further force and effect in that State unless and until the legislation or regulation implementing the opt out is repealed or otherwise becomes ineffective under the laws of the State. If a Compacting State opts out of a Uniform Standard after the Uniform Standard has been made effective in that State, the opt out shall have the same prospective effect as provided under Article XIV for withdrawals.

6. Stay of Uniform Standard. If a Compacting State has formally initiated the process of opting out of a Uniform Standard by regulation, and while the regulatory opt out is pending, the Compacting State may petition the Commission, at least fifteen (15) days before the effective date of the Uniform Standard, to stay the effectiveness of the Uniform Standard in that State. The Commission may grant a stay if it determines the regulatory opt out is being pursued in a reasonable manner and there is a likelihood of success. If a stay is granted or extended by the Commission, the stay or extension thereof may postpone the effective date by up to ninety (90) days, unless affirmatively extended by the Commission; provided, a stay may not be permitted to remain in effect for more than one (1) year unless the Compacting State can show extraordinary circumstances which warrant a continuance of the stay, including, but not limited to, the existence of a legal challenge which prevents the Compacting State from opting out. A stay may be terminated by the Commission upon notice that the rulemaking process has been terminated.

7. Not later than thirty (30) days after a Rule or Operating Procedure is promulgated, any person may file a petition for judicial review of the Rule or Operating Procedure; provided, that the filing of such a petition shall not stay or otherwise prevent the Rule or

Operating Procedure from becoming effective unless the court finds that the petitioner has a substantial likelihood of success. The court shall give deference to the actions of the Commission consistent with applicable law and shall not find the Rule or Operating Procedure to be unlawful if the Rule or Operating Procedure represents a reasonable exercise of the Commission's authority.

ARTICLE VIII. COMMISSION RECORDS AND ENFORCEMENT

1. The Commission shall promulgate Rules establishing conditions and procedures for public inspection and copying of its information and official records, except such information and records involving the privacy of individuals and insurers' trade secrets. The Commission may promulgate additional Rules under which it may make available to federal and state agencies, including law enforcement agencies, records and information otherwise exempt from disclosure, and may enter into agreements with such agencies to receive or exchange information or records subject to nondisclosure and confidentiality provisions.

2. Except as to privileged records, data and information, the laws of any Compacting State pertaining to confidentiality or nondisclosure shall not relieve any Compacting State Commissioner of the duty to disclose any relevant records, data or information to the Commission; provided, that disclosure to the Commission shall not be deemed to waive or otherwise affect any confidentiality requirement; and further provided, that, except as otherwise expressly provided in this Act, the Commission shall not be subject to the Compacting State's laws pertaining to confidentiality and nondisclosure with respect to records, data and information in its possession. Confidential information of the Commission shall remain confidential after such information is provided to any Commissioner.

3. The Commission shall monitor Compacting States for compliance with duly adopted Bylaws, Rules, including Uniform Standards, and Operating Procedures. The Commission shall notify any non-complying Compacting State in writing of its noncompliance with Commission Bylaws, Rules or Operating Procedures. If a non-complying Compacting State fails to remedy its noncompliance within the time specified in the notice of noncompliance, the Compacting State shall be deemed to be in default as set forth in Article XIV.

4. The Commissioner of any State in which an Insurer is authorized to do business, or is conducting the business of insurance, shall continue to exercise his or her authority to oversee

the market regulation of the activities of the Insurer in accordance with the provisions of the State's law. The Commissioner's enforcement of compliance with the Compact is governed by the following provisions:

a. With respect to the Commissioner's market regulation of a Product or Advertisement that is approved or certified to the Commission, the content of the Product or Advertisement shall not constitute a violation of the provisions, standards or requirements of the Compact except upon a final order of the Commission, issued at the request of a Commissioner after prior notice to the Insurer and an opportunity for hearing before the Commission.

b. Before a Commissioner may bring an action for violation of any provision, standard or requirement of the Compact relating to the content of an Advertisement not approved or certified to the Commission, the Commission, or an authorized Commission officer or employee, must authorize the action. However, authorization pursuant to this paragraph does not require notice to the Insurer, opportunity for hearing or disclosure of requests for authorization or records of the Commission's action on such requests.

ARTICLE IX. DISPUTE RESOLUTION

The Commission shall attempt, upon the request of a Member, to resolve any disputes or other issues that are subject to this Compact and which may arise between two or more Compacting States, or between Compacting States and Non-compacting States, and the Commission shall promulgate an Operating Procedure providing for resolution of such disputes.

ARTICLE X. PRODUCT FILING AND APPROVAL

1. Insurers and Third-Party Filers seeking to have a Product approved by the Commission shall file the Product with, and pay applicable filing fees to, the Commission. Nothing in this Act shall be construed to restrict or otherwise prevent an insurer from filing its Product with the insurance department in any State wherein the insurer is licensed to conduct the business of insurance, and such filing shall be subject to the laws of the States where filed.

2. The Commission shall establish appropriate filing and review processes and procedures pursuant to Commission Rules and Operating Procedures. Notwithstanding any provision herein to the contrary, the Commission shall promulgate Rules to establish conditions and procedures under which the Commission will provide public access to Product filing information. In establishing such Rules, the

Commission shall consider the interests of the public in having access to such information, as well as protection of personal medical and financial information and trade secrets, that may be contained in a Product filing or supporting information.

3. Any Product approved by the Commission may be sold or otherwise issued in those Compacting States for which the Insurer is legally authorized to do business.

ARTICLE XI. REVIEW OF COMMISSION DECISIONS
REGARDING FILINGS

1. Not later than thirty (30) days after the Commission has given notice of a disapproved Product or Advertisement filed with the Commission, the Insurer or Third Party Filer whose filing was disapproved may appeal the determination to a review panel appointed by the Commission. The Commission shall promulgate Rules to establish procedures for appointing such review panels and provide for notice and hearing. An allegation that the Commission, in disapproving a Product or Advertisement filed with the Commission, acted arbitrarily, capriciously, or in a manner that is an abuse of discretion or otherwise not in accordance with the law, is subject to judicial review in accordance with Article III, Section 4.

2. The Commission shall have authority to monitor, review and reconsider Products and Advertisement subsequent to their filing or approval upon a finding that the product does not meet the relevant Uniform Standard. Where appropriate, the Commission may withdraw or modify its approval after proper notice and hearing, subject to the appeal process in Section 1 above.

ARTICLE XII. FINANCE

1. The Commission shall pay or provide for the payment of the reasonable expenses of its establishment and organization. To fund the cost of its initial operations, the Commission may accept contributions and other forms of funding from the National Association of Insurance Commissioners, Compacting States and other sources. Contributions and other forms of funding from other sources shall be of such a nature that the independence of the Commission concerning the performance of its duties shall not be compromised.

2. The Commission shall collect a filing fee from each Insurer and Third Party Filer filing a product with the Commission to cover the cost of the operations and activities of the Commission and its staff in a total amount sufficient to cover the Commission's annual budget.

3. The Commission's budget for a fiscal year shall not be approved until it has been subject to notice and comment as set forth in Article VII of this Compact.

4. The Commission shall be exempt from all taxation in and by the Compacting States.

5. The Commission shall not pledge the credit of any Compacting State, except by and with the appropriate legal authority of that Compacting State.

6. The Commission shall keep complete and accurate accounts of all its internal receipts, including grants and donations, and disbursements of all funds under its control. The internal financial accounts of the Commission shall be subject to the accounting procedures established under its Bylaws. The financial accounts and reports including the system of internal controls and procedures of the Commission shall be audited annually by an independent certified public accountant. Upon the determination of the Commission, but no less frequently than every three (3) years, the review of the independent auditor shall include a management and performance audit of the Commission. The Commission shall make an Annual Report to the Governor and legislature of the Compacting States, which shall include a report of the independent audit. The Commission's internal accounts shall not be confidential and such materials may be shared with the Commissioner of any Compacting State upon request provided, however, that any work papers related to any internal or independent audit and any information regarding the privacy of individuals and insurers' proprietary information, including trade secrets, shall remain confidential.

7. No Compacting State shall have any claim to or ownership of any property held by or vested in the Commission or to any Commission funds held pursuant to the provisions of this Compact.

ARTICLE XIII. COMPACTING STATES, EFFECTIVE DATE AND AMENDMENT

1. Any State is eligible to become a Compacting State.

2. The Compact shall become effective and binding upon legislative enactment of the Compact into law by two Compacting States; provided, the Commission shall become effective for purposes of adopting Uniform Standards for, reviewing, and giving approval or disapproval of, Products filed with the Commission that satisfy applicable Uniform Standards only after twenty-six (26) States are Compacting States or, alternatively, by States representing greater than forty percent (40%) of the premium volume for life insurance,

annuity, disability income and long-term care insurance products, based on records of the NAIC for the prior year. Thereafter, it shall become effective and binding as to any other Compacting State upon enactment of the Compact into law by that State.

3. Amendments to the Compact may be proposed by the Commission for enactment by the Compacting States. No amendment shall become effective and binding upon the Commission and the Compacting States unless and until all Compacting States enact the amendment into law.

ARTICLE XIV. WITHDRAWAL, DEFAULT AND TERMINATION

1. Withdrawal

a. Once effective, the Compact shall continue in force and remain binding upon each and every Compacting State; provided, that a Compacting State may withdraw from the Compact ("Withdrawing State") by enacting a statute specifically repealing the statute which enacted the Compact into law.

b. The effective date of withdrawal is the effective date of the repealing statute. However, the withdrawal shall not apply to any product filings approved or self-certified, or any Advertisement of such products, on the date the repealing statute becomes effective, except by mutual agreement of the Commission and the Withdrawing State unless the approval is rescinded by the Withdrawing State as provided in Paragraph e of this section.

c. The Commissioner of the Withdrawing State shall immediately notify the Management Committee in writing upon the introduction of legislation repealing this Compact in the Withdrawing State.

d. The Commission shall notify the other Compacting States of the introduction of such legislation within ten (10) days after its receipt of notice thereof.

e. The Withdrawing State is responsible for all obligations, duties and liabilities incurred through the effective date of withdrawal, including any obligations, the performance of which extend beyond the effective date of withdrawal, except to the extent those obligations may have been released or relinquished by mutual agreement of the Commission and the Withdrawing State. The Commission's approval of Products and Advertisement prior to the effective date of withdrawal shall continue to be effective and be given full force and effect in the Withdrawing State, unless formally rescinded by the Withdrawing State in the same manner as provided by the laws of the Withdrawing State for the prospective disapproval of

products or advertisement previously approved under state law.

f. Reinstatement following withdrawal of any Compacting State shall occur upon the effective date of the Withdrawing State reenacting the Compact.

2. Default

a. If the Commission determines that any Compacting State has at any time defaulted ("Defaulting State") in the performance of any of its obligations or responsibilities under this Compact, the Bylaws or duly promulgated Rules or Operating Procedures, then, after notice and hearing as set forth in the Bylaws, all rights, privileges and benefits conferred by this Compact on the Defaulting State shall be suspended from the effective date of default as fixed by the Commission. The grounds for default include, but are not limited to, failure of a Compacting State to perform its obligations or responsibilities, and any other grounds designated in Commission Rules. The Commission shall immediately notify the Defaulting State in writing of the Defaulting State's suspension pending a cure of the default. The Commission shall stipulate the conditions and the time period within which the Defaulting State must cure its default. If the Defaulting State fails to cure the default within the time period specified by the Commission, the Defaulting State shall be terminated from the Compact and all rights, privileges and benefits conferred by this Compact shall be terminated from the effective date of termination.

b. Product approvals by the Commission or product self-certifications, or any Advertisement in connection with such product, that are in force on the effective date of termination shall remain in force in the Defaulting State in the same manner as if the Defaulting State had withdrawn voluntarily pursuant to Section 1 of this article.

c. Reinstatement following termination of any Compacting State requires a reenactment of the Compact.

3. Dissolution of Compact

a. The Compact dissolves effective upon the date of the withdrawal or default of the Compacting State which reduces membership in the Compact to one Compacting State.

b. Upon the dissolution of this Compact, the Compact becomes null and void and shall be of no further force or effect, and the business and affairs of the Commission shall be wound up and any surplus funds shall be distributed in accordance with the Bylaws.

ARTICLE XV. SEVERABILITY AND CONSTRUCTION

1. The provisions of this Compact shall be severable; and if any phrase, clause, sentence or provision is deemed unenforceable, the remaining provisions of the Compact shall be enforceable.

2. The provisions of this Compact shall be liberally construed to effectuate its purposes.

ARTICLE XVI. BINDING EFFECT OF COMPACT AND OTHER LAWS

1. Other Laws

a. Nothing herein prevents the enforcement of any other law of a Compacting State, except as provided in Paragraph b of this section.

b. For any Product approved or certified to the Commission, the Rules, Uniform Standards and any other requirements of the Commission shall constitute the exclusive provisions applicable to the content, approval and certification of such Products. For Advertisement that is subject to the Commission's authority, any Rule, Uniform Standard or other requirement of the Commission which governs the content of the Advertisement shall constitute the exclusive provision that a Commissioner may apply to the content of the Advertisement. Notwithstanding the foregoing, no action taken by the Commission shall abrogate or restrict: (i) the access of any person to state courts; (ii) remedies available under state law related to breach of contract, tort, or other laws not specifically directed to the content of the Product; (iii) state law relating to the construction of insurance contracts; or (iv) the authority of the attorney general of the state, including but not limited to maintaining any actions or proceedings, as authorized by law.

c. All insurance products filed with individual States shall be subject to the laws of those States.

2. Binding Effect of this Compact

a. All lawful actions of the Commission, including all Rules and Operating Procedures promulgated by the Commission, are binding upon the Compacting States.

b. All agreements between the Commission and the Compacting States are binding in accordance with their terms.

c. Upon the request of a party to a conflict over the meaning or interpretation of Commission actions, and upon a majority vote of the Compacting States, the Commission may issue advisory opinions regarding the meaning or interpretation in dispute.

d. In the event any provision of this Compact exceeds the

constitutional limits imposed on the legislature of any Compacting State, the obligations, duties, powers or jurisdiction sought to be conferred by that provision upon the Commission shall be ineffective as to that Compacting State, and those obligations, duties, powers or jurisdiction shall remain in the Compacting State and shall be exercised by the agency thereof to which those obligations, duties, powers or jurisdiction are delegated by law in effect at the time this Compact becomes effective.

Added by Acts 2005, 79th Leg., Ch. 1132 (H.B. 2613), Sec. 1, eff. September 1, 2005.

CHAPTER 5002. INTERSTATE HEALTH CARE COMPACT

Sec. 5002.001. EXECUTION OF COMPACT. This state enacts the Interstate Health Care Compact and enters into the compact with all other states legally joining in the compact in substantially the following form:

Whereas, the separation of powers, both between the branches of the Federal government and between Federal and State authority, is essential to the preservation of individual liberty;

Whereas, the Constitution creates a Federal government of limited and enumerated powers, and reserves to the States or to the people those powers not granted to the Federal government;

Whereas, the Federal government has enacted many laws that have preempted State laws with respect to Health Care, and placed increasing strain on State budgets, impairing other responsibilities such as education, infrastructure, and public safety;

Whereas, the Member States seek to protect individual liberty and personal control over Health Care decisions, and believe the best method to achieve these ends is by vesting regulatory authority over Health Care in the States;

Whereas, by acting in concert, the Member States may express and inspire confidence in the ability of each Member State to govern Health Care effectively; and

Whereas, the Member States recognize that consent of Congress may be more easily secured if the Member States collectively seek consent through an interstate compact;

NOW THEREFORE, the Member States hereto resolve, and by the adoption into law under their respective State Constitutions of this Health Care Compact, agree, as follows:

Sec. 1. Definitions. As used in this Compact, unless the context clearly indicates otherwise:

"Commission" means the Interstate Advisory Health Care Commission.

"Effective Date" means the date upon which this Compact shall become effective for purposes of the operation of State and Federal law in a Member State, which shall be the later of:

a) the date upon which this Compact shall be adopted under the laws of the Member State, and

b) the date upon which this Compact receives the consent of Congress pursuant to Article I, Section 10, of the United States Constitution, after at least two Member States adopt this Compact.

"Health Care" means care, services, supplies, or plans related to the health of an individual and includes but is not limited to:

(a) preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care and counseling, service, assessment, or procedure with respect to the physical or mental condition or functional status of an individual or that affects the structure or function of the body, and

(b) sale or dispensing of a drug, device, equipment, or other item in accordance with a prescription, and

(c) an individual or group plan that provides, or pays the cost of, care, services, or supplies related to the health of an individual, except any care, services, supplies, or plans provided by the United

States Department of Defense and United States Department of Veterans Affairs, or provided to Native Americans.

"Member State" means a State that is signatory to this Compact and has adopted it under the laws of that State.

"Member State Base Funding Level" means a number equal to the total Federal spending on Health Care in the Member State during Federal fiscal year 2010. On or before the Effective Date, each Member State shall determine the Member State Base Funding Level for its State, and that number shall be binding upon that Member State.

"Member State Current Year Funding Level" means the Member State Base Funding Level multiplied by the Member State Current Year Population Adjustment Factor multiplied by the Current Year Inflation Adjustment Factor.

"Member State Current Year Population Adjustment Factor" means the average population of the Member State in the current year less the average population of the Member State in Federal fiscal year 2010, divided by the average population of the Member State in Federal fiscal year 2010, plus 1. Average population in a Member State shall be determined by the United States Census Bureau.

"Current Year Inflation Adjustment Factor" means the Total Gross Domestic Product Deflator in the current year divided by the Total Gross Domestic Product Deflator in Federal fiscal year 2010. Total Gross Domestic Product Deflator shall be determined by the Bureau of Economic Analysis of the United States Department of Commerce.

Sec. 2. Pledge. The Member States shall take joint and separate action to secure the consent of the United States Congress to this Compact in order to return the authority to regulate Health Care to the Member States consistent with the goals and principles articulated in this Compact. The Member States shall improve Health Care policy within their respective jurisdictions and according to the judgment and discretion of each Member State.

Sec. 3. Legislative Power. The legislatures of the Member States have the primary responsibility to regulate Health Care in their

respective States.

Sec. 4. State Control. Each Member State, within its State, may suspend by legislation the operation of all federal laws, rules, regulations, and orders regarding Health Care that are inconsistent with the laws and regulations adopted by the Member State pursuant to this Compact. Federal and State laws, rules, regulations, and orders regarding Health Care will remain in effect unless a Member State expressly suspends them pursuant to its authority under this Compact. For any federal law, rule, regulation, or order that remains in effect in a Member State after the Effective Date, that Member State shall be responsible for the associated funding obligations in its State.

Sec. 5. Funding.

(a) Each Federal fiscal year, each Member State shall have the right to Federal monies up to an amount equal to its Member State Current Year Funding Level for that Federal fiscal year, funded by Congress as mandatory spending and not subject to annual appropriation, to support the exercise of Member State authority under this Compact. This funding shall not be conditional on any action of or regulation, policy, law, or rule being adopted by the Member State.

(b) By the start of each Federal fiscal year, Congress shall establish an initial Member State Current Year Funding Level for each Member State, based upon reasonable estimates. The final Member State Current Year Funding Level shall be calculated, and funding shall be reconciled by the United States Congress based upon information provided by each Member State and audited by the United States Government Accountability Office.

Sec. 6. Interstate Advisory Health Care Commission.

(a) The Interstate Advisory Health Care Commission is established. The Commission consists of members appointed by each Member State through a process to be determined by each Member State. A Member State may not appoint more than two members to the Commission and may withdraw membership from the Commission at any time. Each Commission member is entitled to one vote. The Commission shall not act unless

a majority of the members are present, and no action shall be binding unless approved by a majority of the Commission's total membership.

(b) The Commission may elect from among its membership a Chairperson. The Commission may adopt and publish bylaws and policies that are not inconsistent with this Compact. The Commission shall meet at least once a year, and may meet more frequently.

(c) The Commission may study issues of Health Care regulation that are of particular concern to the Member States. The Commission may make non-binding recommendations to the Member States. The legislatures of the Member States may consider these recommendations in determining the appropriate Health Care policies in their respective States.

(d) The Commission shall collect information and data to assist the Member States in their regulation of Health Care, including assessing the performance of various State Health Care programs and compiling information on the prices of Health Care. The Commission shall make this information and data available to the legislatures of the Member States. Notwithstanding any other provision in this Compact, no Member State shall disclose to the Commission the health information of any individual, nor shall the Commission disclose the health information of any individual.

(e) The Commission shall be funded by the Member States as agreed to by the Member States. The Commission shall have the responsibilities and duties as may be conferred upon it by subsequent action of the respective legislatures of the Member States in accordance with the terms of this Compact.

(f) The Commission shall not take any action within a Member State that contravenes any State law of that Member State.

Sec. 7. Congressional Consent. This Compact shall be effective on its adoption by at least two Member States and consent of the United States Congress. This Compact shall be effective unless the United States Congress, in consenting to this Compact, alters the fundamental purposes of this Compact, which are:

(a) To secure the right of the Member States to regulate Health Care in their respective States pursuant to this Compact and to suspend the operation of any conflicting federal laws, rules, regulations, and orders within their States; and

(b) To secure Federal funding for Member States that choose to invoke their authority under this Compact, as prescribed by Section 5 above.

Sec. 8. Amendments. The Member States, by unanimous agreement, may amend this Compact from time to time without the prior consent or approval of Congress and any amendment shall be effective unless, within one year, the Congress disapproves that amendment. Any State may join this Compact after the date on which Congress consents to the Compact by adoption into law under its State Constitution.

Sec. 9. Withdrawal; Dissolution. Any Member State may withdraw from this Compact by adopting a law to that effect, but no such withdrawal shall take effect until six months after the Governor of the withdrawing Member State has given notice of the withdrawal to the other Member States. A withdrawing State shall be liable for any obligations that it may have incurred prior to the date on which its withdrawal becomes effective. This Compact shall be dissolved upon the withdrawal of all but one of the Member States.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 12.01, eff. September 28, 2011.

TITLE 20. REGULATION OF OTHER OCCUPATIONS

CHAPTER 6001. FIRE EXTINGUISHER SERVICE AND INSTALLATION

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 6001.001. PURPOSE. The purpose of this chapter is to safeguard lives and property by:

(1) regulating:

(A) the leasing, selling, installing, and servicing of portable fire extinguishers; and

(B) the planning, certifying, installing, and servicing of fixed fire extinguisher systems; and

(2) prohibiting portable fire extinguishers, fixed fire

extinguisher systems, or extinguisher equipment that is not listed by a testing laboratory approved by the department.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 1004 (H.B. 2447), Sec. 2, eff. September 1, 2013.

Sec. 6001.002. DEFINITIONS. In this chapter:

(1) "Firm" means an individual, partnership, corporation, or association.

(2) "Fixed fire extinguisher system" means an assembly of piping, conduits, or containers that convey liquid, powder, or gases to dispersal openings or devices protecting one or more hazards by suppressing or extinguishing fires.

(3) "Hydrostatic testing" means pressure testing by hydrostatic methods.

(4) "Insurance agent" means:

(A) an individual, firm, or corporation licensed under:

(i) Subchapter E, Chapter 981; or

(ii) Subchapter A, B, C, D, E, or G, Chapter 4051;

or

(B) an individual authorized to represent an insurance fund or pool created by a municipality, county, or other political subdivision of this state under Chapter 791, Government Code.

(5) "Portable fire extinguisher" means any device that contains liquid, powder, or gases for suppressing or extinguishing fires.

(5-a) "Portable fire extinguisher inspection" means a monthly inspection to ensure that a portable fire extinguisher:

(A) is in the extinguisher's designated location;

(B) has not been actuated or subject to tampering; and

(C) does not have any obvious physical damage or another condition that may prevent proper operation of the extinguisher.

(6) "Registered firm" means a firm that holds a registration certificate.

(7) "Service" and "servicing" mean servicing a portable

fire extinguisher or a fixed fire extinguisher system by charging, filling, maintaining, recharging, refilling, repairing, or testing.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 450 (S.B. 1598), Sec. 1, eff. September 1, 2011.

**SUBCHAPTER B. POWERS AND DUTIES OF COMMISSIONER,
DEPARTMENT, AND STATE FIRE MARSHAL**

Sec. 6001.051. ADMINISTRATION OF CHAPTER. (a) The department shall administer this chapter.

(b) The commissioner may issue rules the commissioner considers necessary to administer this chapter through the state fire marshal.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

Sec. 6001.052. ADOPTION OF RULES. (a) In adopting necessary rules, the commissioner may use recognized standards, including standards:

- (1) published by the National Fire Protection Association;
- (2) recognized by federal law or regulation;
- (3) published by any nationally recognized standards-making organization; or
- (4) contained in the manufacturer's installation manuals.

(b) The commissioner shall adopt and administer rules determined essentially necessary for the protection and preservation of life and property regarding:

- (1) registration of firms engaged in the business of:
 - (A) installing or servicing portable fire extinguishers or planning, certifying, installing, or servicing fixed fire extinguisher systems; or
 - (B) hydrostatic testing of fire extinguisher cylinders;
- (2) the examination and licensing of individuals to:
 - (A) install or service portable fire extinguishers; and
 - (B) plan, certify, install, or service fixed fire extinguisher systems; and

(3) requirements for:

(A) installing or servicing portable fire extinguishers; and

(B) planning, certifying, installing, or servicing fixed fire extinguisher systems.

(c) The commissioner by rule shall prescribe requirements for applications and qualifications for licenses, permits, and certificates issued under this chapter.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

Sec. 6001.053. RULES RESTRICTING ADVERTISING OR COMPETITIVE BIDDING. (a) The commissioner may not adopt rules restricting advertising or competitive bidding by the holder of a license, permit, certificate, or approval issued under this chapter except to prohibit false, misleading, or deceptive practices.

(b) In the commissioner's rules to prohibit false, misleading, or deceptive practices, the commissioner may not include a rule that:

(1) restricts the use of any medium for advertising;

(2) restricts the use of a license, permit, certificate, or approval holder's personal appearance or voice in an advertisement;

(3) relates to the size or duration of an advertisement by the license, permit, certificate, or approval holder; or

(4) restricts the license, permit, certificate, or approval holder's advertisement under a trade name.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

Sec. 6001.054. GENERAL POWERS AND DUTIES OF DEPARTMENT. (a) The department shall evaluate the qualifications of a firm:

(1) applying for a registration certificate to engage in the business of installing or servicing portable fire extinguishers or planning, certifying, installing, or servicing fixed fire extinguisher systems; or

(2) seeking approval as a testing laboratory.

(b) The department shall issue:

(1) registration certificates for firms that qualify under

commissioner rules to engage in the business of installing or servicing portable fire extinguishers or planning, certifying, installing, or servicing fixed fire extinguisher systems; and

(2) licenses, apprentice permits, and authorizations to perform hydrostatic testing to firms or individuals that qualify.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

Sec. 6001.055. FEES. (a) The commissioner shall set the fee for:

(1) an initial firm registration certificate in an amount not to exceed \$450;

(2) the renewal of a firm registration certificate in an amount not to exceed \$300 annually;

(3) an initial branch office registration certificate in an amount not to exceed \$100;

(4) the renewal of a branch office registration certificate in an amount not to exceed \$100 annually;

(5) an initial registration certificate to perform hydrostatic testing of fire extinguishers manufactured in accordance with the specifications and procedures of the United States Department of Transportation in an amount not to exceed \$250;

(6) the renewal of a registration certificate to perform hydrostatic testing of fire extinguishers manufactured in accordance with the specifications and procedures of the United States Department of Transportation in an amount not to exceed \$150 annually;

(7) an initial employee license fee in an amount not to exceed \$70;

(8) the annual renewal of an employee license in an amount not to exceed \$50; and

(9) an apprentice permit in an amount not to exceed \$30.

(b) Unless the examination or reexamination for an employee license is administered by a testing service, the commissioner shall set a nonrefundable fee for:

(1) the initial examination in an amount not to exceed \$30; and

(2) each reexamination in an amount not to exceed \$20.

(c) The commissioner shall set a fee in an amount not to exceed \$20 for:

(1) a duplicate registration certificate, license, or apprentice permit issued under this chapter; or

(2) any request requiring changes to a registration certificate, license, or permit.

(d) On a change of ownership of a registered firm, the department shall issue a new registration certificate with a new number for a fee set by the commissioner in an amount not to exceed \$450. On a change of ownership of a branch office, the commissioner shall charge a fee in an amount not to exceed \$100.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

Sec. 6001.056. DEPOSIT IN OPERATING ACCOUNT. All money collected under this chapter, other than penalties and monetary forfeitures, shall be paid to the department and deposited in the state treasury to the credit of the Texas Department of Insurance operating account for use in administering this chapter.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

SUBCHAPTER D. REGISTRATION, LICENSE, AND PERMIT REQUIREMENTS

Sec. 6001.151. FIRM REGISTRATION CERTIFICATE REQUIRED. Unless the firm holds a registration certificate issued by the department, a firm may not engage in the business of:

(1) installing or servicing portable fire extinguishers; or

(2) planning, certifying, installing, or servicing fixed fire extinguisher systems.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

Sec. 6001.152. BRANCH OFFICE REGISTRATION CERTIFICATE REQUIRED.

(a) Each separate office location of a firm holding a registration certificate, other than the location identified on the firm's

certificate, must have a branch office registration certificate issued by the department.

(b) Before issuing a branch office registration certificate, the department must determine that the branch office location is part of a registered firm.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

Sec. 6001.153. HYDROSTATIC TESTING; REGISTRATION CERTIFICATE REQUIRED. (a) A firm may not perform hydrostatic testing of fire extinguishers manufactured in accordance with the specifications and procedures of the United States Department of Transportation unless the firm:

(1) complies with the procedures specified by that department for compressed gas cylinders; and

(2) holds a registration certificate issued by the state fire marshal authorizing hydrostatic testing.

(b) The license of an individual qualified to do work described by Subsection (a) must indicate the authority of the individual to perform that work.

(c) Hydrostatic testing of fire extinguishers that is not performed under the specifications of the United States Department of Transportation must be performed in the manner recommended by the National Fire Protection Association.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

Sec. 6001.154. REQUIRED INSURANCE COVERAGE FOR REGISTRATION CERTIFICATE. (a) The department may not issue a registration certificate under this chapter unless the applicant files with the department evidence of a general liability insurance policy that includes products and completed operations coverage. The policy must be conditioned to pay on behalf of the insured those amounts that the insured becomes legally obligated to pay as damages because of bodily injury and property damage caused by an occurrence involving the insured or the insured's officer, agent, or employee in the conduct of any activity that requires a registration certificate or license

under this chapter.

(b) Unless the commissioner, after notice and an opportunity for a hearing, increases or decreases the limits, the limits of insurance coverage required by Subsection (a) must be at least:

(1) \$100,000 combined single limits for bodily injury and property damage for each occurrence; and

(2) \$300,000 aggregate for all occurrences for each policy year.

(c) The evidence of insurance required by this section must be in the form of a certificate of insurance executed by an insurer authorized to engage in the business of insurance in this state and countersigned by an insurance agent licensed in this state. A certificate of insurance for surplus lines coverage procured in compliance with Chapter 981 through a surplus lines agent that is licensed under Subchapter E, Chapter 981, and resident in this state may be filed with the department as evidence of the coverage required by this section.

(d) An insurance certificate executed and filed with the department under this section remains in force until the insurer has terminated future liability by the notice required by the department.

(e) Failure to maintain the liability insurance required by this section constitutes grounds for the denial, suspension, or revocation, after notice and opportunity for hearing, of a registration certificate issued under this chapter.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

Sec. 6001.155. EMPLOYEE LICENSE REQUIRED. (a) Except as provided by Section 6001.156, an individual, other than an apprentice, must hold a license issued by the department before:

(1) installing or servicing portable fire extinguishers;

(2) installing, servicing, or certifying preengineered fixed fire extinguisher systems; or

(3) planning, supervising, servicing, or certifying the installation of fixed fire extinguisher systems other than preengineered systems.

(b) An individual who holds a license to install or service portable fire extinguishers or install and service fixed fire

extinguisher systems must be an employee or agent of a registered firm.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

Sec. 6001.156. ACTIVITIES NOT REGULATED BY CHAPTER. (a) The licensing provisions of this chapter do not apply to:

(1) the filling or charging of a portable fire extinguisher by the manufacturer before initial sale of the fire extinguisher;

(2) the servicing by a firm of the firm's portable fire extinguishers or fixed systems by the firm's personnel who are specially trained for that servicing;

(2-a) the inspection of a firm's portable fire extinguisher by a person who is:

(A) specially trained to perform portable fire extinguisher inspections; and

(B) under contract with the firm for that purpose;

(3) the installation of portable fire extinguishers in a building by the building owner, the owner's managing agent, or an employee of the building owner or the owner's managing agent;

(4) the installation or servicing of water sprinkler systems installed in compliance with the National Fire Protection Association's Standards for the Installation of Sprinkler Systems;

(5) a firm that is engaged in the retail or wholesale sale of portable fire extinguishers that carry the listing of a testing laboratory approved by the department, but that is not engaged in the installation or servicing of those extinguishers;

(6) a fire department that services portable fire extinguishers as a public service without charge, if the members of the fire department are trained in the proper servicing of the fire extinguishers;

(7) a firm that is a party to a contract under which:

(A) the installation of portable fire extinguishers or a fixed fire extinguisher system is performed under the direct supervision of and certified by a firm appropriately registered to install and certify portable extinguishers or fixed systems; and

(B) the registered firm assumes full responsibility for the installation; or

(8) an engineer licensed under Chapter 1001, Occupations Code, while acting solely in the engineer's professional capacity.

(b) Except as provided by Subsection (a), only the holder of a license or an apprentice permit issued under this chapter may:

- (1) install or service portable fire extinguishers; or
- (2) install and maintain fixed fire extinguisher systems.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 450 (S.B. 1598), Sec. 2, eff. September 1, 2011.

Acts 2013, 83rd Leg., R.S., Ch. 1004 (H.B. 2447), Sec. 3, eff. September 1, 2013.

Sec. 6001.157. LICENSE EXAMINATION. (a) The state fire marshal shall:

(1) establish the scope and type of an examination required by this chapter; and

(2) examine each applicant for a license under this chapter.

(b) The state fire marshal may administer the examination or may enter into an agreement with a testing service.

(c) If a testing service is used, the state fire marshal may contract with the testing service regarding requirements for the examination, including:

- (1) examination development;
- (2) scheduling;
- (3) site arrangements;
- (4) grading;
- (5) reporting;
- (6) analysis; or
- (7) other administrative duties.

(d) The state fire marshal may require the testing service to:

(1) correspond directly with a license applicant regarding the administration of the examination;

(2) collect a reasonable fee from an applicant for administering the examination; or

(3) administer the examination at a specific location or

time.

(e) The state fire marshal shall adopt rules as necessary to implement examination requirements under this chapter.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

Sec. 6001.158. EXAMINATION RESULTS. (a) Not later than the 30th day after the date on which a licensing examination is administered under this chapter, the state fire marshal shall send notice to each examinee of the results of the examination.

(b) If an examination is conducted, graded, or reviewed by a testing service, the state fire marshal shall send notice to the examinees of the results of the examination not later than the 14th day after the date on which the state fire marshal receives the results from the testing service.

(c) If the notice of the examination results will be delayed for more than 90 days after the examination date, the state fire marshal, before the 90th day, shall send notice to the examinee of the reason for the delay.

(d) The state fire marshal may require a testing service to notify an examinee of the results of the examinee's examination under Subsections (a) and (b).

(e) If requested in writing by an individual who fails the licensing examination administered under this chapter, the state fire marshal shall send to the individual an analysis of the individual's performance on the examination.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

Sec. 6001.159. CONTINUING EDUCATION REQUIREMENTS. (a) The commissioner may adopt procedures for certifying and may certify continuing education programs for individuals licensed under this chapter.

(b) Participation in the continuing education programs is voluntary.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001,

eff. April 1, 2009.

Sec. 6001.160. RECIPROCAL LICENSE. The department may waive any license requirement for an applicant who holds a license issued by another state that has license requirements substantially equivalent to the license requirements of this state.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

Sec. 6001.161. APPRENTICE PERMIT REQUIRED. (a) An individual may not install or service portable fire extinguishers or fixed fire extinguisher systems as an apprentice unless the individual holds an apprentice permit issued by the department.

(b) An apprentice may perform a service described by Subsection (a) only under the direct supervision of an individual who holds a license issued under this chapter and who works for the same firm as the apprentice.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

Sec. 6001.162. NOT TRANSFERABLE. A registration certificate, license, or permit issued under this chapter is not transferable.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

SUBCHAPTER E. RENEWAL OF REGISTRATION, LICENSE, OR PERMIT

Sec. 6001.201. RENEWAL REQUIRED; FEE. (a) A renewal of a registration certificate or license issued under this chapter is valid for a period of two years. The license or registration fee for each year of the two-year period is payable on renewal.

(b) An apprentice permit expires on the first anniversary of the date of issuance.

(c) The commissioner by rule may adopt a system under which registration certificates, licenses, and permits expire on various

dates during the year. For the year in which an expiration date of a registration certificate, license, or permit is less than one year from its issuance or anniversary date, the fee shall be prorated on a monthly basis so that each holder of a registration certificate, license, or permit pays only that portion of the renewal fee that is allocable to the number of months during which the registration certificate, license, or permit is valid. On each subsequent renewal, the total renewal fee is payable.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

Sec. 6001.202. NOTICE OF EXPIRATION. At least 30 days before the expiration date of a registration certificate or license, the state fire marshal shall send written notice of the impending expiration to the holder of the registration certificate or license at the holder's last known address.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

Sec. 6001.203. RENEWAL PROCEDURES. (a) The holder of an unexpired registration certificate or license may renew the certificate or license by paying the required renewal fee to the department before the expiration date of the certificate or license.

(b) A firm or individual whose registration certificate or license has been expired for 90 days or less may renew the certificate or license by paying to the department:

- (1) the required renewal fee; and
- (2) a fee equal to one-half of the initial fee for the certificate or license.

(c) A firm or individual whose registration certificate or license has been expired for more than 90 days but less than two years may renew the certificate or license by paying to the department:

- (1) all unpaid renewal fees; and
- (2) a fee that is equal to the initial fee for the certificate or license.

(d) A firm or individual whose registration certificate or

license has been expired for two years or longer may not renew the certificate or license. The firm or individual may obtain a new registration certificate or license by complying with the requirements and procedures for obtaining an initial registration certificate or license.

(e) This section may not be construed to prevent the department from denying or refusing to renew a license under applicable law or commissioner rules.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

**SUBCHAPTER F. PROHIBITED PRACTICES
AND DISCIPLINARY PROCEDURES**

Sec. 6001.251. PROHIBITED PRACTICES. (a) An individual or firm may not:

(1) engage in the business of installing or servicing portable fire extinguishers without holding a registration certificate;

(2) engage in the business of planning, certifying, installing, or servicing fixed fire extinguisher systems without holding a registration certificate;

(3) install, service, or certify the servicing of portable fire extinguishers or plan, certify, service, or install fixed fire extinguisher systems without holding a license;

(4) perform hydrostatic testing of fire extinguisher cylinders manufactured in accordance with the specifications and requirements of the United States Department of Transportation without holding a hydrostatic testing registration certificate;

(5) obtain or attempt to obtain a registration certificate or license by fraudulent representation;

(6) install or service portable fire extinguishers or plan, certify, service, or install fixed fire extinguisher systems in violation of this chapter or the rules adopted and administered under this chapter;

(7) except as provided by Subsection (b), install, service, or hydrostatically test a fire extinguisher that does not have the proper identifying labels;

(8) sell, install, service, or recharge a carbon

tetrachloride fire extinguisher; or

(9) except as provided by Subsection (b), lease, sell, service, or install a portable fire extinguisher, a fixed fire extinguisher system, or extinguisher equipment unless it carries an approval label or listing label issued by a testing laboratory approved by the department.

(b) The commissioner by rule shall permit an individual or firm to service a portable fire extinguisher regardless of whether the extinguisher carries a label described by Subsection (a).

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

Sec. 6001.252. DISCIPLINARY ACTIONS. (a) The state fire marshal may suspend, revoke, or refuse to issue or renew a registration certificate, license, or permit if, after notice and hearing, the state fire marshal finds that the applicant, registrant, license holder, or permit holder has engaged in acts that:

- (1) violate this chapter;
- (2) violate rules or standards adopted under this chapter;

or

- (3) constitute misrepresentation made in connection with:
 - (A) the sale of products; or
 - (B) services rendered.

(b) Subject to Section 6001.253, the commissioner may suspend, revoke, or refuse to issue or renew a certificate, license, permit, or approval.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

Sec. 6001.253. DISCIPLINARY HEARING. (a) If the state fire marshal proposes to suspend, revoke, or refuse to renew a license, permit, certificate, or approval issued under this chapter, the holder of the license, permit, certificate, or approval is entitled to a hearing conducted by the State Office of Administrative Hearings.

(b) Proceedings for a disciplinary action are governed by Chapter 2001, Government Code.

(c) Rules of practice adopted by the commissioner applicable to the proceedings for a disciplinary action may not conflict with rules adopted by the State Office of Administrative Hearings.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

Sec. 6001.254. REAPPLICATION REQUIREMENTS. (a) An applicant or holder of a registration certificate, license, or permit whose certificate, license, or permit has been refused or revoked under this chapter, other than for failure to pass a required written examination, may not file another application for a registration certificate, license, or permit before the first anniversary of the effective date of the refusal or revocation.

(b) After the first anniversary of the effective date of the refusal or revocation, the applicant may:

(1) reapply; and

(2) in a public hearing, show good cause why the issuance of the registration certificate, license, or permit is not against the public safety and welfare.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

Sec. 6001.255. REEXAMINATION AFTER REVOCATION. An individual whose license to service portable fire extinguishers or to install or service fixed fire extinguisher systems has been revoked must retake and pass the required written examination before a new license may be issued.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

SUBCHAPTER G. CRIMINAL PENALTY

Sec. 6001.301. CRIMINAL PENALTY. (a) A person commits an offense if the person knowingly violates Section 6001.251(a).

(b) An offense under this section is a Class B misdemeanor.

(c) Venue for an offense under this section is in Travis County

or the county in which the offense is committed.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

CHAPTER 6002. FIRE DETECTION AND ALARM DEVICE INSTALLATION
SUBCHAPTER A. GENERAL PROVISIONS

Sec. 6002.001. PURPOSE. The purpose of this chapter is to safeguard lives and property by:

(1) regulating the planning, certifying, leasing, selling, servicing, installing, monitoring, and maintaining of fire detection and fire alarm devices and systems; and

(2) except as provided by rules adopted under Section 6002.051 or 6002.052, prohibiting fire detection and fire alarm devices, equipment, and systems not labeled or listed by a nationally recognized testing laboratory.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

Sec. 6002.002. DEFINITIONS. Except as otherwise provided by this chapter, in this chapter:

(1) "Fire alarm device" means any device capable, through audible or visible means, of warning that fire or combustion has occurred or is occurring.

(2) "Fire alarm planning superintendent" means a licensed individual designated by a registered firm to:

(A) plan a fire alarm or detection system that conforms to applicable adopted National Fire Protection Association standards or other adopted standards; and

(B) certify that each fire alarm or detection system as planned meets the standards as provided by law.

(3) "Fire alarm technician" means a licensed individual designated by a registered firm to:

(A) inspect and certify that each fire alarm or detection system as installed meets the standards provided by law; or

(B) perform or directly supervise the servicing or maintaining of a previously installed fire alarm device or system and certify that service or maintenance.

(4) "Fire detection device" means any arrangement of materials, the sole function of which is to indicate the existence of fire, smoke, or combustion in its incipient stages.

(5) "Individual" means a natural person, including an owner, manager, officer, employee, occupant, or other individual.

(6) "Installation" means:

(A) the initial placement of equipment; or

(B) the extension, modification, or alteration of equipment already in place.

(7) "Insurance agent" means:

(A) an individual, firm, or corporation licensed under:

(i) Subchapter E, Chapter 981; or

(ii) Subchapter A, B, C, D, E, or G, Chapter 4051;

or

(B) an individual authorized to represent an insurance fund or pool created by a municipality, county, or other political subdivision of this state under Chapter 791, Government Code.

(8) "Maintenance" means the maintenance of a fire alarm device or a fire detection device in a condition of repair that provides performance as originally designed or intended.

(9) "Monitoring" means the receipt of fire alarm and supervisory signals or communication of those signals to a fire service communications center in this state or serving property in this state.

(10) "Organization" means a corporation, a government or a governmental subdivision or agency, a business trust, an estate, a trust, a partnership, a firm or association, two or more individuals with a joint or common interest, or any other legal or commercial entity.

(11) "Registered firm" means an individual or organization that holds a registration certificate.

(12) "Residential fire alarm superintendent" means a licensed individual designated by a registered firm to:

(A) plan a residential single-family or two-family fire alarm or detection system that conforms to applicable adopted National Fire Protection Association standards or other adopted standards; and

(B) certify that each fire alarm or detection system as planned meets the standards as provided by law.

(12-a) "Residential fire alarm technician" means a licensed

individual who is designated by a registered firm to install, service, inspect, and certify residential single-family or two-family fire alarm or detection systems.

(13) "Sale" means the sale or offer for sale, lease, or rent of any merchandise, equipment, or service at wholesale or retail, to the public or any individual, for an agreed sum of money or other consideration.

(14) "Service" or "servicing" means inspection, maintenance, repair, or testing of a fire alarm device or a fire detection device.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 87 (S.B. 1969), Sec. 14.018(a), eff. September 1, 2009.

Sec. 6002.003. EFFECT ON LOCAL REGULATION. (a) This chapter and the rules adopted under this chapter have uniform force and effect throughout this state. A municipality or county may not enact an ordinance or rule inconsistent with this chapter or rules adopted under this chapter. An inconsistent ordinance or rule is void and has no effect.

(b) Notwithstanding Subsection (a), a municipality or county may:

(1) mandate that a fire alarm or detection system be installed in certain facilities, if the installation conforms to applicable state law;

(2) require a better type of alarm or detection system or otherwise safer condition than the minimum required by state law; and

(3) require regular inspections by local officials of smoke detectors in dwelling units, as that term is defined by Section 92.251, Property Code, and require the smoke detectors to be operational at the time of inspection.

(c) A municipality, county, or other political subdivision of this state may not require, as a condition of engaging in business or performing any activity authorized under this chapter, that a registered firm, a license holder, or an employee of a license holder:

(1) obtain a registration, franchise, or license from the political subdivision;

(2) pay any fee or franchise tax to the political subdivision; or

(3) post a bond.

(d) Notwithstanding any other provision of this section or Section 6002.155, a municipality or county may require a registered firm to obtain a permit and pay a permit fee for the installation of a fire alarm or fire detection device or system and require that the installation of such a system be in conformance with the building code or other construction requirements of the municipality or county and state law.

(e) Notwithstanding Subsection (d), a municipality or county may not impose qualification or financial responsibility requirements other than proof of a registration certificate.

(f) A political subdivision may not require a registered firm, a license holder, or an employee of a registered firm to maintain a business location or residency within that political subdivision to engage in a business or perform any activity authorized under this chapter.

(g) A municipality or county may by ordinance require a registered firm to make a telephone call to a monitored property before the firm notifies the municipality or county of an alarm signal received by the firm from a fire detection device.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 87 (S.B. 1969), Sec. 14.018(b), eff. September 1, 2009.

Sec. 6002.004. PROVISION OF CERTAIN SERVICES BY POLITICAL SUBDIVISION. (a) In this section, "monitoring" means the receipt of fire alarm or supervisory signals or retransmission or communication of those signals to a fire service communications center that is located in this state or serves property in this state.

(b) Except as provided by Subsection (c), a political subdivision may not offer alarm system sales, service, installation, or monitoring unless the political subdivision has been providing

monitoring services within the boundaries of the political subdivision as of September 1, 1999. Any fee charged by the political subdivision under this subsection may not exceed the cost of the monitoring.

(c) A political subdivision may:

(1) offer service, installation, or monitoring for property owned by the political subdivision or another political subdivision;

(2) allow for the response to an alarm or detection device by:

(A) a law enforcement agency or fire department; or

(B) a law enforcement officer or firefighter acting in an official capacity; or

(3) offer monitoring to a financial institution, as defined by Section 59.301, Finance Code, that requests, in writing, that the political subdivision provide monitoring service to the financial institution.

(d) Subsection (b) does not apply to a political subdivision:

(1) in a county with a population of less than 80,000; or

(2) in which monitoring is not otherwise provided or available.

(e) This section is not intended to require a political subdivision to hold a license under this chapter.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 87 (S.B. 1969), Sec. 14.018(c), eff. September 1, 2009.

**SUBCHAPTER B. POWERS AND DUTIES OF COMMISSIONER, DEPARTMENT,
AND STATE FIRE MARSHAL**

Sec. 6002.051. ADMINISTRATION OF CHAPTER; RULES. (a) The department shall administer this chapter.

(b) The commissioner may adopt rules as necessary to administer this chapter, including rules the commissioner considers necessary to administer this chapter through the state fire marshal.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

Sec. 6002.052. ADOPTION OF RULES; STANDARDS. (a) In adopting necessary rules, the commissioner may use:

(1) recognized standards, such as, but not limited to:

- (A) standards of the National Fire Protection Association;
 - (B) standards recognized by federal law or regulation;
- or
- (C) standards published by a nationally recognized standards-making organization;

(2) the National Electrical Code; or

(3) information provided by individual manufacturers.

(b) Under rules adopted under Section 6002.051, the department may create specialized licenses or registration certificates for an organization or individual engaged in the business of planning, certifying, leasing, selling, servicing, installing, monitoring, or maintaining fire alarm or fire detection devices or systems. The rules must establish appropriate training and qualification standards for each kind of license and certificate.

(c) The commissioner shall also adopt standards applicable to fire alarm devices, equipment, or systems regulated under this chapter. In adopting standards under this subsection, the commissioner may allow the operation of a fire alarm monitoring station that relies on fire alarm devices or equipment approved or listed by a nationally recognized testing laboratory without regard to whether the monitoring station is approved or listed by a nationally recognized testing laboratory if the operator of the station demonstrates that the station operating standards are substantially equivalent to those required to be approved or listed.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

Sec. 6002.053. RULES RESTRICTING ADVERTISING OR COMPETITIVE BIDDING. (a) The commissioner may not adopt rules restricting advertising or competitive bidding by the holder of a license or registration certificate issued under this chapter except to prohibit false, misleading, or deceptive practices.

(b) In the commissioner's rules to prohibit false, misleading, or deceptive practices, the commissioner may not include a rule that:

- (1) restricts the use of any medium for advertising;
- (2) restricts the use of a license or registration certificate holder's personal appearance or voice in an advertisement;
- (3) relates to the size or duration of an advertisement by the license or registration certificate holder; or
- (4) restricts the license or registration certificate holder's advertisement under a trade name.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 1J.001, eff. April 1, 2009.

Sec. 6002.0531. RULES REQUIRING FINANCIAL RESPONSIBILITY. The commissioner may not adopt a rule to administer this chapter that requires a person who holds a license under this chapter to obtain additional certification that imposes a financial responsibility on the license holder.

Added by Acts 2009, 81st Leg., R.S., Ch. 87 (S.B. [1969](#)), Sec. 14.018(i), eff. September 1, 2009.

Sec. 6002.054. FEES. (a) The commissioner shall set the fee for:

- (1) an initial registration certificate in an amount not to exceed \$500;
- (2) the renewal of a registration certificate for each year in an amount not to exceed \$500;
- (3) the renewal of a registration certificate for an individual or organization engaged in the business of planning, certifying, leasing, selling, servicing, installing, monitoring, or maintaining exclusively single station devices in an amount not to exceed \$250 annually;
- (4) an initial branch office registration certificate in an amount not to exceed \$150;
- (5) the renewal of a branch office registration certificate for each year in an amount not to exceed \$150;
- (6) an initial or renewal training school approval in an amount not to exceed \$500 annually;
- (7) an initial or renewal of a training school instructor

approval in an amount not to exceed \$50 annually;

(8) an initial license in an amount not to exceed \$120, except as provided by Subdivision (10);

(9) the renewal of a license for each year in an amount not to exceed \$100, except as provided by Subdivision (10); and

(10) an initial license fee, in an amount not to exceed \$50, and an annual renewal fee, in an amount not to exceed \$50, for a residential fire alarm technician license.

(b) Unless the examination or reexamination for a license is administered by a testing service, the commissioner shall set a nonrefundable fee for:

(1) the initial examination in an amount not to exceed \$30; and

(2) each reexamination in an amount not to exceed \$20.

(c) The commissioner shall set a fee in an amount not to exceed \$20 for:

(1) a duplicate registration certificate or license issued under this chapter; and

(2) any request requiring changes to a registration certificate or license.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 87 (S.B. 1969), Sec. 14.018(d), eff. September 1, 2009.

Sec. 6002.055. DEPOSIT IN OPERATING ACCOUNT. The fees collected under this chapter shall be deposited in the state treasury to the credit of the Texas Department of Insurance operating account.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

Sec. 6002.056. DEPARTMENT RECORDS. Records maintained by the department under this chapter on the home address, home telephone number, driver's license number, or social security number of an applicant or a license or registration holder are confidential and

are not subject to mandatory disclosure under Chapter 552, Government Code.

Added by Acts 2009, 81st Leg., R.S., Ch. 87 (S.B. 1969), Sec. 14.018(j), eff. September 1, 2009.

SUBCHAPTER D. REGISTRATION, LICENSE, AND APPROVAL REQUIREMENTS

Sec. 6002.151. FIRM REGISTRATION CERTIFICATE REQUIRED; LIMITED CERTIFICATE. (a) An individual or organization may not engage in the business of planning, certifying, leasing, selling, installing, servicing, monitoring, or maintaining fire alarm or fire detection devices or systems unless the individual or organization holds a registration certificate issued by the department.

(b) The department may issue a limited registration certificate to an individual or organization whose business is restricted to monitoring.

(c) Applications for registration certificates and qualifications for those certificates are subject to rules adopted by the commissioner.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

Sec. 6002.152. BRANCH OFFICE REGISTRATION CERTIFICATE REQUIRED.

(a) Except as provided by Subsection (c), each separate office location of a registered firm, other than the location identified on the firm's registration certificate, must have a branch office registration certificate issued by the department.

(b) Before issuing a branch office registration certificate, the department must determine that the branch office location is part of a registered firm.

(c) A registered firm that is engaged in the business of planning, certifying, leasing, selling, servicing, installing, monitoring, or maintaining exclusively single station devices is not required to apply for or obtain a branch office registration certificate for a separate office or location of the firm.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

Sec. 6002.153. REQUIRED INSURANCE COVERAGE FOR REGISTRATION CERTIFICATE. (a) The department may not issue a registration certificate under this chapter unless the applicant files with the department evidence of a general liability insurance policy that includes products and completed operations coverage. The policy must be conditioned to pay on behalf of the insured those amounts that the insured becomes legally obligated to pay as damages because of bodily injury and property damage caused by an occurrence involving the insured or the insured's officer, agent, or employee in the conduct of any business that requires a registration certificate or license under this chapter.

(b) Unless the commissioner increases or decreases the limits under rules adopted under Section 6002.051(b), the limits of insurance coverage required by Subsection (a) must be at least:

(1) \$100,000 combined single limits for bodily injury and property damage for each occurrence; and

(2) \$300,000 aggregate for all occurrences for each policy year.

(c) The evidence of insurance required by this section must be in the form of a certificate of insurance executed by an insurer authorized to engage in the business of insurance in this state and countersigned by an insurance agent licensed in this state. A certificate of insurance for surplus lines coverage procured in compliance with Chapter 981 through a surplus lines agent that is licensed under Subchapter E, Chapter 981, and resident in this state may be filed with the department as evidence of the coverage required by this section.

(d) An insurance certificate executed and filed with the department under this section remains in force until the insurer has terminated future liability by the notice required by the department.

(e) Failure to maintain the liability insurance required by this section constitutes grounds for the denial, suspension, or revocation, after notice and opportunity for hearing, of a registration certificate issued under this chapter.

(f) For an individual or organization licensed to install or service burglar alarms under Chapter 1702, Occupations Code, compliance with the insurance requirements of that chapter constitutes compliance with the insurance requirements of this

section if the insurance held by the individual or organization complies with the requirements of this section in amounts and types of coverage.

(g) This section does not affect the rights of the insured to negotiate or contract for limitations of liability with a third party, including a customer of the insured.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

Sec. 6002.154. FIRE ALARM TECHNICIAN, RESIDENTIAL FIRE ALARM SUPERINTENDENT, AND FIRE ALARM PLANNING SUPERINTENDENT. (a) Each registered firm, including a firm engaged in the business of planning, certifying, leasing, selling, servicing, installing, monitoring, or maintaining exclusively single station devices, must employ at least one employee who is a fire alarm technician, residential fire alarm superintendent, or fire alarm planning superintendent.

(b) A fire alarm technician, residential fire alarm technician, residential fire alarm superintendent, or fire alarm planning superintendent must hold a license issued by the department, conditioned on the successful completion of a written license examination.

(c) To engage in the activity for which the license is granted, an individual licensed under this chapter must be an employee or agent of an individual or entity that holds a registration certificate.

(d) A fire alarm technician may perform or supervise monitoring. A fire alarm planning superintendent may act as a fire alarm technician or a residential fire alarm superintendent. A residential fire alarm superintendent may act as a fire alarm technician.

(d-1) A residential fire alarm technician may only provide direct on-site supervision to an employee of a registered firm for work performed under this chapter in a single-family or two-family dwelling.

(d-2) An applicant for a residential fire alarm technician license must provide with the required license application evidence of the applicant's successful completion of the required instruction

from a training school approved by the state fire marshal in accordance with Section 6002.158.

(e) Applications for licenses and qualifications for those licenses are subject to rules adopted by the commissioner.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 87 (S.B. 1969), Sec. 14.018(e), eff. September 1, 2009.

Acts 2009, 81st Leg., R.S., Ch. 87 (S.B. 1969), Sec. 14.018(g), eff. September 1, 2009.

Sec. 6002.155. ACTIVITIES NOT REGULATED BY CHAPTER. The licensing provisions of this chapter do not apply to:

(1) an individual or organization in the business of building construction that installs electrical wiring and devices that may include, in part, the installation of a fire alarm or detection system if:

(A) the individual or organization is a party to a contract that provides that:

(i) the installation will be performed under the direct supervision of and certified by a licensed employee or agent of a firm registered to install and certify such an alarm or detection device; and

(ii) the registered firm assumes full responsibility for the installation of the alarm or detection device; and

(B) the individual or organization does not plan, certify, lease, sell, service, or maintain fire alarms or detection devices or systems;

(2) an individual or organization that:

(A) owns and installs a fire detection or fire alarm device on the individual's or organization's own property; or

(B) if the individual or organization does not charge for the device or its installation, installs the device for the protection of the individual's or organization's personal property located on another's property and does not install the device as a normal business practice on the property of another;

(3) an individual who holds a license or other authority issued by a municipality to practice as an electrician and who installs fire or smoke detection and alarm devices only in a single family or multifamily residence if:

(A) the devices installed are:

(i) single station detectors; or

(ii) multiple station detectors capable of being connected in a manner that actuation of one detector causes all integral or separate alarms to operate if the detectors are not connected to a control panel or to an outside alarm, do not transmit a signal off the premises, and do not use more than 120 volts; and

(B) all installations comply with the adopted edition of National Fire Protection Association Standard No. 72;

(4) an individual or organization that:

(A) sells fire detection or fire alarm devices exclusively over-the-counter or by mail order; and

(B) does not plan, certify, install, service, or maintain the devices;

(5) a law enforcement agency or fire department or a law enforcement officer or firefighter acting in an official capacity that responds to a fire alarm or detection device;

(6) an engineer licensed under Chapter 1001, Occupations Code, acting solely in the engineer's professional capacity;

(7) an individual or organization that provides and installs at no charge to the property owners or residents a battery-powered smoke detector in a single-family or two-family residence if:

(A) the smoke detector bears a label of listing or approval by a testing laboratory approved by the department;

(B) the installation complies with the adopted edition of National Fire Protection Association Standard No. 72;

(C) the installers are knowledgeable in fire protection and the proper use of smoke detectors; and

(D) the detector is a single station installation and not a part of or connected to any other detection device or system;

(8) an employee of a registered firm who is under the direct on-site supervision of a license holder;

(9) a building owner, the owner's managing agent, or an employee of the owner or agent who installs battery-operated single station smoke detectors or monitor fire alarm or fire detection devices or systems in the owner's building, and in which the

monitoring:

(A) is performed at the owner's property at no charge to the occupants of the building;

(B) complies with applicable standards of the National Fire Protection Association as may be adopted by rule under this chapter; and

(C) uses equipment approved by a testing laboratory approved by the department for fire alarm monitoring;

(10) an individual employed by a registered firm that sells and installs a smoke or heat detector in a single-family or two-family residence if:

(A) the detector bears a label of listing or approval by a testing laboratory approved by the department;

(B) the installation complies with the adopted edition of National Fire Protection Association Standard No. 72;

(C) the installers are knowledgeable in fire protection and the proper use and placement of detectors; and

(D) the detector is a single station installation and not a part of or connected to any other detection device or system; or

(11) an individual or organization licensed to install or service burglar alarms under Chapter 1702, Occupations Code, that provides and installs in a single-family or two-family residence a combination keypad that includes a panic button to initiate a fire alarm signal if the fire alarm signal:

(A) is monitored by a fire alarm firm registered under this chapter; and

(B) is not initiated by a fire or smoke detection device.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 87 (S.B. 1969), Sec. 14.018(f), eff. September 1, 2009.

Sec. 6002.156. LICENSE EXAMINATION. (a) The state fire marshal shall establish the scope and type of an examination required by this chapter. The examination must cover this chapter and

commissioner rules and include specific testing of all license categories.

(b) The state fire marshal may administer the examination or may enter into an agreement with a testing service.

(c) If a testing service is used, the state fire marshal may contract with the testing service regarding requirements for the examination, including:

- (1) examination development;
- (2) scheduling;
- (3) site arrangements;
- (4) grading;
- (5) reporting;
- (6) analysis; or
- (7) other administrative duties.

(d) The state fire marshal may require the testing service to:

- (1) correspond directly with an applicant regarding the administration of the examination;
- (2) collect a reasonable fee from an applicant for administering the examination; or
- (3) administer the examination at a specific location or time.

(e) Approval for a testing service is valid for one year.

(f) The state fire marshal shall adopt rules as necessary to implement examination requirements under this chapter.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 1J.001, eff. April 1, 2009.

Sec. 6002.157. EXAMINATION RESULTS. (a) Not later than the 30th day after the date on which an examination is administered under this chapter, the state fire marshal shall send notice to each examinee of the results of the examination.

(b) If an examination is conducted, graded, or reviewed by a testing service, the state fire marshal shall send notice to each examinee of the results of the examination within two weeks after the date on which the state fire marshal receives the results from the testing service.

(c) If the notice of the examination results will be delayed for more than 90 days after the examination date, the state fire

marshal shall send notice to the examinee of the reason for the delay before the 90th day.

(d) The state fire marshal may require a testing service to notify an examinee of the results of the examinee's examination under this section.

(e) If requested in writing by an individual who fails the examination administered under this chapter, the state fire marshal shall send to the individual an analysis of the individual's performance on the examination.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

Sec. 6002.158. TRAINING SCHOOLS AND INSTRUCTORS; APPROVAL. (a) An applicant for approval as a training school must submit an application to the state fire marshal, accompanied by the applicant's complete course or testing curriculum. A registered firm, or an affiliate of a registered firm, is not eligible for approval as a training school.

(b) The state fire marshal shall review the materials submitted for course approval and shall approve or deny approval in a letter provided not later than the 60th day after the date of receipt of the application. A denial of approval must disclose specific reasons for the denial. An applicant whose approval is denied may reapply at any time.

(c) Training school instructors must be approved by the state fire marshal. To be eligible for approval, an instructor must:

(1) hold a fire alarm planning superintendent license, a residential fire alarm superintendent license, or a fire alarm technician license; and

(2) have at least three years of experience in fire alarm installation, service, or monitoring.

(d) Approval for a training school or instructor is valid for one year.

(e) The curriculum for a residential fire alarm technician course must consist of at least seven hours of instruction on installing, servicing, and maintaining single-family and two-family residential fire alarm systems as defined by National Fire Protection Standard No. 72 and an examination on National Fire Protection

Standard No. 72 for which at least one hour is allocated for completion. The examination must consist of at least 25 questions, and an applicant must accurately answer at least 80 percent of the questions to pass the examination.

(f) After approval, each training school must annually conduct, within 125 miles of each county with a population greater than 500,000, at least two classes that are open to the public.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 87 (S.B. 1969), Sec. 14.018(h), eff. September 1, 2009.

Acts 2011, 82nd Leg., R.S., Ch. 1147 (H.B. 1951), Sec. 15.001, eff. September 1, 2011.

Acts 2013, 83rd Leg., R.S., Ch. 172 (H.B. 458), Sec. 1, eff. September 1, 2013.

Sec. 6002.159. CONTINUING EDUCATION PROGRAMS. (a) The commissioner may adopt procedures for certifying and may certify continuing education programs.

(b) Participation in the continuing education programs is voluntary.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

Sec. 6002.160. RECIPROCAL LICENSE. The department may waive any license requirement for an applicant who holds a license issued by another state that has license requirements substantially equivalent to the license requirements of this state.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

Sec. 6002.161. NOT TRANSFERABLE. A registration certificate or license issued under this chapter is not transferable.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

SUBCHAPTER E. RENEWAL OF REGISTRATION CERTIFICATE OR LICENSE

Sec. 6002.201. RENEWAL REQUIRED; FEE. (a) A renewal of a registration certificate or license issued under this chapter is valid for a period of two years. The license or registration renewal fee for each year of the two-year period is payable on renewal.

(b) The commissioner by rule may adopt a system under which registration certificates and licenses expire on various dates during the year. For the year in which an expiration date of a registration certificate or license is less than one year from its issuance or anniversary date, the fee shall be prorated on a monthly basis so that each holder of a registration certificate or license pays only that portion of the renewal fee that is allocable to the number of months during which the registration certificate or license is valid. The total renewal fee is payable on renewal on the new expiration date.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

Sec. 6002.202. NOTICE OF EXPIRATION. At least 30 days before the expiration date of a registration certificate or license, the state fire marshal shall send written notice of the impending expiration to the holder of the registration certificate or license at the holder's last known address.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

Sec. 6002.203. RENEWAL PROCEDURES. (a) The holder of an unexpired registration certificate or license may renew the certificate or license by paying the required renewal fee to the department before the expiration date of the certificate or license.

(b) An individual or organization whose registration certificate or license has been expired for 90 days or less may renew the certificate or license by paying to the department:

(1) the required renewal fee; and

(2) a fee that does not exceed one-fourth of the initial fee for the certificate or license.

(c) An individual or organization whose registration certificate or license has been expired for more than 90 days but less than two years may renew the certificate or license by paying to the department:

(1) all unpaid renewal fees; and

(2) a fee that does not exceed the initial fee for the certificate or license.

(d) An individual or organization whose registration certificate or license has been expired for two years or longer may not renew the certificate or license. The individual or organization may obtain a new registration certificate or license by complying with the requirements and procedures for obtaining an initial registration certificate or license.

(e) This section may not be construed to prevent the department from denying or refusing to renew a license under applicable law or commissioner rules.

(f) A license or registration certificate issued under this chapter expires at midnight on the date printed on the license or certificate. A renewal application and fee for the license or registration certificate must be postmarked on or before the expiration date to be accepted as timely.

(g) If a renewal application is not complete but there has been no lapse in the required insurance, the applicant is entitled to 30 days from the date that the applicant is notified by the department of the deficiencies in the renewal application to comply with any additional requirement. If an applicant fails to respond and correct all deficiencies in the renewal application within the 30-day period, the department may charge a late fee.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 1J.001, eff. April 1, 2009.

Sec. 6002.204. RENEWAL OF CERTAIN LICENSES. A license holder with an unexpired license who is not employed by a registered firm at the time of the license renewal may renew that license, but the license holder may not engage in any activity for which the license

was granted until the license holder is employed by a registered firm.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

**SUBCHAPTER F. SELLING OR LEASING OF FIRE ALARM
OR FIRE DETECTION DEVICES**

Sec. 6002.251. REQUIRED LABEL; EXCEPTIONS. (a) Except as provided by Subsections (b) and (c), a detection or alarm device, alarm system, or item of monitoring equipment, a purpose of which is to detect or give alarm of fire, may not be sold, offered for sale, leased, installed, or used to monitor property in this state unless the device, system, or item of equipment carries a label of approval or listing of a testing laboratory approved by the department.

(b) Except as provided by Subsection (c), a detection or alarm device, alarm system, or item of monitoring equipment in a one-family or two-family residence, a purpose of which is to detect or give alarm of fire, may not be sold, offered for sale, leased, installed, or used to monitor property in this state after April 14, 1989, unless the device, system, or equipment carries a label of approval or listing of a testing laboratory approved by the department.

(c) Subsections (a) and (b) do not prohibit the continued use or monitoring of equipment in place if the equipment:

- (1) complied with the law applicable on the date of the equipment's original placement; and
- (2) has not been extended, modified, or altered.

(d) Fire alarm devices that are not required by this chapter or rules adopted under this chapter and that do not impair the operation of fire alarm or fire detection devices required by this chapter or the rules adopted under this chapter are exempt from the label and listing requirements described by Subsections (a) and (b) if the devices are approved by the local authority with jurisdiction.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

Sec. 6002.252. REQUIRED PURCHASE AND INSTALLATION INFORMATION. A fire detection or fire alarm device may not be sold or installed in

this state unless the device is accompanied by printed information that:

- (1) is supplied to the owner by the supplier or installing contractor; and
- (2) concerns:
 - (A) instructions describing the installation, operation, testing, and proper maintenance of the device;
 - (B) information to aid in establishing an emergency evacuation plan for the protected premises;
 - (C) the telephone number and location, including notification procedures, of the nearest fire department; and
 - (D) information that will aid in reducing the number of false alarms.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 87 (S.B. 1969), Sec. 14.018(k), eff. September 1, 2009.

Sec. 6002.253. TRAINING AND SUPERVISION OF CERTAIN EXEMPT EMPLOYEES. Each registered firm that employs an individual who is exempt from the licensing requirements of this chapter under Section 6002.155(10) shall appropriately train and supervise the individual to ensure that:

- (1) each installation complies with the adopted provisions of National Fire Protection Association Standard No. 72 or other adopted standards;
- (2) each smoke or heat detector installed or sold carries a label or listing of approval by a testing laboratory approved by the department; and
- (3) the individual is knowledgeable in fire protection and the proper use and placement of detectors.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 87 (S.B. 1969), Sec. 14.018(l), eff. September 1, 2009.

SUBCHAPTER G. PROHIBITED PRACTICES AND DISCIPLINARY PROCEDURES

Sec. 6002.301. PROHIBITED PRACTICES. An individual or organization may not:

(1) plan, certify, lease, sell, service, install, monitor, or maintain a fire alarm or fire detection device or system without a license or registration certificate;

(2) obtain or attempt to obtain a registration certificate or license by fraudulent representation; or

(3) plan, certify, lease, sell, service, install, monitor, or maintain a fire alarm or fire detection device or system in violation of this chapter or the rules adopted under this chapter.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

Sec. 6002.302. DISCIPLINARY ACTIONS. (a) The state fire marshal may suspend, revoke, or refuse to issue or renew a registration certificate or license if, after notice and hearing, the state fire marshal finds that the applicant, registrant, or license holder has engaged in acts that:

(1) violate this chapter;

(2) violate rules or standards adopted under this chapter;

or

(3) constitute misrepresentation made in connection with the sale of products or services rendered.

(b) An original or renewal registration certificate, license, or testing laboratory approval may be denied, suspended, or revoked, if after notice and public hearing the commissioner, through the state fire marshal, determines from the evidence presented at the hearing that this chapter or a rule adopted under this chapter has been violated.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

Sec. 6002.303. DISCIPLINARY HEARING. (a) If the state fire marshal proposes to suspend, revoke, or refuse to renew a license or registration certificate issued under this chapter, the holder of the license or certificate is entitled to a hearing conducted by the

State Office of Administrative Hearings.

(b) Proceedings for a disciplinary action are governed by Chapter 2001, Government Code.

(c) Rules of practice adopted by the commissioner applicable to the proceedings for a disciplinary action may not conflict with rules adopted by the State Office of Administrative Hearings.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

Sec. 6002.304. REAPPLICATION REQUIREMENTS. (a) A holder of a registration certificate, license, or testing laboratory approval that has been revoked under this chapter may not file another application for a registration certificate, license, or approval before the first anniversary of the effective date of the revocation.

(b) An individual or organization reapplying under this section must request a public hearing to show cause why the issuance of a new registration certificate, license, or approval should not be denied.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

SUBCHAPTER H. CRIMINAL PENALTY

Sec. 6002.351. CRIMINAL PENALTY. (a) An individual or organization commits an offense if the individual or organization violates Section 6002.151, 6002.152, or 6002.154.

(b) An offense under this section is a Class B misdemeanor.

(c) Venue for an offense under this section is in Travis County or the county in which the offense is committed.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

CHAPTER 6003. FIRE PROTECTION SPRINKLER SYSTEM SERVICE AND INSTALLATION

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 6003.001. DEFINITIONS. In this chapter:

(1) "Fire protection sprinkler system" means an assembly of

underground or overhead piping or conduits that conveys water with or without other agents to dispersal openings or devices to:

(A) extinguish, control, or contain fire; and

(B) provide protection from exposure to fire or the products of combustion.

(2) "Fire protection sprinkler system contractor" means an individual or organization that offers to undertake, represents itself as being able to undertake, or undertakes the plan, sale, installation, maintenance, or servicing of:

(A) a fire protection sprinkler system; or

(B) any part of a fire protection sprinkler system.

(3) "Individual" means a natural person, including an owner, manager, officer, employee, or occupant.

(4) "Installation" means:

(A) the initial placement of equipment; or

(B) the extension, modification, or alteration of equipment after initial placement.

(5) "Insurance agent" means:

(A) an individual, firm, or corporation licensed under:

(i) Subchapter E, Chapter 981; or

(ii) Subchapter A, B, C, D, E, or G, Chapter 4051;

or

(B) an individual authorized to represent an insurance fund or pool created by a municipality, county, or other political subdivision of this state under Chapter 791, Government Code.

(6) "License" means the document issued to a responsible managing employee authorizing the employee to engage in the fire protection sprinkler system business in this state.

(7) "Maintenance" means the maintenance of a fire protection sprinkler system or any part of a fire protection sprinkler system in the condition of repair that provides performance as originally planned.

(8) "Organization" means a corporation, a partnership or other business association, a governmental entity, or any other legal or commercial entity.

(9) "Registration certificate" means the document issued to a fire protection sprinkler system contractor authorizing the contractor to engage in business in this state.

(10) "Responsible managing employee" means an individual designated by a company that plans, sells, installs, maintains, or

services fire protection sprinkler systems to ensure that each fire protection sprinkler system, as installed, maintained, or serviced, meets the standards for the system as provided by law.

(11) "Service" means maintenance, repair, or testing.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

Sec. 6003.002. APPLICABILITY OF CHAPTER. (a) This chapter does not apply to:

(1) an employee of the United States, this state, or any political subdivision of this state who acts as a fire protection sprinkler system contractor for the employing governmental entity;

(2) the plan, sale, installation, maintenance, or servicing of a fire protection sprinkler system in any property owned by the United States or this state;

(3) an individual or organization acting under court order as authorization;

(4) an individual or organization that sells or supplies products or materials to a registered fire protection sprinkler system contractor;

(5) an installation, maintenance, or service project for which the total contract price for labor, materials, and all other services is less than \$100, if:

(A) the project is not a part of a complete or more costly project, whether the complete project is to be undertaken by one or more fire protection sprinkler system contractors; or

(B) the project is not divided into contracts of less than \$100 for the purpose of evading this chapter;

(6) an engineer licensed under Chapter 1001, Occupations Code, acting solely in the engineer's professional capacity;

(7) a regular employee of a registered fire protection sprinkler system contractor; or

(8) an owner or lessee of property that:

(A) installs a fire protection sprinkler system on the owned or leased property for the owner's or lessee's own use or for family members' use; and

(B) does not offer the property for sale or lease before the first anniversary of the date of installation of the fire

protection sprinkler system.

(b) This chapter does not authorize an individual or organization to practice professional engineering other than in compliance with Chapter 1001, Occupations Code.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

Sec. 6003.003. EFFECT ON LOCAL REGULATION. (a) This chapter and the rules adopted under this chapter have uniform force and effect throughout this state. A municipality or county may not enact an order, ordinance, or rule requiring a fire protection sprinkler system contractor to obtain a registration certificate from the municipality or county. A municipality or county may not impose on a fire protection sprinkler system contractor qualification or financial responsibility requirements other than proof of a registration certificate.

(b) Notwithstanding any other provision of this chapter, a municipality or county may require a fire protection sprinkler system contractor to obtain a permit and pay a permit fee for the installation of a fire protection sprinkler system and require the installation of a fire protection sprinkler system to conform to the building code or other construction requirements of the municipality or county.

(c) A municipal or county order, ordinance, or rule in effect on September 1, 1983, is not invalidated because of any provision of this chapter.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

**SUBCHAPTER B. POWERS AND DUTIES OF COMMISSIONER,
DEPARTMENT, AND STATE FIRE MARSHAL**

Sec. 6003.051. ADMINISTRATION OF CHAPTER. (a) The department shall administer this chapter.

(b) The commissioner may issue rules necessary to administer this chapter through the state fire marshal.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001,

eff. April 1, 2009.

Sec. 6003.052. ADOPTION OF RULES. (a) In adopting necessary rules, the commissioner may use recognized standards, including standards:

- (1) adopted by federal law or regulation;
- (2) published by a nationally recognized standards-making organization; or
- (3) developed by individual manufacturers.

(b) Under rules adopted under Section 6003.051(b), the department may create a specialized licensing or registration program for fire protection sprinkler system contractors.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

Sec. 6003.053. RULES RESTRICTING ADVERTISING OR COMPETITIVE BIDDING. (a) The commissioner may not adopt rules restricting advertising or competitive bidding by the holder of a license or registration certificate issued under this chapter except to prohibit false, misleading, or deceptive practices.

(b) In the commissioner's rules to prohibit false, misleading, or deceptive practices, the commissioner may not include a rule that:

- (1) restricts the use of any medium for advertising;
- (2) restricts the use of a license or registration certificate holder's personal appearance or voice in an advertisement;
- (3) relates to the size or duration of an advertisement by the license or registration certificate holder; or
- (4) restricts the license or registration certificate holder's advertisement under a trade name.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

Sec. 6003.054. GENERAL POWERS AND DUTIES OF COMMISSIONER, STATE FIRE MARSHAL, AND DEPARTMENT. (a) The commissioner may delegate authority to exercise all or part of the commissioner's functions,

powers, and duties under this chapter, including the issuance of licenses and registration certificates, to the state fire marshal. The state fire marshal shall implement the rules adopted by the commissioner for the protection and preservation of life and property in controlling:

(1) the registration of an individual or an organization engaged in the business of planning, selling, installing, maintaining, or servicing fire protection sprinkler systems; and

(2) the requirements for the plan, sale, installation, maintenance, or servicing of fire protection sprinkler systems by:

(A) determining the criteria and qualifications for registration certificate and license holders;

(B) evaluating the qualifications of an applicant for a registration certificate to engage in the business of planning, selling, installing, maintaining, or servicing fire protection sprinkler systems;

(C) conducting examinations and evaluating the qualifications of a license applicant; and

(D) issuing registration certificates and licenses to qualified applicants.

(b) The commissioner shall establish a procedure for reporting and processing complaints relating to the business of planning, selling, installing, maintaining, or servicing fire protection sprinkler systems in this state.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

Sec. 6003.055. FEES. (a) The commissioner shall set the fee for:

(1) a registration certificate application in an amount not to exceed \$100;

(2) an initial or renewal registration certificate in an amount not to exceed \$1,200 annually; and

(3) an initial or renewal responsible managing employee license fee in an amount not to exceed \$200 annually.

(b) Unless the examination for a responsible managing employee license is administered by a testing service, the commissioner shall set a nonrefundable fee for each examination in an amount not to

exceed \$100.

(c) The commissioner shall set a fee in an amount not to exceed \$70 for:

(1) a duplicate registration certificate or license issued under this chapter; or

(2) any request requiring changes to a registration certificate or license.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

Sec. 6003.056. DEPOSIT IN OPERATING ACCOUNT. All fees collected under this chapter shall be deposited in the state treasury to the credit of the Texas Department of Insurance operating account for use in administering this chapter.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

SUBCHAPTER D. REGISTRATION AND LICENSE REQUIREMENTS

Sec. 6003.151. FIRE PROTECTION SPRINKLER SYSTEM CONTRACTOR; REGISTRATION CERTIFICATE REQUIRED. (a) Unless the individual or organization holds a registration certificate issued by the department, an individual or organization may not plan, sell, install, maintain, or service a fire protection sprinkler system.

(b) An applicant for a registration certificate must apply to the department on a form prescribed by the commissioner.

(c) An organization that is a partnership or joint venture is not required to register under the name of the organization if each partner or joint venturer holds a registration certificate.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

Sec. 6003.152. REQUIRED INSURANCE COVERAGE FOR REGISTRATION CERTIFICATE. (a) The department may not issue a registration certificate under this chapter unless the applicant files with the department evidence of a general liability insurance policy that

includes products and completed operations coverage. The policy must be conditioned to pay on behalf of the insured those amounts that the insured becomes legally obligated to pay as damages because of bodily injury and property damage caused by an occurrence involving the insured or the insured's officer, agent, or employee in the conduct of any activity that requires a registration certificate or license under this chapter.

(b) Unless the commissioner, after notice and an opportunity for a hearing, increases or decreases the limits, the limits of insurance coverage required by Subsection (a) must be at least:

(1) \$100,000 combined single limits for bodily injury and property damage for each occurrence; and

(2) \$300,000 aggregate for all occurrences for each policy year.

(c) The evidence of insurance required by this section must be in the form of a certificate of insurance executed by an insurer authorized to engage in the business of insurance in this state and countersigned by an insurance agent licensed in this state. A certificate of insurance for surplus lines coverage procured in compliance with Chapter 981 through a surplus lines agent that is licensed under Subchapter E, Chapter 981, and resident in this state may be filed with the department as evidence of the coverage required by this section.

(d) An insurance certificate executed and filed with the department under this section remains in force until the insurer has terminated future liability by the notice required by the department.

(e) Failure to maintain the liability insurance required by this section constitutes grounds for the denial, suspension, or revocation, after notice and opportunity for hearing, of a registration certificate issued under this chapter.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 1J.001, eff. April 1, 2009.

Sec. 6003.153. RESPONSIBLE MANAGING EMPLOYEE: LICENSE REQUIRED.

(a) Each fire protection sprinkler system contractor must employ at least one licensed responsible managing employee on a full-time basis.

(b) A person may not act as a responsible managing employee

unless the person holds a license issued by the department, conditioned on the successful completion of the license examination and compliance with the requirements of the rules adopted under this chapter.

(c) Notwithstanding Subsection (a), an individual or organization with a current registration certificate may act as a fire protection sprinkler system contractor for 30 days after the death or dissociation of its licensed responsible managing employee or for a longer period approved by the commissioner under the rules adopted under this chapter.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

Sec. 6003.154. POSTING OF LICENSE OR CERTIFICATE REQUIRED. Each registration certificate and license issued under this chapter must be posted in a conspicuous place in the fire protection sprinkler system contractor's place of business.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

Sec. 6003.155. DISPLAY OF REGISTRATION CERTIFICATE NUMBER ON CERTAIN DOCUMENTS REQUIRED. Each bid, proposal, offer, and installation drawing for a fire protection sprinkler system must prominently display the registration certificate number of the fire protection sprinkler system contractor.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

Sec. 6003.156. LICENSE EXAMINATION. (a) The state fire marshal shall establish the scope and type of an examination required by this chapter.

(b) The state fire marshal may administer the examination or may enter into an agreement with a testing service.

(c) If a testing service is used, the state fire marshal may contract with the testing service regarding requirements for the

examination, including:

- (1) examination development;
- (2) scheduling;
- (3) site arrangements;
- (4) grading;
- (5) reporting;
- (6) analysis; or
- (7) other administrative duties.

(d) The state fire marshal may require the testing service to:

- (1) correspond directly with an applicant regarding the administration of the examination;
- (2) collect a reasonable fee from an applicant for administering the examination; or
- (3) administer the examination at a specific location or time.

(e) The state fire marshal shall adopt rules as necessary to implement examination requirements under this chapter.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 1J.001, eff. April 1, 2009.

Sec. 6003.157. EXAMINATION RESULTS. (a) Not later than the 30th day after the date on which an examination is administered under this chapter, the state fire marshal shall send notice to each examinee of the results of the examination.

(b) If an examination is graded or reviewed by a testing service, the state fire marshal shall send notice to each examinee of the results of the examination not later than the 14th day after the date on which the state fire marshal receives the results from the testing service.

(c) If the notice of the examination results will be delayed for more than 90 days after the examination date, the state fire marshal, before the 90th day, shall send notice to the examinee of the reason for the delay.

(d) The state fire marshal may require a testing service to notify an examinee of the results of the examinee's examination.

(e) If requested in writing by an individual who fails the examination administered under this chapter, the state fire marshal shall send to the individual an analysis of the individual's

performance on the examination.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

Sec. 6003.158. CONTINUING EDUCATION REQUIREMENTS. (a) The commissioner may adopt procedures for certifying and may certify continuing education programs.

(b) Participation in the continuing education programs is voluntary.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

Sec. 6003.159. RECIPROCAL LICENSE. The department may waive any license requirement for an applicant who holds a license issued by another state that has license requirements substantially equivalent to the license requirements of this state.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

Sec. 6003.160. NOT TRANSFERABLE. A registration certificate or license issued under this chapter is not transferable.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

SUBCHAPTER E. RENEWAL OF REGISTRATION CERTIFICATE OR LICENSE

Sec. 6003.201. RENEWAL REQUIRED; FEE. (a) Except as otherwise provided by this subsection, an initial registration certificate or license is valid for a period of one year from the date of issue and is renewable on payment of the renewal fee. An initial registration certificate or license issued on or after September 1, 1983, may be issued for a period of less than one year and the renewal fee shall be prorated proportionally.

(b) A renewal of a registration certificate or license issued

under this chapter is valid for a period of two years. The license or registration fee for each year of the two-year period is payable on renewal.

(c) The commissioner by rule may adopt a system under which registration certificates and licenses expire on various dates during the year. For the year in which an expiration date of a registration certificate or license is less than one year from its issuance or anniversary date, the fee shall be prorated on a monthly basis so that each holder of a registration certificate or license pays only that portion of the renewal fee that is allocable to the number of months during which the registration certificate or license is valid. On renewal on the new expiration date, the total renewal fee is payable.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

Sec. 6003.202. NOTICE OF EXPIRATION. At least 30 days before the expiration date of a registration certificate or license, the department shall send written notice of the impending expiration to the holder of the registration certificate or license at the holder's last known address.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

Sec. 6003.203. RENEWAL PROCEDURES. (a) The holder of an unexpired registration certificate or license may renew the certificate or license by paying the required renewal fee to the department before the expiration date of the certificate or license.

(b) An individual or organization whose registration certificate or license has been expired for 90 days or less may renew the certificate or license by paying to the department:

(1) the required renewal fee; and
(2) a fee equal to one-half of the initial fee for the certificate or license.

(c) An individual or organization whose registration certificate or license has been expired for more than 90 days but less than two years may renew the certificate or license by paying to

the department:

- (1) all unpaid renewal fees; and
- (2) a fee that is equal to the initial fee for the certificate or license.

(d) An individual or organization whose registration certificate or license has been expired for two years or longer may not renew the certificate or license. The individual or organization may obtain a new registration certificate or license by complying with the requirements and procedures for obtaining an initial registration certificate or license.

(e) This section may not be construed to prevent the department from denying or refusing to renew a license under applicable law or commissioner rules.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

**SUBCHAPTER F. PROHIBITED PRACTICES
AND DISCIPLINARY PROCEDURES**

Sec. 6003.251. PROHIBITED PRACTICES. An individual or organization may not:

- (1) obtain or attempt to obtain a registration certificate or license by fraudulent representation; or
- (2) plan, sell, install, maintain, or service a fire protection sprinkler system in violation of this chapter or the rules adopted under this chapter.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

Sec. 6003.252. DISCIPLINARY ACTIONS. The state fire marshal may suspend, revoke, or refuse to issue or renew a registration certificate or license if, after notice and hearing, the state fire marshal finds that the applicant, registrant, or license holder has engaged in acts that:

- (1) violate this chapter;
 - (2) violate rules or standards adopted under this chapter;
- or
- (3) constitute misrepresentation made in connection with:

- (A) the sale of products; or
- (B) services rendered.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

Sec. 6003.253. DISCIPLINARY HEARING. (a) If the state fire marshal proposes to suspend, revoke, or refuse to renew a license or registration certificate issued under this chapter, the holder of the license or certificate is entitled to a hearing conducted by the State Office of Administrative Hearings.

(b) Rules of practice adopted by the commissioner applicable to the proceedings for a disciplinary action may not conflict with rules adopted by the State Office of Administrative Hearings.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

Sec. 6003.254. APPLICABILITY OF ADMINISTRATIVE PROCEDURE ACT. Proceedings for the denial, suspension, or revocation of a registration certificate or license, appeals from those proceedings, and any other proceedings for a disciplinary action are governed by Chapter 2001, Government Code.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

Sec. 6003.255. REAPPLICATION REQUIREMENTS. (a) An applicant or holder of a registration certificate or license whose certificate or license has been denied, refused, or revoked under this chapter, other than for failure to pass a required written examination, may not file another application for a registration certificate or license before:

- (1) the first anniversary of the effective date of the denial, refusal, or revocation; or
- (2) if judicial review of the denial, refusal, or revocation is sought, before the first anniversary of the date of the final court order or decree affirming the action.

(b) The commissioner may deny an application described by Subsection (a) unless the applicant shows good cause why the denial, refusal, or revocation of the registration certificate or license should not be considered a bar to the issuance of a new registration certificate or license.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

SUBCHAPTER G. CRIMINAL PENALTY

Sec. 6003.301. CRIMINAL PENALTY. (a) A person commits an offense if the person knowingly violates Section 6003.151(a), 6003.153, or 6003.251.

(b) An offense under this section is a Class B misdemeanor.

(c) Venue for an offense under this section is in Travis County or the county in which the offense is committed.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1J.001, eff. April 1, 2009.

TITLE 21. DISCOUNT HEALTH CARE PROGRAMS

CHAPTER 7001. REGISTRATION OF DISCOUNT HEALTH CARE PROGRAM OPERATORS

Sec. 7001.001. DEFINITIONS. In this chapter:

(1) "Discount health care program" means a business arrangement or contract in which an entity, in exchange for fees, dues, charges, or other consideration, offers its members access to discounts on health care services provided by health care providers. The term does not include an insurance policy, certificate of coverage, or other product otherwise regulated by the department or a self-funded or self-insured employee benefit plan.

(2) "Discount health care program operator" means a person who, in exchange for fees, dues, charges, or other consideration, operates a discount health care program and contracts with providers, provider networks, or other discount health care program operators to offer access to health care services at a discount and determines the charge to members.

(3) "Health care services" includes physician care, inpatient care, hospital surgical services, emergency services,

ambulance services, laboratory services, audiology services, dental services, vision services, mental health services, substance abuse services, chiropractic services, and podiatry services, and the provision of medical equipment and supplies, including prescription drugs.

(4) "Marketer" means a person who sells or distributes, or offers to sell or distribute, a discount health care program, including a private label entity that places its name on and markets or distributes a discount health care program, but does not operate a discount health care program.

(5) "Member" means a person who pays fees, dues, charges, or other consideration for the right to participate in a discount health care program.

(6) "Program operator" means a discount health plan program operator.

(7) "Provider" means a person who is licensed or otherwise authorized to provide health care services in this state.

Added by Acts 2009, 81st Leg., R.S., Ch. 1331 (H.B. 4341), Sec. 2, eff. September 1, 2009.

Sec. 7001.002. EXEMPTION. This chapter does not apply to a program operator who is an insurer and who holds a certificate of authority under Title 6, or a health care sharing ministry operated under Chapter 1681.

Added by Acts 2009, 81st Leg., R.S., Ch. 1331 (H.B. 4341), Sec. 2, eff. September 1, 2009.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 455 (S.B. 874), Sec. 5, eff. June 14, 2013.

Sec. 7001.003. RULES. The commissioner shall adopt rules in the manner prescribed by Subchapter A, Chapter 36, as necessary to implement this chapter.

Added by Acts 2009, 81st Leg., R.S., Ch. 1331 (H.B. 4341), Sec. 2, eff. September 1, 2009.

Sec. 7001.004. REGISTRATION REQUIRED. A discount health care program operator may not offer a discount health care program in this state unless the program operator is registered with the department.

Added by Acts 2009, 81st Leg., R.S., Ch. 1331 (H.B. 4341), Sec. 2, eff. September 1, 2009.

Sec. 7001.005. APPLICATION FOR REGISTRATION AND RENEWAL OF REGISTRATION. (a) An applicant for registration under this chapter or an applicant for renewal of registration under this chapter whose information has changed shall submit:

(1) a completed registration application on the form prescribed by the department indicating the program operator's name, physical address, and mailing address and its agent for service of process;

(2) a list of names, addresses, official positions, and biographical information of:

(A) the individuals responsible for conducting the program operator's affairs, including:

(i) each member of the board of directors, board of trustees, executive committee, or other governing board or committee;

(ii) the officers of the program operator; and

(iii) any contracted management company personnel;

and

(B) any person owning or having the right to acquire 10 percent or more of the voting securities of the program operator;

(3) a statement generally describing the applicant, its facilities and personnel, and the health care services or products for which a discount will be made available under its discount health care programs;

(4) a list of the marketers authorized to sell or distribute the program operator's programs under the program operator's name, a list of the marketing entities authorized to private label the program operator's programs, and other information about the marketers and marketing entities considered necessary by the commissioner; and

(5) a copy of the form of all contracts made or to be made between the program operator and any providers or provider networks regarding the provision of health care services or products to

members.

(b) After the initial registration, if the form of a contract described by Subsection (a)(5) changes, the program operator must file the modified contract form with the department before it may be used.

(c) As part of the registration required under Subsection (a), and annually thereafter, the program operator shall certify in writing to the department that its programs comply with the requirements of this chapter and Chapter 562.

Added by Acts 2009, 81st Leg., R.S., Ch. 1331 (H.B. 4341), Sec. 2, eff. September 1, 2009.

Sec. 7001.006. FEES. A discount health care program operator shall pay the department an initial registration fee of \$1,000 and an annual renewal fee in the amount set by the commissioner not to exceed \$500.

Added by Acts 2009, 81st Leg., R.S., Ch. 1331 (H.B. 4341), Sec. 2, eff. September 1, 2009.

Sec. 7001.007. DEPOSIT IN OPERATING ACCOUNT. All fees collected by the department under this chapter shall be deposited to the credit of the Texas Department of Insurance operating account.

Added by Acts 2009, 81st Leg., R.S., Ch. 1331 (H.B. 4341), Sec. 2, eff. September 1, 2009.

Sec. 7001.008. CRIMINAL BACKGROUND CHECK. The department may conduct a criminal background check on:

- (1) the individuals responsible for conducting the program operator's affairs;
- (2) each member of the board of directors, board of trustees, executive committee, or other governing board or committee;
- (3) the officers of the program operator;
- (4) any contracted management company personnel; and
- (5) any person owning or having the right to acquire 10 percent or more of the voting securities of the program operator.

Added by Acts 2009, 81st Leg., R.S., Ch. 1331 (H.B. 4341), Sec. 2, eff. September 1, 2009.

Sec. 7001.009. ENFORCEMENT. (a) The department may deny a registration application or take any action authorized under Chapters 82, 83, and 84 if the department determines that the applicant or registered discount health care program operator, individually or through an officer, director, or shareholder:

(1) has wilfully violated a provision of this code or an order or rule of the commissioner;

(2) has intentionally made a material misstatement in the registration application;

(3) has obtained or attempted to obtain a registration by fraud or misrepresentation;

(4) has misappropriated, converted to the applicant's or registration holder's own use, or illegally withheld money belonging to a member of a discount health care program;

(5) has engaged in fraudulent or dishonest acts or practices; or

(6) has been convicted of a felony.

(b) Chapter 2001, Government Code, applies to an action taken under this section.

Added by Acts 2009, 81st Leg., R.S., Ch. 1331 (H.B. 4341), Sec. 2, eff. September 1, 2009.

CHAPTER 7002. SUPPLEMENTAL PROVISIONS RELATING TO DISCOUNT HEALTH CARE OPERATORS

Sec. 7002.001. DEFINITION. For purposes of Chapters 562 and 7001, Insurance Code, consideration provided to a discount health care program or a discount health care program operator includes patient information or patient prescription drug history provided by members, if the entity engages in the transfer or sale of such patient information, patient prescription drug history, or drug manufacturer rebates.

Added by Acts 2009, 81st Leg., R.S., Ch. 1245 (S.B. 2423), Sec. 3, eff. September 1, 2009.

Sec. 7002.002. REQUIRED DISCLOSURE. If a discount health care program operator engages in the transfer or sale of a member's patient information or patient prescription drug history, the program operator shall, before enrollment, provide each prospective member disclosure materials describing the program operator's practices regarding such transfer or sale.

Added by Acts 2009, 81st Leg., R.S., Ch. 1245 (S.B. 2423), Sec. 3, eff. September 1, 2009.

Sec. 7002.003. VIOLATION; PENALTIES. A violation of this chapter may be enforced in the same manner as a violation of Chapter 562 or 7001.

Added by Acts 2009, 81st Leg., R.S., Ch. 1245 (S.B. 2423), Sec. 3, eff. September 1, 2009.

Sec. 7002.004. EXEMPTION. This chapter does not apply to a health care sharing ministry operated under Chapter 1681.

Added by Acts 2013, 83rd Leg., R.S., Ch. 455 (S.B. 874), Sec. 6, eff. June 14, 2013.